ETHICS AND PUBLIC POLICY CENTER

November 14, 2025

Submitted via email to nchsicd10cm@cdc.gov

ICD-10 Coordination and Maintenance Committee
Centers for Disease Control and Prevention (CDC)
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: **ICD-10-CM Committee and HHS Consideration of Proposed Codes for "Gender Identity Disorder, in Remission (Desistance)"**

Dear Committee Members:

We are scholars at the Ethics and Public Policy Center (EPPC). Mary Rice Hasson is the Kate O'Beirne Senior Fellow at EPPC, an attorney, and co-founder of EPPC's Person and Identity Project, an initiative that equips parents and faith-based institutions to counter gender ideology and promote the truth of the human person. Rachel Morrison is an EPPC Fellow, the director of EPPC's ASAP, and a former attorney with the Equal Employment Opportunity Commission. Eric Kniffin is an EPPC Fellow, member of EPPC's Administrative State Accountability Project (ASAP), and a former attorney in the U.S. Department of Justice's (DOJ) Civil Rights Division.

We write to offer public comment on the Committee's and the Department of Health and Human Services' (HHS) consideration of the proposed ICD-10 codes for "Gender Identity Disorder, in Remission (Desistance)," copied below, that were presented to the ICD-10 Coordination and Maintenance Committee during its meeting on September 10, 2025.

Add the following codes:

- F64.A Gender identity disorder, in remission (desistance)
- F64.B Post transition Distress
- Z87.893 Personal history of gender transition, social
- Z87.894 Personal history of detransition

Split the current code, "Z87.890 Personal history of sex reassignment" into:

- Z87.8901 Personal history of sex reassignment, surgical
- Z87.8902 Personal history of sex reassignment, medical

We support the addition of new ICD-10 codes, such as the ones proposed, to account for the medical needs of those who previously underwent, but then discontinued, sex-rejecting[1] social, hormonal, or surgical interventions. Our comments briefly address the historical context and need for these codes, before offering some caveats and suggestions on the specific language in the proposed codes.

Historical Context and Need for Proposed Codes

Over the past decade, the number of individuals experiencing identity- or body-related distress, typically diagnosed as "gender identity disorder" or "gender dysphoria,"[2] has risen dramatically. This sharp increase has been accompanied by a significant shift in patient demographics, from predominately male to predominately female, and—in minors—from predominately childhood onset to onset in adolescence or later.[3]

The treatment protocols also have changed over time. Traditional approaches, which for decades eschewed medical interventions for identity-distressed minors, were displaced first by the controversial Dutch Protocol, which prescribed drugs with permanent effects (puberty suppressing drugs and masculinizing/feminizing hormones) to identity-distressed minors, alongside psychiatric assessment and treatment. By 2015, the Dutch Protocol had given way to an accelerated, child-led model of sex-rejection and body modification often called "gender-affirming care," which encouraged social "transition" (i.e., changes to name, pronouns, hair and clothing styles, as well as breast binding and genital tucking), promoted early use of puberty-suppressing drugs, endorsed masculinizing/feminizing hormones for young teens, and approved breast and genital surgeries with no minimum age requirements. This "affirmative" model requires minimal psychological assessment for minors,[4] and none at all for older teens and young adults who are able to access hormones through "informed consent clinics," such as Planned Parenthood or Folx.[5]

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[1] *Cf.* Eric Kniffin, Mary Rice Hasson, & Rachel N. Morrison, Terminology and Definition: Replacing "Gender-Affirming Care" with "Sex-Rejecting Procedures," EPPC, May 2, 2025, https://eppc.org/wp-content/uploads/2025/05/Replacement-Term-for-GAC.pdf.

[2] The experience of identity-or body-related distress is typically diagnosed as "gender identity disorder" under the ICD-10 (F-64 and related codes) or, additionally or alternatively, diagnosed as "gender dysphoria" under the DSM-5-TR. For purposes of this comment, we will refer only to the relevant diagnoses under the ICD-10.

[3] Office of Population Affairs, HHS, Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, May 2025, https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf.

[4] Boston Children's Hospital, which opened the first U.S. gender clinic in 2007, initially aspired to provide a lengthy Dutch-style psychological assessment, but by 2018 was spending only two hours "assessing" children before approving them for medical interventions. Benjamin Ryan, '*Shocking and Reckless': Top Gender Clinic Assesses Children for Gender-Altering Medical Treatment in Just 2 Hours, Lawsuit Lays Bare*, New York Sun (Oct. 31, 2024), https://www.nysun.com/article/shocking-and-reckless-top-gender-clinic-assesses-children-for-gender-altering-medical-treatments-in-just-2-hours-lawsuit-lays-bare?member_gift=CUZ5qwd3crq4pmz-xrd.

[5] See, for example, Virginia League for Planned Parenthood, https://www.plannedparenthood.org/planned-parenthood-virginia-league/for-patients/transgender-services, and Folx, https://www.folxhealth.com/gender-affirming-care.

By 2020, both the Dutch Protocol and the "gender-affirming care" model faced growing criticism and serious scrutiny.[6] Multiple systematic evidence reviews have now demonstrated that these approaches rested on "weak," "low" quality evidence.[7] The positive outcomes initially reported by the Dutch researchers not only were not replicated by the subsequent, more rigorous research, they were contradicted in significant respects.[8]

The experiences of young people who underwent these controversial sex-rejecting procedures as minors—but later regretted them—began to trickle out and, by 2024, became impossible to ignore. Their public testimonies (and in some cases, lawsuits) against "gender-affirming" medical providers exposed the irreparable harm caused by those earlier interventions.[9] Twenty-seven states to date have recognized the harms of sex-rejecting procedures in minors and passed legislation to restrict or ban them.[10]

But these testimonies also exposed an ongoing harm: the injuries and ongoing healthcare needs of those who underwent sex-rejecting procedures—and subsequently discontinued those procedures—are invisible to the medical system. There is no recognized name for this population. Colloquially, some call themselves "detransitioners." However, studies show that not all individuals who have abandoned the use of sex-rejecting procedures embrace the term "detransitioner," as the motives for terminating sex-rejecting procedures are varied, including unwanted side effects as well as embracing one's given sexual identity as male or female.[11] Regardless of individual motivations for discontinuing these interventions, the medical needs of this population are complex. There is no systematic way of tracking how many individuals fall into this category or of describing their specific medical needs. There is no recognized label for their condition or its characteristic injuries, symptoms, and outcomes. There are no protocols to

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[6] Riittakerttu Kaltiala, *Gender-Affirming Care is Dangerous. I Know, Because I Helped Pioneer It,* The Free Press (Oct. 30, 2023), https://www.thefp.com/p/gender-affirming-care-dangerous-finland-doctor.

[7] Office of Population Affairs, HHS, Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, May 2025, https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf; Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report, Apr. 2024, https://cass.independent-review.uk/home/publications/final-report/.

[8] Michael Biggs, *The Dutch Protocol for Juvenile Transsexuals: Origins and Evidence*, Journal of Sex & Marital Therapy, 49:4, 348-368 (2023), https://pubmed.ncbi.nlm.nih.gov/36120756/; Office of Population Affairs, HHS, Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, May 2025, https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf; Hilary Cass, Independent Review of Gender Identity Services for Children and Young People: Final Report, April 2024, https://cass.independent-review.uk/home/publications/final-report/.

[9] *See, e.g.,* Chloe Cole testimony before Congress in 2023. Josh Christenson, *Detransitioner Tells Congress Her "Childhood was Ruined' by Gender Reassignment*, New York Post (July 27, 2023), https://nypost.com/2023/07/27/detransitioner-tells-congress-her-childhood-was-ruined-by-gender-reassignment/. *See generally U.S. Detransitioner Cases*, Themis Resource Fund (2025), https://themisresourcefund.org/detransitioner-cases/ (collecting "detransitioner" lawsuits).

[10] *See* Appendix B, EPPC Comment on HHS-CMS Proposed Rule, "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability," RIN 0938-AV61, CMS-9884-P (April 11, 2025), https://eppc.org/wp-content/uploads/2025/04/EPPC-Comment-HHS-PPACA-Markeplace-Integrity-rev.pdf (collecting state laws restricting sex-rejecting procedures).

[11] Kinnon R. MacKinnon, et al., *Exploring the Gender Care Experiences and Perspectives of Individuals Who Discontinued Their Transition or Detransitioned in Canada*, 18 PLoS ONE e0293868 (2023), https://doi.org/10.1371/journal.pone.0293868.

guide physicians in ways to help these vulnerable patients reverse the damage done by de-masculinizing and de-feminizing interventions. A small but growing body of research on this population gives some answers but, on the whole, reinforces how much we still don't know.[12]

Without appropriate diagnostic codes to indicate the etiology of their condition, and its current manifestation, these patients—and their injuries—are invisible to the healthcare system. They are seeking to recover their health and to alleviate suffering that is a direct result of a zealous, ideology-driven experiment, unsupported by reliable medical evidence. The Committee and HHS should, as a matter of justice, do what it can to help provide the structural framework, including appropriate medical codes, that will permit the healthcare system to respond effectively and systematically to their needs.

Furthermore, adopting medical codes, such as those presented at the Committee's September 10 meeting, aligns with President Trump's policy priorities to protect children from "chemical and surgical mutilation," combat gender ideology extremism, restore biological truth to the federal government, and Make America Healthy Again (MAHA).[13]

Support, Caveats, and Suggestions re: Proposed Codes

Below we address each proposed code in turn, explaining our support and providing some caveats and suggestions concerning the specific language used for certain codes.

F64.A Gender identity disorder, in remission (desistance): We support the proposed language. "Gender identity disorder" is a recognized disorder in the ICD-10, and the concept of "remission" is found elsewhere in the ICD-10, applied in a similar way for other disorders when the underlying disorder has abated or is no longer symptomatic or causing distress or injury. We have concerns over the use of "desistance," as it is undefined in the ICD-10. "Desistance" typically "refers to the waning of gender dysphoria prior to medical gender transition,"[14] and the proposed code presumably is intended to apply to remission of "gender identity disorder," whether prior to or after sex-rejecting medical or surgical procedures.

F64.B Post transition Distress: We support the concept of a code that captures the phenomenon of distress that occurs after, and is related to, sex-rejecting procedures. However, the term "transition" is used elsewhere in the ICD-10 to convey a meaning unrelated to "gender identity disorder." It appears, for example, as a "Z" code to describe "problems of adjustment to life-cycle transitions" (Z60.0), a phase of life descriptor, and as a counseling descriptor related to

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[12] *See generally* Office of Population Affairs, HHS, Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, May 2025, https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf (summarizing research and discussing issues more broadly).

[13] *See, e.g.*, Exec. Order 14187, Protecting Children From Chemical and Surgical Mutilation, 90 Fed. Reg. 8771 (Jan. 28, 2025), https://www.federalregister.gov/d/2025-02194; Exec. Order 14187, Protecting Children From Chemical and Surgical Mutilation, 90 Fed. Reg. 8771 (Jan. 20, 2025), https://www.federalregister.gov/d/2025-02194; Exec. Order 14212, Establishing the President's Make American Healthy Again Commission, 90 Fed. Reg. 9833 (Feb. 13, 2025), https://www.federalregister.gov/d/2025-02871.

[14] Lisa Littman, et al., *Detransition and Desistance Among Previously Trans-Identified Young Adults*, 53 Arch. Sex. Behav. 57 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10794437/.

"pediatric to adult transition," (Z71.87). We believe it is unwise to include the term "transition" in the proposed code because "transition" is undefined in the context of "gender identity disorder," and is used to convey different meanings elsewhere in the ICD-10. The term "post transition" is also ambiguous; it is unclear whether this code applies only to situations where distress is experienced after sex-rejecting interventions were undertaken and then discontinued, or whether it also applies to situations where distress is experienced after sex-rejecting interventions have begun but are still ongoing. We urge the Committee and HHS to consider adopting alternative language. Replacing "transition" with "treatment" would solve the problem: "**gender identity disorder, post-treatment distress**." Significantly, post-treatment distress could occur at any point after treatment—whether treatment is ongoing or discontinued—and would not be contingent on whether a "transition" is achieved.

Z87.893 Personal history of gender transition, social: We support this code, in concept. However, we have concerns about using a term—"gender transition"—that is not defined and open to interpretation. We urge the Committee and HHS to consider adopting alternative language that is clear on its face. Replacing "gender transition" with "sex rejection" would solve the problem: "**personal history of sex rejection, social.**"

Z88.894 Personal history of detransition: We support this code in concept. However, we have concerns about using a term—"detransition"—that is not defined and open to interpretation. In addition, not all individuals who discontinue the use of sex-rejecting procedures do so because they have embraced their given sexual identity as male or female. Regardless of motivation for discontinuance, these individuals face the same difficulty: complex health needs that often go unaddressed and that are not reflected in medical codes. We urge the Committee and HHS to consider adopting alternative language that is more closely tied to the discontinuance of specific medical interventions. Replacing "detransition" with discontinuance of sex-rejecting procedures would solve the problem: "**Personal history of discontinuence of sex-rejecting procedures**" or "**Personal history of sex-rejecting procedures, discontinued**."

Z87.8901 Personal history of sex reassignment, surgical and **Z87.8902 Personal history of sex reassignment, medical:** We support these codes in concept, particularly the need for two distinct codes, because the kinds of sex-rejecting ("sex reassignment") procedures that a person might pursue are varied, with significant differences accruing to medical versus surgical interventions. It makes sense to split the old code into two—one for surgical and one for medical history of "sex reassignment"—in order to better account for the differences.

However, we have concerns about the use of the term "sex reassignment." Sex is an immutable characteristic that is neither assigned nor "reassigned."[15] As we have proposed elsewhere, a more accurate term to describe these procedures is "sex-rejecting procedures."[16] As

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[15] *See* Colin M. Wright, *Why There Are Exactly Two Sexes*, Arch. Sex. Behav., Nov. 2025, https://link.springer.com/article/10.1007/s10508-025-03348-3.

[16] *See* Eric Kniffin, Mary Rice Hasson, & Rachel N. Morrison, Terminology and Definition: Replacing "Gender-Affirming Care" with "Sex-Rejecting Procedures," EPPC, May 2025, https://eppc.org/wp-content/uploads/2025/05/Replacement-Term-for-GAC.pdf; *see also* EPPC Scholars Comment for EO 12866 Meeting on RIN 0938-AV87 and RIN0938-AV73 at 4 (Aug. 28, 2025), https://eppc.org/wp-content/uploads/2025/08/EPPC-Comment-for-EO-12866-Meeting-on-CMS-Proposed-Rules.pdf (documenting

such, we propose using that more accurate term here: "**Personal history of sex-rejecting procedures, surgical**" and **"Personal history of sex-rejecting procedures, medical**."

We also note that there are Z codes that pertain to a "follow-up examination" (Z09) or an "encounter for other aftercare and medical care" (Z51) related to other medical conditions. We suggest consideration of similar language for new Z codes for "follow-up" or "aftercare" related to "gender identity disorder" or "sex-rejecting procedures." For example, new Z codes that contain the following language might prove helpful to clinicians: "**sex-rejecting procedures, follow-up examination**," "**sex-rejecting procedures, encounter for other aftercare and medical care**," or "**gender identity disorder, encounter for other aftercare and medical care**."

Conclusion

We are grateful to the Committee and to HHS for consideration of our public comment on the proposed codes for "Gender Identity Disorder, in Remission (Desistance)." We urge the Committee to recommend and HHS to adopt new codes in light of the above caveats and suggestions.

Sincerely,

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growing consensus around the term "sex-rejecting procedures," including its support by "leading organizations, medical professionals, attorneys, and parents seeking to protect children and others from gender ideology" and its use "by individuals and organizations in various outlets from op-eds to court briefs to describe federal actions, Trump Administration policies, state laws, and court decisions involving the medical procedures").