ETHICS AND PUBLIC POLICY CENTER

April 17, 2026

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: Transition and Detransition Codes"**

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 Administrative State Accountability Project (ASAP), and a former attorney with the Equal Employment Opportunity Commission. Eric Kniffin is an EPPC Fellow, member of EPPC's 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: Transition and Detransition Codes," copied below, that were presented to the ICD-10 Coordination and Maintenance Committee during its meeting on March 17, 2026.

First, we thank the Committee and HHS for adding the new code F64.A "Gender identity disorder, in remission; Gender Dysphoria, in remission (desistance)," and for considering revised proposed codes related to detransition and sex-rejecting interventions.[1] These codes are much needed.

[1] *See* Eric Kniffin, Mary 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/2025/09/Replacement-Term-for-GAC.pdf (proposing the term "sex-rejecting procedures" as a replacement for "gender-affirming care" and other terms for "medical procedures connected with a so-called 'gender transition'"); Press Release, Dep't of Health & Hum. Servs, HHS Acts to Bar Hospitals from Performing Sex-Rejecting Procedures on Children (Dec. 18, 2025), https://www.hhs.gov/press-room/hhs-acts-bar-hospitals-performing-sex-rejecting-procedures-children.html (using the term "sex-rejecting procedures" to discuss medical interventions for gender dysphoria, including puberty-suppressing hormones, cross-sex hormones, and surgical

Second, we urge the Committee and HHS, as a matter of justice, to exercise their authority to provide the structural framework—including adopting medical codes—to facilitate medicine's systematic and effective response to the complicated medical needs of individuals who discontinue sex-rejecting procedures and desire to restore their bodies to health and wholeness, consistent with their given sex.

Brief Historical Context for Revised Proposed Codes

In our November 2025 comment on the prior September 2025 proposal, we briefly addressed the historical context for these codes.[2] The demographics and treatment protocols related to "gender identity disorder" have changed dramatically over the past decade, upending clinical assumptions and exposing significant gaps in the care of individuals undergoing—and discontinuing—sex-rejecting procedures. The difficulties of young people who have undergone these controversial sex-rejecting procedures as minors—and later discontinued them—are impossible to ignore. Their public testimonies (and in some cases, lawsuits) against "gender-affirming" medical providers have exposed the irreparable harm caused by those earlier interventions.[3]

Since our November 2025 comment, new research has emerged to further discredit claims that sex-rejecting procedures for minors provide mental health benefits and prevent suicide. A well-designed 2026 study from Finland found that the data "does not support the suggested improvement in mental health after medical [gender reassignment] initiated during developmental years."[4] The researchers went on to note that "in some individuals, medical [gender reassignment] appears to be linked to deterioration in mental health."[5] The new results align with a 2020 Swedish study of gender dysphoric adults, which found no difference in utilization of mental health services (psychiatric medications, visits to psychiatric providers, and

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procedures); Off. of the Sec'y, Dep't of Health & Human Servs., Declaration Re: Safety, Effectiveness, and Professional Standards of Care for Sex-Rejecting Procedures on Children and Adolescents, Dec. 2025 (defining "sex-rejecting procedures" as "pharmaceutical or surgical interventions, including puberty blockers, cross-sex hormones, and surgeries such as mastectomies, vaginoplasties, and other procedures, that attempt to align an individual's physical appearance or body with an asserted identity that differs from the individual's sex.").

[2] EPPC Comment re: ICD-10-CM Committee and HHS Consideration of Proposed Codes for "Gender Identity Disorder, in Remission (Desistance)" at 2-4 (Nov. 14, 2025), https://media.eppc.org/2025/11/EPPC-Comment-on-Proposed-ICD-10-Codes.pdf.

[3] Detransitioner Chloe Cole spoke on this matter in her 2023 testimony before Congress. *See* Josh Christenson, *Detransitioner Tells Congress Her 'Childhood Was Ruined' by Gender Reassignment*, N.Y. 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).

[4] Sami-Matti Ruuska, et al., *Psychiatric Morbidity Among Adolescents and Young Adults Who Contacted Specialised Gender Identity Services in Finland in 1996–2019: A Register Study* at 6, Acta Paediatrica (Apr. 4, 2026), https://onlinelibrary.wiley.com/doi/10.1111/apa.70533.

[5] *Id.* at 7. In an interview with journalist Benjamin Ryan, one of the study's primary authors, Riittakerttu Kaltiala, clarified that the increase in psychiatric services reflected specialty services provided for severe mental health disorders, not routine counseling. Benjamin Ryan, *The Author of a Controversial Finnish Study on Youth Gender Care Responds to Critics*, Hazard Ratio Substack (Apr. 16, 2026), https://benryan.substack.com/p/the-author-of-the-controversial-finnish.

hospitalizations after suicide attempts) by adults who had undergone sex-rejecting surgeries, compared with those who had not.

Suicide in transgender-identified individuals is, thankfully, rare—a finding reported in several recent studies and conceded by ACLU attorney Chase Strangio in oral argument before the Supreme Court.[6] Contrary to activists' claims, there is no evidence that sex-rejecting procedures prevent suicide.[7] The small increase in suicide risk noted among adolescents diagnosed with gender dysphoria is linked to the psychiatric co-morbidities of those individuals—not the diagnosis of gender dysphoria.[8] At the same time, policymakers and legal advocates express growing concern over the harms of sex-rejecting procedures, and the wellbeing and medical needs of individuals who have discontinued the use of sex-rejecting procedures. A jury in New York recently returned a $2 million medical malpractice verdict for a young woman who, after initially rejecting her sex and undergoing a double mastectomy, quickly regretted those actions.[9] Like others who have discontinued sex-rejecting procedures, she now faces an uncertain medical future, compounded by the lack of medical codes to diagnose and treat the consequent harm.[10]

Importantly, patient testimonies exposed not only the damage done by past sex-rejecting procedures, but also the reality of ongoing harm from the detransitioning process and lack of medical care specific to their needs. No recognized diagnostic term exists to capture the experiences of this population, or their characteristic injuries, symptoms, and outcomes. Colloquially, some self-describe as "detransitioners." However, not all individuals who have

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[6] Leor Sapir, *ACLU Attorney Confesses: Transgender-Suicide Claim is a Myth*, City Journal (Dec. 5, 2024), https://www.city-journal.org/article/aclu-attorney-confesses-transgender-suicide-claim-is-a-myth; Michael Biggs, *Puberty blockers and suicidality in adolescents suffering from gender dysphoria*, 49 Arch. Sex. Behav. 2227 (2020); Louis Appleby, Dep't of Health and Social Care (UK), *Review of Suicides and Gender Dysphoria at the Tavistock and Portman NHS Foundation Trust: Independent Report* (July 2024), https://www.gov.uk/government/publications/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust/review-of-suicides-and-gender-dysphoria-at-the-tavistock-and-portman-nhs-foundation-trust-independent-report.

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

[8] Sami-Matti Ruuska, et al., *All-cause and suicide mortalities among adolescents and young adults who contacted specialised gender identity services in Finland in 1996–2019: A register study*. 27 BMJ Mental Health e300940 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10875569/. More generally, research consistently shows higher rates of suicidality in individuals who have undergone sex-rejecting procedures, with the average time to suicide about six years after initiating sex-rejecting interventions. CM Wiepjes, et al., *Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017)*, 141 Acta Psych. Scand. 486 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC7317390/.

[9] *See* Benjamin Ryan, *A Legal First That Could Change Gender Medicine*, The Free Press (Feb. 1, 2026), https://www.thefp.com/p/a-legal-first-that-could-change-gender; Andrew Jacobs, *Woman Wins Malpractice Suit Over Gender Surgery as a Minor*, N.Y. Times (Feb. 3, 2026), https://www.nytimes.com/2026/02/03/health/gender-surgery-malpractice-varian.html.

[10] Shane Galvin, *Detransitioner wins $2 million* against *New York docs who pushed double mastectomy*, N.Y. Post (Jan. 31, 2026), https://nypost.com/2026/01/31/us-news/detransitioner-wins-2-million-against-new-york-docs-who-pushed-double-mastectomy/.

abandoned the use of sex-rejecting procedures embrace the term "detransitioner." Motives for terminating sex-rejecting procedures vary, encompassing, for example, isolation and lack of support, the desire to stop or prevent unwanted side effects, and the desire to embrace one's given sexual identity as male or female.[11]

Regardless of individual motivations for discontinuing sex-rejecting interventions, the medical needs of this population are complex. The current coding system prevents systematic tracking of the numbers of individuals in this category, their specific histories of sex-rejecting procedures, and the consequent medical needs. No protocols exist to guide physicians in how to assess the physical status of these vulnerable patients, to anticipate future complications, or to reverse the damage done by sex-rejecting procedures. A small but growing body of research on this population provides some answers, but, on the whole, raises more questions, reinforcing how much we still don't know.[12]

Need for and Benefit of Revised Proposed Codes

"Detransition"—an individual's decision to stop sex-rejecting interventions and embrace his or her sex—is an emerging area of medical practice. In the absence of appropriate diagnostic codes, patients with a history of "gender identity disorder" or sex-rejecting procedures—and their injuries—are invisible to the healthcare system. Their treatment needs are unacknowledged and underserved.[13] As the CDC itself notes, developing accurate codes would "allow providers to more accurately document an individual's clinical state," "support the appropriate delivery of care," and "the resultant clinical data" would "support and improve the quality of care for patients" who detransition.[14] Young people who have discontinued the use of sex-rejecting procedures make the same point.[15]

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[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.

[12] *See generally* Off. of Pop. Affs., 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] Elie Vandenbussche, *Detransition-Related Needs and Support: A Cross-Sectional Online Survey*, 69 J. Homosexuality 1602, 1611 (2022), https://www.tandfonline.com/doi/full/10.1080/00918369.2021.1919479 (detransitioners reported "negative experiences with medical professionals" and "strong difficulties finding the help that they needed during their detransition process"); Nora Hesse et al., *A Qualitative Metasummary of Detransition Experiences*, PLoS ONE (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11091498/ ("there is currently no guidance to support providers working with individuals who detransition and informal resources are scarce. In practice, this means that individuals who detransition may have unmet health needs, while providers may be unaware of or unprepared to respond to the diversity of detransition experiences and trajectories." (citations omitted)).

[14] ICD-10 Coordination and Maintenance Committee Meeting March 17-18, 2026, ICD-10 CM Diagnosis Agenda, at 59, https://www.cdc.gov/nchs/data/icd/topic-packet-March-2026.pdf.

[15] *Detransitioners need more than one day of recognition: They need diagnosis codes*, Do No Harm, March 12, 2025, https://donoharmmedicine.org/in-the-news/2025/03/12/detransitioners-need-more-than-one-day-of-recognition-they-need-diagnosis-codes/.

Over the past few decades, the medical system has perpetrated an ideologically driven "gender" experiment, unsupported by reliable medical evidence, on an undefined population of vulnerable minors and adults.[16] Some of those treated have stopped, or will stop, using sex-rejecting procedures and re-identify with their sex. This number is likely to increase significantly in coming years, as the social contagion of gender ideology wanes[17] and a cohort of patients whose interventions began in adolescence become adults and reassess their trajectories in the face of lifelong medical consequences.

Individuals with a history of sex-rejecting procedures experience significant health consequences that directly result from these interventions.[18] The complex medical needs that result from initiating sex-rejecting procedures can be compounded by lack of treatment when an individual discontinues the procedures. The result is often a series of unpredictable health consequences—which are not addressed medically—and an uncertain medical future. These individuals need specialized medical care to recover their health and alleviate their suffering. Medicine has a responsibility, as a matter of justice, to meet those needs.

The absence of such codes does not only hinder current patient care; it also constrains medical research. To date, research on the discontinuance of sex-rejecting interventions generally has attempted to assess only the experience of "regret," an overbroad category which captures an emotional response to the use of sex-rejecting procedures but fails to acknowledge medical and psychological motivations for—and ramifications of—the discontinuance of sex-rejecting interventions. The limited concept of "regret" provides little medical insight into a patient's specific history of sex-rejecting interventions and the related factors likely to affect the individual's lifelong health. Accurate codes for individuals who experience "detransition" would help close the related gaps in clinical care and research.

New codes would provide a common language and consistent framework to measure accurately the frequency of "detransition," the demographics of those who experience it, and the medical consequences of both sex-rejecting procedures and their discontinuance. Codes that identify a personal history of sex-rejecting interventions would assist clinicians in making a differential diagnosis of the patient's presenting symptoms, recognizing them either as the

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[16] Current U.S. data does not offer an accurate way to estimate the number of minors or adults who have undergone sex-rejecting procedures. Insurance data released by the medical advocacy group Do No Harm provides some information, although these figures are widely acknowledged as incomplete. Additional analyses by Manhattan Institute scholars found that the billing practices by gender clinicians appear vulnerable to billing fraud, which further complicates efforts to document the number of people affected. Stop the Harm Database, https://stoptheharmdatabase.com/about/. Leor Sapir, *Insurance Fraud is Widespread in Transgender Medicine*, City Journal (Oct. 31, 2025), https://cityjournal.substack.com/p/leor-sapir-insurance-fraud-is-widespread.

[17] *See* Eric Kaufmann, *The Decline of Trans and Queer Identity among Young Americans*, Ctr. for Heterodox Soc. Sci., CHSS Rep. No. 5 (Oct. 10, 2025), https://www.heterodoxcentre.com/research/chss-report-no-5/.

[18] For example, the HHS Report describes the "significant harms" linked to sex-rejecting procedures in minors, "including infertility/sterility, sexual dysfunction, impaired bone density accrual, adverse cognitive impacts, cardiovascular disease and metabolic disorders, psychiatric disorders, surgical complications, and regret, and that there has been inadequate research into the frequency and severity of these harms. Meanwhile, systematic reviews of the evidence have revealed deep uncertainty about the purported benefits of these interventions." Off. of Pop. Affs., HHS, Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices, May 2025, at 10. https://opa.hhs.gov/sites/default/files/2025-05/gender-dysphoria-report.pdf.

medical sequelae of sex-rejecting interventions or as an unrelated medical issue. Currently, clinicians have no formal mechanism to acknowledge the very real health challenges resulting from or related to a history of sex-rejecting interventions, including lingering ailments and the still unclear long-term consequences of those interventions. Accurate diagnostic coding would allow medical research in this area to advance by facilitating consistent identification of a patient's history of sex-rejecting interventions and tracking relevant symptoms, treatments, and outcomes.

We also note that adopting new medical codes, such as those discussed at the March 17, 2026 ICD-10 Coordination and Maintenance Committee 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)[19]—policy priorities which we applaud and for which we are truly grateful.

Revised Proposed Codes

On March 17, 2026, the following revised proposed codes were presented to the ICD-10 Coordination and Maintenance Committee.[20]

Z87.890	Personal history of sex reassignment; **Personal history of gender transition**[21]
Z87.8901	**Personal history of social gender transition**
Z87.8902	**Personal history of medical gender transition;** **Personal history of pharmacological (hormonal) gender transition**
Z87.8903	**Personal history of surgical gender transition**
Z87.8904	**Personal history of intersex surgery**
Z87.8909	**Personal history of unspecified gender transition**
Z87.893	**Personal history of gender detransition**

[19] *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 14168, Defending Women From Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, 90 Fed. Reg. 8615 (Jan. 20, 2025), https://www.federalregister.gov/d/2025-02090; 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.

[20] ICD-10 Coordination and Maintenance Committee Meeting March 17-18, 2026, ICD-10 CM Diagnosis Agenda, at 58-60, https://www.cdc.gov/nchs/data/icd/topic-packet-March-2026.pdf.

[21] The proposal would add the inclusion term "Personal history of gender transition" to the existing code Z87.890 "Personal History of Sex Reassignment."

The Revised Proposed Codes Should be Adopted with Additional Inclusion Terms

In our November 2025 comment, we provided some concerns and suggestions concerning the specific language used for the September 2025 proposed codes.[22] The code F64.A "Gender identity disorder, in remission; Gender dysphoria, in remission (desistance)" was adopted. In response to feedback, the other September 2025 proposed codes were revised and reproposed in March 2026. The revisions do not address all of our concerns. Nevertheless, we do support the need for new codes that more specifically describe the kinds of sex-rejecting interventions received by the patient.

On balance, due to the significant need for medical codes (detailed above), we think it is better for the revised proposed codes to be adopted than to cause further delay in having medical codes. But we ask for the following additional inclusion terms to address some of the concerns we have over the language used in the revised proposed codes.

Below we address the new code and revised proposed codes in turn, explaining our concerns and proposing additional inclusion terms to address those concerns.

F64.A Gender identity disorder, in remission; Gender Dysphoria, in remission (desistance). We support the new code accepted by the Committee. "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.

Z87.890 Personal history of gender transition. The current code Z87.890 describes in non-specific terms a "Personal history of sex reassignment." We support the need to clarify "sex reassignment" with a more accurate term. Sex is an immutable characteristic that is neither assigned nor "reassigned."[23] As we have proposed elsewhere, a more accurate term to describe these procedures is "sex-rejecting procedures."[24] The term "gender transition" obscures the nature of the condition: it is not about "gender," it is about the person's sex. Further, the term "gender transition" is not defined in the ICD-10 and is thus open to broad interpretation. We urge

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[22] EPPC Comment re: ICD-10-CM Committee and HHS Consideration of Proposed Codes for "Gender Identity Disorder, in Remission (Desistance)" (Nov. 14, 2025), https://media.eppc.org/2025/11/EPPC-Comment-on-Proposed-ICD-10-Codes.pdf.

[23] *See* Colin M. Wright, *Why There Are Exactly Two Sexes*, 54 Arch. Sex. Behav. 3941 (Nov. 4, 2025), https://link.springer.com/article/10.1007/s10508-025-03348-3.

[24] *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 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").

the Committee and HHS to consider adopting an alternative or additional inclusion term that is clear on its face: "**personal history of sex rejection."**

Z87.8901 Personal history of social gender transition. We support the addition of this new code, in concept. Changes to a person's name, pronouns, and appearance, as well as non-invasive efforts to minimize the appearance of female breasts (binding) or male genitalia (tucking) are sex-rejecting interventions, even though the interventions are non-medical and non-surgical. A patient's personal history of sex rejection, expressed through social interventions, is relevant to further care and treatments. However, we reiterate our concerns over the use of the undefined term "gender transition" and suggest an inclusion term with the clarifying term "sex rejection," as in "**personal history of sex rejection, social.**"

Z87.8902 Personal history of medical gender transition; Personal history of pharmacological (hormonal) gender transition. We support the addition of this new code, including the inclusion term that clarifies that "medical" interventions (undefined) are specifically "pharmacological (hormonal)" interventions. However, we reiterate our concerns over the use of the undefined term "gender transition" and suggest describing these interventions as "sex-rejecting procedures." We propose the following additional inclusion terms: "**Personal history of sex-rejecting procedures, medical" and "personal history of sex-rejecting procedures, pharmacological (hormonal)."**

Z87.8903 Personal history of surgical gender transition. We support the need for a code that specifies "surgical" (as opposed to medical, pharmacological (hormonal), or social) sex-rejecting interventions. However, we reiterate our concerns over the use of the undefined term "gender transition" and suggest replacing it with the more accurate description of "sex-rejecting procedures." As such, we propose the following inclusion term: "**Personal history of sex-rejecting procedures, surgical.**"

Z87.8904 Personal history of intersex surgery. We recognize the need to distinguish a personal history of surgery to address a disorder of sexual development from a personal history of sex-rejecting surgery, especially in light of state laws that prohibit sex-rejecting surgeries for minors but which permit surgery to address disorders of sexual development. The addition of a code that captures this distinction is important. However, we urge the Committee to adopt an inclusion term with the more precise terminology of "disorder of sexual development" (rather than the colloquial term "intersex"): "**Personal history of surgery for a disorder of sexual development."**

Z87.8909 Personal history of unspecified gender transition. We support the addition of this code, in concept, as a broadly inclusive code covering a personal history of sex rejection. However, we urge the Committee to adopt an inclusion term that uses the more precise terminology of "sex rejection" instead of the undefined term "gender transition": "**Personal history of sex rejection, unspecified."**

Z87.893 Personal history of gender detransition. We support this code in concept. However, we have concerns about using the term "detransition," which is not defined in the ICD-10 and is open to broad interpretation. We note too that not all individuals who discontinue

the use of sex-rejecting procedures embrace the descriptor "detransition." Individuals may discontinue social, medical, or surgical sex-rejecting interventions for a variety of reasons and motivations and, regardless of motivation, are likely to face complex mental and physical challenges that should be reflected in the diagnostic codes. Current medical codes fail to acknowledge the significance of a personal history of sex-rejection and its likely effect on individual health. We urge the Committee and HHS to adopt an inclusion term with language that better expresses the nature of this personal history: "**Personal history of sex rejection, discontinued."**

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: Transition and Detransition Codes." We urge the Committee to recommend and HHS to adopt the revised proposed codes with the inclusion terms suggested above.

Sincerely,

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