

TRANSGENDER BENEFIT POLICY

DEFINITIONS

Cross Sex-Hormone Therapy means a course of hormone replacement therapy intended to induce or change secondary sex characteristics.

Gender Confirmation Surgery means a surgery to change primary or secondary sex characteristics to affirm a person's gender identity. Also known as gender affirmation surgery or sex reassignment surgery.

Gender Dysphoria means either: gender dysphoria, as defined in the Diagnostic Statistical Manual of Mental Disorders, 5th Edition (DSM-5), codes 302.85 or 302.6; or gender identity disorder, as defined in the International Classification of Disease, 10th Edition (ICD-10), codes F64. 1-9, or Z87.890.

Gonadotropin-Releasing Hormone Therapy means a course of reversible pubertal or gonadal suppression therapy used to block the development of secondary sex characteristics in adolescents.

CLIENT ELIGIBILITY

1. Clients with a clinical diagnosis of gender dysphoria are eligible for the Transgender Benefit, subject to the service-specific criteria and restrictions detailed in the Covered Services section.

PROVIDER ELIGIBILITY

1. Enrolled providers are eligible to provide transgender services if:
 - a. Licensed by the Colorado Department of Regulatory Agencies or the licensing agency of the state in which the provider practices;
 - b. Services are within the scope of the provider's practice; and
 - c. Knowledgeable about gender nonconforming identities and expressions, and the assessment and treatment of gender dysphoria.

COVERED SERVICES

1. Requirements for all covered transgender services:
 - a. Client has a clinical diagnosis of gender dysphoria;
 - b. Requested service is medically necessary, as defined in Section 8.076.1.8;

- c. Any contraindicated medical and behavioral health conditions have been addressed and are well-controlled;
 - d. Client has given informed consent for the service; and
 - e. Subject to the exceptions in C.R.S. §13-22-103, if client is under 18 years of age, client's parent(s) or legal guardian has given informed consent for the service.
2. Requests for services for clients under 21 years of age are evaluated in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program criteria detailed in Section 8.280.

3. **Hormone Therapy**

a. Gonadotropin-Releasing Hormone (GnRH) Therapy

- i) GnRH therapy is a covered service for a client who:
 - 1) Meets the criteria at [Covered Services 1.a. – 1.e.];
 - 2) Is 16 years of age or younger;
 - 3) Exhibits physical changes of puberty consistent with Tanner stage 2 or higher;
 - 4) Has been referred to a licensed behavioral health provider and has a plan in place to receive behavioral health counseling concurrent with GnRH therapy; and
 - 5) Meets the applicable pharmacy criteria at Section 8.800.

b. Cross-Sex Hormone Therapy

- i) Cross-sex hormone therapy is a covered service for a client who:
 - 1) Meets the criteria at [Covered Services 1.a. – 1.e.];
 - 2) Is 16 years of age or older; and
 - 3) Meets the applicable pharmacy criteria at Section 8.800.
- ii) Other cross-sex hormone therapy requirements
 - 1) Prior to beginning cross-sex hormone therapy:
 - a) A licensed behavioral health provider, with whom the client has an established and ongoing relationship, must determine that any behavioral health conditions or concerns have been addressed and are well-controlled.
 - 2) For the first twelve (12) months of cross-sex hormone therapy:
 - a) Client must receive ongoing behavioral health counseling at a frequency determined to be clinically appropriate by the behavioral health provider; and

- b) Client must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.

4. **Surgical Procedures**

- a. A surgical procedure listed in Section [4.b. – 4.d.] is a covered service for a client who:
 - i) Meets the criteria at [Covered Services 1.a. – 1.d.];
 - ii) Is 18 years of age or older;
 - iii) Has lived in the preferred gender role for twelve (12) continuous months;
 - iv) Has completed twelve (12) continuous months of hormone therapy, unless medically contraindicated;
 - v) Has been evaluated by a licensed medical provider within the past sixty (60) days; and
 - vi) Has been evaluated by a licensed behavioral health provider within the past sixty (60) days.

- b. Covered genital surgeries are limited to the following:
 - i) Ovariectomy/oophorectomy
 - ii) Salpingo-oophorectomy
 - iii) Hysterectomy
 - iv) Vaginectomy
 - v) Vulvectomy
 - vi) Metoidioplasty
 - vii) Phalloplasty
 - viii) Erectile prosthesis
 - ix) Scrotoplasty
 - x) Testicular prostheses
 - xi) Urethroplasty
 - xii) Orchiectomy
 - xiii) Penectomy
 - xiv) Prostatectomy
 - xv) Clitoroplasty
 - xvi) Vaginoplasty

- xvii) Vulvoplasty
 - xviii) Labiaplasty
 - xix) Permanent hair removal to treat surgical tissue donor sites
- c. Covered breast/chest surgeries are limited to the following:
- i) Mastectomy
 - ii) Mammoplasty is covered when:
 - 1) Client has completed twenty-four (24) continuous months of hormone therapy that has proven ineffective for breast development, unless medically contraindicated.
 - iii) Permanent hair removal to treat surgical tissue donor sites
- d. Pre- and post-operative services are covered when:
- i) Related to a covered surgical procedure included in [Covered Services 4. Surgical Procedures]; and
 - ii) Medically necessary, as defined in Section 8.076.1.8.
5. Behavioral health services are covered in accordance with Section 8.212.

PRIOR AUTHORIZATION

- 1. Prior authorization for hormone therapy services listed in Section [3.a. – 3.b.] must be submitted in accordance with the requirements in Section 8.800.7.
- 2. Prior authorization is required for all surgical procedures listed in Section [4.b. – 4.c].
 - a. Prior authorization requests must include both:
 - i) A signed statement from a licensed behavioral health provider, with whom the client has an established and ongoing relationship, demonstrating that:
 - 1) Criteria in [Covered Services 4. Surgical Procedures a.(i) – (iv) and (vi)] have been met; and
 - 2) A post-operative care plan is in place.
 - ii) A signed statement from a licensed medical provider, with whom the client has an established and ongoing relationship, demonstrating:
 - 1) Criteria in [Covered Services 4. Surgical Procedures a.(i) – (v)] have been met; and
 - 2) A post-operative care plan is in place.

3. All prior authorization requests must provide documentation demonstrating that requirements listed in Covered Services section have been met.

NON-COVERED SERVICES

1. The following services are not covered under the Transgender Benefit:
 - a. Any service not listed in [Covered Services section].
 - b. Any items or services excluded from coverage under Section 8.011.1.
 - c. Reversal of surgical procedures listed in [Covered Services section].

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