**Transgender Services Benefit**

Providers must be enrolled as a Health First Colorado provider in order to:
- Treat a Health First Colorado member; and,
- Submit claims for payment to Health First Colorado.

Enrolled providers are eligible to provide transgender services if:
- The provider is licensed by the Colorado Department of Regulatory Agencies or the licensing agency of the state in which the provider practices;
- The services are within the scope of the provider’s practice; and,
- The provider is knowledgeable about gender non-conforming identities and expressions and the assessment and treatment of gender dysphoria.

Health First Colorado provides transgender services benefits to eligible members. Providers should refer to the Code of Colorado Regulations, Program Rules (10 CCR 2505-10 8.735), for specific information when providing these benefits.

**Member Eligibility**

Members with a clinical diagnosis of gender dysphoria are eligible for the transgender services benefit, subject to the service-specific criteria and restrictions detailed in 10 CCR 2505-10 8.735.5:
- Client has a clinical diagnosis of gender dysphoria;
- Requested service is medically necessary, as defined in section 8.076.1.8;
- Any contraindicated medical and behavioral health conditions have been addressed and are well-controlled;
- Client has given informed consent for the service; and,
- 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.

**Members Under 21 Years of Age**

Requests for services for members 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.

**Covered Services**

**Hormone Therapy**

Covered hormone therapy services are limited to Gonadotropin-Releasing Hormone Therapy and Cross-Sex Hormone Therapy.

**Gonadotropin-Releasing Hormone Therapy**

Gonadotropin-Releasing Hormone Therapy (GnRH) is a course of reversible pubertal or gonadal suppression therapy used to block the development of secondary sex characteristics in adolescents. GnRH therapy is a covered service for a client who:
- Meets the Member Eligibility criteria listed above;
- Meets the applicable pharmacy criteria at section 8.800; and,
- Has been referred to a licensed behavioral health provider and has a plan in place to receive
behavioral health counseling concurrent with GnRH therapy.

**Cross Sex-Hormone Therapy**

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

Cross-sex hormone therapy is a covered service for a client who:

- Meets the Member Eligibility criteria listed above; and
- Meets the applicable pharmacy criteria at section 8.800.

Other cross-sex hormone therapy requirements include:

- Prior to beginning cross-sex hormone therapy, 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.
- For the first twelve (12) months of cross-sex hormone therapy:
  - Client must receive ongoing behavioral health counseling at a frequency determined to be clinically appropriate by the behavioral health provider; and,
  - Client must receive medical assessments at a frequency determined to be clinically appropriate by the prescribing provider.

**Surgical Procedures**

Gender Confirmation Surgery means a surgery to change primary or secondary sex characteristics to affirm a person’s gender identity. This is also known as gender affirmation surgery or sex reassignment surgery.

Covered surgical procedures are benefits to a member who:

- Meets the Member Eligibility criteria listed above;
- Is 18 years of age or older;
- Has lived in the preferred gender role for twelve (12) continuous months;
- Has completed twelve (12) continuous months of hormone therapy, unless medically contraindicated;
- Has been evaluated by a licensed medical provider within the past sixty (60) days; and,
- Has been evaluated by a licensed behavioral health provider within the past sixty (60) days.

Rendering surgical providers must retain the following documentation for each client:

- A signed statement from a licensed behavioral health provider, with whom the client has an established and ongoing relationship, demonstrating that:
  - Surgical procedure criteria have been met (8.735.5.E.1.a-d and f.); and,
  - A post-operative care plan is in place.
- A signed statement from a licensed medical provider, with whom the client has an established and ongoing relationship, demonstrating that:
  - Surgical procedure criteria have been met (8.735.5.E.1.a-e.); and,
  - A post-operative care plan is in place.

**Covered Genital Surgeries**

- Ovariectomy/oophorectomy
- Salpingo-oophorectomy
- Hysterectomy
- Vaginectomy
- Vulvectomy
• Metoidioplasty
• Phalloplasty
• Erectile prosthesis
• Scrotoplasty
• Testicular prostheses
• Urethroplasty
• Orchiectomy
• Penectomy
• Prostatectomy
• Clitoroplasty
• Vaginoplasty
• Vulvoplasty
• Labiaplasty

**Covered Breast/Chest Surgeries**

• Mastectomy
• Mammaplasty
  - Mammaplasty is covered when a member has completed twenty-four (24) continuous months of hormone therapy that has proven ineffective for breast development, unless medically contraindicated.

**Pre- and Post-Operative Services**

Pre- and Post-Operative services are covered when related to a covered surgical procedure and medically necessary, as defined in 10 CCR 2505-10 8.076.1.8. Pre-surgical permanent hair removal/ electrolysis to treat surgical sites is a covered benefit.

**Physical Therapy**

Outpatient physical therapy is a covered benefit. Please refer to the [Outpatient PT/OT website](#) for details.

**Documentation**

Rendering surgical providers must retain the following documentation for each member:

- A signed statement from a licensed behavioral health provider, with whom the member has an established and ongoing relationship, demonstrating that:
  - Surgical procedure criteria have been met (10 CCR 2505-10 8.735.5.E.1.a-d and f); and,
  - A post-operative care plan is in place.

- A signed statement from a licensed medical provider, with whom the client has an established and ongoing relationship, demonstrating:
  - Surgical procedure criteria have been met (10 CCR 2505-10 8.735.5.E.1.a-e); and,
  - A post-operative care plan is in place.

**Non-Covered Services**

The following services are not covered under the transgender services benefit:

- Reversal of covered surgical procedures
- Any items or services excluded from coverage under 10 CCR 2505-10 8.011.1
Billing Information

Refer to the General Provider Information Manual for general billing information.

Gender-Specific Procedures

Many procedures that are restricted to a transgender member’s assigned sex at birth will still be medically necessary after legally changing their gender. If a gender-specific procedure conflicts with the member’s identified gender in the Colorado Benefits Management System (CBMS), please follow the billing guidance below:

- **CMS-1500/837P Claims**: Attach the KX modifier to the appropriate line items.
- **UB-04/837I Claims**: Attach condition code 45 to indicate a procedure is medically necessary despite a gender conflict.

The KX modifier and condition code 45 will allow the Department to identify and reprocess these claims.

Prior Authorization Requests

All prior authorization requests must provide documentation demonstrating that the applicable requirements in 10 CCR 2505-10 8.735.5 have been met. Prior authorization requests must be submitted in accordance with the requirements in 10 CCR 2505-10 8.800.7.

For all covered services, general requirements for prior authorization requests include:

- Member has a clinical diagnosis of gender dysphoria;
- Requested service is medically necessary, as defined in 10 CCR 2505-10 8.076.1.8;
- Any contraindicated medical and behavioral health conditions have been addressed and are well-controlled;
- Member has given informed consent for the service; and,
- Subject to the exceptions in C.R.S. §13-22-103, if the member is under 18 years of age, client’s parent(s) or legal guardian has given informed consent for the service.

For hormone therapy services, in addition to the above general requirements, the member’s health care provider shall provide any information requested by the Fiscal Agent including, but not limited to:

- Member name, Health First Colorado identification number, and birth date;
- Name of the drug(s) requested;
- Strength and quantity of drug(s) requested; and,
- Prescriber’s name and medical license number, Drug Enforcement Administration number, or National Provider Identifier

For surgical procedures, in addition to the above general requirements, prior authorization requests must provide documentation demonstrating that the member:

- Is 18 years of age or older;
- Has lived in the preferred gender role for twelve (12) continuous months;
- Has completed twelve (12) continuous months of hormone therapy, unless medically contraindicated;
- Has been evaluated by a licensed medical provider within the past sixty (60) days; and
- Has been evaluated by a licensed behavioral health provider within the past sixty (60) days.
# Revision Log

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<td>Creation of Transgender Services manual</td>
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