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National Center for Health Statistics
Classification of Diseases, Functioning, and Disability
ICD-10 Coordination and Maintenance Committee
U.S. Centers for Disease Control and Prevention
3311 Toledo Rd
Hyattsville, MD 20782

RE: CDC/CMS Request for Comment: Medical Codes for Detransitioning

Dear Director Moyer:

The National Catholic Bioethics Center (NCBC), the Catholic Medical Association (CMA), the National Association of Catholic Nurses, USA (NACN-USA), and the National Catholic Partnership on Disability (NCPD) write in support of the need for additions to the current diagnostic classification system, ICD-10-CM[1] to address the growing needs of those who regret being subjected to sex-rejecting interventions to address their gender dysphoria. Unfortunately, there is evidence of insurance refusal to cover treatments to restore physical and psycho-social health, even though there are individuals living in physical agony as well as with crippling mental and psychological anguish.[2] Moreover, increasingly detransitioners are forced to pay out of pocket, or rely on charity, even when they have insurance. This sets the stage for the

[1] World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines* (Geneva: World Health Organization, 1993).
[2] See, Identity Crisis, *IW Features* (2022), https://www.iwfeatures.com/watch/identity-crisis/ (providing a list of detransitioners and their compelling stories of being misinformed about the need to transition.); Chloe Cole, *Written Testimony of Chloe Cole for Kansas House Bill 2071* (Jan. 28, 2025), Kansas Legislature, House HHS Committee, Committee Document No. CTTE_H_HHS_1, https://www.kslegislature.gov/li/b2025_26/committees/ctte_h_hhs_1/documents/testimony/20250128_01.pdf (highlighting her story from transition to detransition); Matt Fradd, *Trans Surgeries: The ACTUAL Story! w/ Chloe Cole,* YouTube (May 31, 2024). https://www.youtube.com/watch?v=_tGseOJI6iI; and *Chloe Cole's Testimony*, Purpose Driven Lawyers (July 27, 2023), https://purposedrivenlawyers.com/chloe-coles-testimony/.

refusal by health care professionals to help them. This is a serious injustice. Specifically:

There is a critical need for data on detransition and the harmful effects from social, medical (including hormonal and other pharmacological), surgical, and other sex-rejecting interventions. Such data collection needs to begin, and cannot without correct diagnostic coding. Claims that detransition and harm are rare are unsubstantiated and ideological. The supportive studies that are cited have serious flaws. Additionally, tracking these diagnosis codes over time may not capture all those harmed, because many of those harmed may never come forward. The magnitude of this scandal may never be fully known. However, tracking data over time will provide a sense of magnitude. It is already well beyond past time that we start collecting the data to enable an understanding of the realities of what has occurred.

Secondly, this diagnostic data can be used for research purposes. Until the problem is identified and measured, it will not be studied. The investigators and funding for those studies will materialize only when the problem has been well defined.

Thirdly, and probably most importantly, detransitioners will be able to access care. If the health care professionals who are courageous enough to care for those that have been harmed can identify diagnostic codes, they can bill, and be compensated, and thus provide encouragement to other professionals to provide access to such care. The increased access to care is what matters the most, so that those who have been harmed will be recognized and can get the needed care.

Specifically, the current ICD-10-CM fails to account for desistance, detransition, and the distress (regret/grief, for instance) one may suffer post-transition. Individuals within this clinical context, unfortunately, remain invisible to the existing diagnostic framework.

The National Catholic Bioethics Center (NCBC) is a faith-based organization engaged in bioethics publication, education and consultation to thousands of persons seeking its services. It regularly is commissioned by Catholic health care facilities, through its Catholic Identity and Ethics Review (CIER) services,[3] to document their compliance with the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs).[4] The NCBC is also commissioned by Catholic dioceses and other Catholic organizations for Catholic Health Insurance Ethics Reviews (CHIER), which involve ethical analysis of health benefit plan design with recommendations on coverage and denial of coverage based on Catholic moral teaching, preauthorization of claims on the basis of Catholic moral teaching, and audits of past claims for compliance with Catholic moral teaching based on diagnosis and procedures codes. Correct ICD-10 codes and their pairing with procedure codes are a necessary foundation for the accuracy of this work. Treatments that are morally permissible under the ERDs and Catholic moral teaching could be denied because of the absence of correct ICD-10 diagnostic coding.

[3] See https://www.ncbcenter.org/catholic-identity-and-ethics-reviews-cier.

[4] The U.S. Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* 7th ed. (Washington, DC: USCCB, 2025). https://www.usccb.org/resources/ethical-and-religious-directives-catholic-healthcare-services.

The NCBC has a membership of over five hundred members, representing individuals, dioceses, parishes, health care corporations, educational institutions, among many others. Thus, the impact on membership far exceeds the official number of members. Through our services, increasingly we are made aware of challenges families face, particularly vulnerable children, who believe their only option to address gender dysphoria is to accept sex-rejecting interventions that perpetuate psycho-social, and at times spiritual harm, and that permanently damage healthy organs and tissues. When provided with truth and the resources that support individuals and families and their suffering children, such persons often choose the methods of care that genuinely assist them in upholding their dignity as human beings. By misrepresenting so-called gender affirming interventions, those who advance them have created a whole new category of unaddressed diagnoses and corresponding therapeutic needs. Furthermore, health care professionals who provide care to address these needs face challenges in identifying them in a manner that will allow these victims to secure insurance coverage as they seek care.

The Catholic Medical Association (CMA) has over 3,000 physicians and allied health members nationwide. CMA members seek to uphold the principles of the Catholic faith in the science and practice of medicine—including the belief that every person's life, physical, psychological, and spiritual integrity, and conscience and religious freedoms, should be protected. The CMA's mission includes defending its members' right to provide care to address the best interest of their patients, and in so doing follow their consciences and Catholic teaching within the physician/professional-patient relationship. This includes the growing necessity to meet the needs of persons who regret having been led into sex-rejecting interventions, now seeking restorative wellness. However, there are limited mechanisms or ICD-10 diagnostic codes to provide insurance coverage to achieve such wellness. We are requesting a mechanism for insurance coverage, without which results in a de facto denial of coverage.

The National Association of Catholic Nurses, USA (NACN-USA) is a non-profit organization of nurses from different backgrounds and specialties. NACN-USA shares the ministry of Catholic Nursing which advocates for human rights of vulnerable populations. Significantly this includes the right to health care which heals, not harms all persons, especially the young persons impacted by sex-rejecting interventions. Through prayer, leadership, fellowship, education, and the formation of conscience, NACN-USA members strive to imitate Jesus Christ and His teachings. Members endorse the sanctity of all human life from conception to natural death, and the innate dignity of all human beings, born or unborn, who must be protected from harmful procedures in the name of health care. There is a growing need to meet the needs of persons who regret having been led into sex-rejecting interventions, now seeking restorative wellness. The federal government must be a party in promoting remedies to address the lasting consequences of sex-rejecting interventions on suffering children and adults. Such remedies can be advanced, in part, by providing a mechanism for true health care, and its availability through insurance coverage, which a revision of the ICD-10 diagnostic codes will advance.

The National Catholic Partnership on Disability (NCPD) was established in 1982 to foster implementation of the *Pastoral Statement of U.S. Catholic Bishops on People with Disabilities*.[5] NCPD works with dioceses, parishes, ministers, and laity to promote the full and meaningful participation of persons with disabilities in the life of the Church. It promotes this ever-evolving mission to renovate and sustain ministry to-and-with all people with disabilities and their families, advocating for policies that respect the life, full dignity, and inclusion of all persons, especially those with varying abilities. The overwhelming majority of those

[5] U.S. Conference of Catholic Bishops, *Pastoral Statement of U.S. Catholic Bishops on People with Disabilities* (1978; Rev. 2023).

who seek to undergo sex-rejecting interventions have a co-morbid mental health diagnosis, and a significant number have autism.[6] These patients are vulnerable to the suggestion that destroying their reproductive functions and secondary sex characteristics will heal their pain, even though these interventions have lifelong negative consequences for their physical and mental health. Accordingly, NCPD regards the revision of ICD codes as a matter of justice to those whose health is made worse by aggressive interventions that fail to address the underlying mental health issues of these patients. Finally, NCPD is concerned that there is a pervasive attitude that detransitioners should have to live with the consequences of their decisions to undergo these sex-rejecting interventions. This kind of judgmental attitude has no place in healthcare. Those who are suffering from a disability deserve to have access to care, no matter whether their disability is congenital, due to illness, or the result of misguided choices.

Growing Need to Undo the Harm

There has been a dramatic rise in persons, particularly minors, identifying as transgender,[7] and the number of those seeking sex-rejecting interventions has surged. A growing number of medical centers have developed departments dedicated to providing experimental drugs and medically invasive surgeries, resulting in irreversible damage to otherwise healthy bodies.[8] However, the November 2025 U.S. Health and Human Services *HHS Final Report*,[9] in identifying the harm to minors, countered errors of major medical groups' deference to the World Professional Association for Transgender Health (WPATH)[10] in addressing the health care needs of minors with gender identity disorder. As children mature, it is not unusual for them to explore aspects of their identity. Encouraging them to make permanent what is an otherwise temporary phase is not compassionate or supportive–it is cruel. Furthermore, as a number of these youths mature, they experience extreme regret, seeking restorative treatment. However, there is no definitive mechanism to identify the diagnostic need for providing and reimbursing restorative treatments.

A recently released study of thousands of persons who have been subjected to sex-rejecting interventions has concluded that: "Severe psychiatric morbidity is common among gender-referred adolescents and appears to be more prevalent in those referred after the recent surge in referrals. Psychiatric needs do

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[6] D. Glidden, et al., "Gender dysphoria and autism spectrum disorder: A systematic review of the literature," *Sexual Medicine Reviews,* 4:1 (2016) 3–14. https://pubmed.ncbi.nlm.nih.gov/27872002/. Also, Kasia Kozlowska, et al., "Attachment Patterns in Children and Adolescents with Gender Dysphoria," *Frontiers in Psychology* (January 12, 2021). https://www.usccb.org/resources/Kozlowska%20et%20al.%20-%202021%20-%20Attachment%20Patterns%20in%20Children%20and%20Adolescents%20Wi%20(1).pdf.

[7] The number of gender-affirming surgeries in the U.S. increased from 4,552 in 2016 to a peak of 13,011 in 2019, before slightly decreasing to 12,818 in 2020. This significant rise over that period was followed by a slight decline, largely attributed to the COVID-19 pandemic. See Jason D Wright, *et al.,* "National Estimates of Gender-Affirming Surgery in the US," *JAMA Netw Open* 6:8 (2023 Aug 23). https://pmc.ncbi.nlm.nih.gov/articles/PMC10448302/#:~:text=The%20absolute%20number%20of%20GAS,were%20aged12%20to%2018%20years.

[8] Society for Evidenced Based Gender Medicine, "'Gender-affirming' Hormones and Surgeries for Gender-Dysphoric US Youth" (May 28, 2021). https://segm.org/ease_of_obtaining_hormones_surgeries_GD_US#:~:text=There%20are%20over%2060%20pediatric,currently%20estimated%20at%20over%20300.

[9] U.S. Department of Health and Human Services, *Treatment for Pediatric Gender Dysphoria: Review of Evidence and Best Practices* (November 19, 2025). https://opa.hhs.gov/gender-dysphoria-report.

[10] World Professional Association for Transgender Health Archived 2018-10-04 at the Wayback Machine. *Tax Exempt Organization Search*. Internal Revenue Service.

not subside after medical gender reassignment."[11] The number of persons trapped in this dilemma is growing, and increasingly victims of these sex-rejecting interventions are stepping forward publicly to tell their stories. *Identity Crisis* was established in 2022 to provide an avenue for sharing "real stories about escaping gender ideology." Their stories are compelling.[12] Furthermore, several individuals have spoken out publicly against the professionals providing, promoting, or cooperation in the sex-rejecting interventions, highlighting what some believe were deceptive or unfair tactics used to convince them and their parents into consenting to surgical procedures and hormone interventions.[13] Some are seeking legal remedies. One such person is Chloe Cole.[14]

The Personal Experience of a Regretful Detransitioner

As *Identity Crisis* has presented, above, several individuals have spoken out publicly against the providers of so-called gender-affirming interventions, highlighting what they believe were deceptive and unfair tactics used to convince them and their parents into consenting to surgical procedures and hormonal interventions. The following is one example of a minor, who now is an adult, who has reported having suffered irreparable harm at the hands of health care professionals who have engaged in practices which she believes failed to adequately disclose the many risks of sex-rejecting procedures.

The Story of Chloe Cole[15]

"It looked like a war had just taken place on my body. . . I felt like a Frankenstein monster," detransitioner, Chloe Cole, remarked in a 2024 interview with Matthew Fradd,[16] recounting her double mastectomy at just 15 years old. Chloe Cole was just 12 years old when she started experiencing discomfort with her sexual development, having already begun puberty around 8–9 years old. Having heard of the struggles that are associated with menstruation, childbirth, and menopause, Chloe was afraid of developing through womanhood. Moreover, Chloe, being on the autism spectrum, and being influenced by her older brothers, was more object-oriented and "tomboyish" than other girls her age.

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[11] 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," *Acta Paediatrica* (April 4, 2026) **https://doi.org/10.1111/apa.70533Digital Object Identifier (DOI)**.

[12] See *Supra, note* 2.

[13] Keira Bell, *Keira Bell: My Story*, PERSUASION (Apr. 7, 2021), https://www.persuasion.community/p/keira-bell-my-story; *see also* Center for American Liberty, *Meet Layla Jane: Rushed into Double Mastectomy at 13 Years Old,* https://libertycenter.org/cases/layla/.

[14] H.R. 5483 (IH) - *Chloe Cole Act*. On September 18, 2025, Congressman Onder of Missouri's Third Congressional District introduced the "Chloe Cole Act," which will be sponsored in the Senate by Senator Marsha Blackburn of Tennessee. https://www.govinfo.gov/app/details/BILLS-119hr5483ih#:~:text=Document%20Citations,/details/BILLS%2D119hr5483ih..

[15] *See generally* Chloe Cole, *Written Testimony of Chloe Cole for Kansas House Bill 2071* (Jan. 28, 2025), Kansas Legislature, House HHS Committee, Committee Document No. CTTE_H_HHS_1, https://www.kslegislature.gov/li/b2025_26/committees/ctte_h_hhs_1/documents/testimony/20250128_01.pdf (highlighting her story from transition to detransition).

[16] Matt Fradd, *Trans Surgeries: The ACTUAL Story! w/ Chloe Cole, YouTube* (May 31, 2024). https://www.youtube.com/watch?v=_tGseOJI6iI.

Chloe reports the following:

That after consulting with medical professionals, she was fast-tracked on the transitioning path, being placed on cross-sex hormones and testosterone at just 13 years old.[17] Chloe's parents, who initially pushed back on their daughter's transition, were told that Chloe would likely commit suicide without so called gender-affirming care—and that the rate of regret is less than 1%–2%.

Two years later, at just 15 years old, Chloe reports her gender specialist referred her to a surgeon who would provide her with a double mastectomy, removing both of her healthy, developing breasts.[18] The surgeon did inform Chloe that she would lose the capacity to breastfeed as a result of the procedure; however, it is not reasonable to expect a 15-year-old to comprehend the ramifications of such a loss. Wanting so badly to be "a boy," and not being old enough to consider her future desire for a family, Chloe accepted the surgery with excitement and anticipation. Around one year following her double mastectomy, and having taken hormone supplements for around three years, Chloe quickly began regretting her decision to transition. She indicated that she believes she received little to no help from her gender specialist, and quit the supplements "cold turkey,"[19] causing complications compounded on the physical pelvic pain she was already experiencing from the prescribes hormones. Additionally, Chloe reports that when she contacted the surgeon regarding her long-term mastectomy wounds that would not heal, he simply instructed her to "put Vaseline on it," which resulted in further complications and infections.[20]

Thus, Chloe will never get to form the natural and intimate bond with her future children through breastfeeding. She may never even be able to conceive children following her hormone interventions. Chloe is not alone in her suffering, as many other children, teens, and parents have been influenced by what some have perceived to be the misleading practices of those who practice so-called gender-affirming care.[21]

Recommendations

We recognize, with gratitude, the U.S. Centers for Disease Control and Prevention's (CDC) recognition of the need to provide a code for identifying gender identity disorder in remission: F64.A Gender identity disorder, in remission (desistance). More is needed. Persons who are living with the regret for engaging in sex-rejecting interventions are living in physical agony as well as with crippling mental and psychological anguish. Unfortunately, without a correct diagnostic code, insurance may not cover treatments to restore physical and psycho-social health. This is compounded by the developmental stresses already

[17] *See Chloe Cole's Testimony*, Purpose Driven Lawyers (July 27, 2023), https://purposedrivenlawyers.com/chloe-coles-testimony/.
[18] *Id.*
[19] Kelsey Bolar, *Why Chloe Cole Deserves the Jazz Jennings Treatment—and More*, IW Features (Feb. 7, 2023). https://www.iwfeatures.com/documentary/why-chloe-cole-deserves-the-jazz-jennings-treatment-and-more/.
[20] Althea Cole*, A 'Detransitioned' Teen Tells Her Story at the University of Iowa,* The Gazette (Oct. 22, 2023). https://www.thegazette.com/staff-columnists/a-detransitioned-teen-tells-her-story-at-the-university-of-iowa/.
[21] S*ee Identity Crisis, IW Features (2022), https://www.iwfeatures.com/watch/identity-crisis/*, (providing a list of detransitioners and their compelling stories of being misinformed about the need to transition.)*; see also* Keira Bell, *Keira Bell: My Story*, PERSUASION (Apr. 7, 2021) https://www.persuasion.community/p/keira-bell-my-story; *see also* Center for American Liberty, *Meet Layla Jane: Rushed into Double Mastectomy at 13 Years Old,* https://libertycenter.org/cases/layla/.

experienced by young persons, some of which led to the very interventions now needing to be reversed, if possible. Furthermore, without accurate diagnostic codes it is difficult to access health care professionals willing to intervene. In fact, there is evidence of health care professionals being penalized unless they affirm transitioning.[22] This is not only unjust to the health care professional attempting to respond to this suffering, but even more importantly to the individuals suffering from the sex-rejecting interventions.

Thus, we Recommend: Add to/Edit the Existing ICD-10 Codes[23]

Establish "in remission" diagnostic classification (desistance), and "Posttransition Distress;" thus, add the following ICD-10 codes:

F64.A Gender identity disorder, in remission (desistance) [We are grateful for CDC's recognition of this need]

F64.B Posttransition distress

Distinguish social, medical, and surgical "sex reassignment"/"gender transition" & note complications. Maintain and edit as an "inclusion term" the current code Z87.890, edited as "Personal history of gender transition," and then distinguish social, medical, and surgical sex reassignment/gender transition, among these and from intersex surgery:

Z87.890 Personal history of gender transition

Z87.8901 Personal history of social gender transition

Z87.8902 Personal history of medical gender transition: Creates an inclusion code; need to capture personal history of pharmaco (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

And add and account for personal history of detransition & note complications:

Z87.893 Personal history of gender detransition

<u>Impact of Recommendations</u>

Most importantly, there needs to be a recognition that if the gender dysphoria of minors is not addressed by so-called gender affirming interventions, the dysphoria usually abates, especially as the natural hormones of puberty perform their natural functions.[24] There is no diagnostic code to reference this reality and thus code F64.A "Gender identity disorder, in remission (desistance)" needs to be identified. Furthermore, and unfortunately, the absence of each of the aforementioned ICD-10 codes, particularly addressing post-transition distress, escalates the suffering, and the unaddressed needs of those who have transitioned. There is not even an ICD-10 code for a personal history of detransition. Without the

[22] *Chiles v. Salazar, 607 U.S. ___ (2026)*; *Valerie Kloosterman v. Metropolitan Hospital*, 24-1398, (6th Cir.)

[23] Existing ICD-10 Codes: F64, Gender Identity Disorders; F64.0, Transexualism, F64.1 Dual Role Transvestism, F64.2, Gender Identity Disorder of Childhood; F 64.8 Other Gender Identity Disorders; F64.9, Gener Identity Disorder, Unspecified; and Z87.890 Personal History of Sex Reassignment.

[24] J. Ristori, TD Steensma, "Gender dysphoria in childhood," *Int Rev Psychiatry.* 2016;28(1):13–20.

proposed code Z87.893: "Personal history of gender detransition," such persons are invisible and without any specifically identified health care support.

Data support that the incidence of post transition distress-accompanied suicide ideation has escalated.[25] Thus, there is a significant need for Identifying diagnostic codes: F64.B "Posttransition distress," and Z87.8901, Z87.8902, Z87.8903, Z87.8904, and Z87.8909, to identify the specific, as well as unspecified social, medical (including pharmacological), and surgical history of social gender transition. These not only will provide a mechanism for recognizing this diagnostic reality but also promote prevention and treatment through insurance coverage. Very importantly, this initiative will encourage the American Psychiatric Association[26] to recognize the reality of post transition distress and the poorly researched social foundations for gender transition.[27]

Furthermore, those engaged in the care of those who are suffering are restricted from alleviating this distress and even penalized for so doing. Inclusion of these new ICD-10 codes provides much needed legitimization of the reality of these diagnoses, needing therapeutic remediation. Specifically, a Colorado therapist, Kaley Chiles', Free Speech Clause of the First Amendment allegedly was violated when, by patient request, she engaged in talk therapy. She has been accused of violating the state's "conversion therapy" law. The only talk therapy purportedly that Colorado law allows is one-directional, affirming sex-rejecting interventions. The U.S. Supreme Court has heard the case and in March 2026 decided in favor of the rights of Chiles.[28] However, the distress not only she, but clients seeking relief from gender dysphoria potentially had a negative impact.

Also, there are cases in which anomalous genitalia, as well as altered genetic and chromosomal patterns cause atypical phenotypes.[29] There is a need for the diagnostic code to address what may be the ongoing need for treatment: Z87.8904 Personal history of intersex surgery. Thus, we suggest this addition to distinguish such persons, often minors, from those with a personal history of gender transition.

More precise codes will fill significant gaps not only in health care but critically needed research. Currently, there is a drastic gap in documentation of the science behind so-called gender affirming care.[30] There is an erroneous narrative that those with desistance/detransition not only are not suffering, but, in fact that they do not exist. They are invisible to the diagnostic classification system. Specifically, these new codes will give visibility to those facing these clinical conditions without corresponding treatment. These codes will promote research through the collection of valuable health information not just nationally, but internationally. Specifically, sound public health policy development relies upon clinician-

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[25] C M Wiepjes , et al., "Trends in suicide death risk in transgender people: results from the Amsterdam Cohort of Gender Dysphoria study (1972–2017)," *Acta Psychiatr Scand.* 141:6 (2020 Mar 12) 486–491.

[26] American Psychiatric Association (APA) is an organization of psychiatrists working together to ensure humane care and effective treatment for all persons with mental illness….See https://www.psychiatry.org.

[27] Lawrence S. Mayer, M.B., M.S., Ph.D. Paul R. McHugh, M.D., "Sexuality and Gender Findings from the Biological, Psychological, and Social Sciences: Special Report," *The New Atlantis* 50 (Fall 2016).

[28] *Chiles v. Salazar, 607 U.S. ___ (2026)*; Amy Howe, "Majority of court appears skeptical of Colorado's "conversion therapy" ban," *A Dispatch Media Company* (October 7, 2025) https://www.scotusblog.com/2025/10/majority-of-court-appears-skeptical-of-colorados-conversion-therapy-ban/#:~:text=Colorado%20passed%20the%20law%20at,10th%20Circuit%20upheld%20that%20ruling..

[29] Cleveland Clinic, "Atypical Genitalia (Formerly Known as Ambiguous Genitalia)" (Last updated on 03/09/2022). https://my.clevelandclinic.org/health/diseases/22470-atypical-genitalia-formerly-known-as-ambiguous-genitalia.

[30] See *Supra,* note 27.

to-clinician communication within the medical records. Currently there is no such data collection because these codes are not included in electronic health records. Such data collection informs the recognition of public health needs, which are invisible, even though they are real, in the public health sector for this population of detransitioners.

Furthermore, in direct clinical care situations, there is an absence of informed clinical practice guidelines for care to address desistance, post transition distress, and the needs of detransitioners, as we ll as those seeking detransition. There needs to be a clear identification and delineation between the types of sex-rejecting interventions to which persons have been subjected, e.g., Z87.8902 "Personal history of medical gender transition" vs Z87.8903 "Personal history of surgical gender transition." For example, currently there are no established guidelines for clinicians to follow in the diagnosis and treatment that allow a patient to be safely weaned off cross-sex hormones compared to the needs of those placed on replacement hormones for surgically absent gonads.[31] While there is information on the side effects from absent or sudden withdrawal of feminizing hormones, more research is needed.[32] There is, to a lesser degree, some concern for sudden withdrawal of male hormones.[33] Yet without identifying the diagnostic needs, there is a great paucity in practice guidelines to address these and other critical needs of those experiencing post-transition distress.

For example, there is a significant need for research into how to remedy the drastic surgical mutilations that have occurred, labeled as "gender affirming care."[34] Young women who will never be able to breast feed their babies, if they even are capable of engendering new life, may meet with insurer-resistance for reconstructive surgeries. While such reconstruction will not allow for lactation, at least it will provide for more physiological and psychological integrity, much greater than just what is deemed cosmetic relief. The paucity of practice guidelines for addressing the needs of males who have experienced, and now regret castration is significant.[35] Again, without diagnostic codes to address these needs results in a lack of clinically needed research and the development of therapeutic clinical practice guidelines. The inclusion of these aforementioned ICD-10 codes will foster such research and the resulting clinical practice guidelines.

For those engaged in the delivery of health care consistent with the *Ethical and Religious Directives for Catholic Health Care Services*, the correct coding may make the difference between treatment and non-treatment. For example, a vaginoplasty for a biological female to address the diagnosis of Z87.8903 "Personal history of surgical gender transition" would morally justify the vaginoplasty which would not be

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[31] Kinnon R MacKinnon, et al., "Health Care Experiences of Patients Discontinuing or Reversing Prior Gender-Affirming Treatments," *AMA Netw Open*. 5: 7 (2022 Jul 25). https://pmc.ncbi.nlm.nih.gov/articles/PMC9315415/#:~:text=experience%20of%20gender.-,1,15.

[32] Sarah Hillman, *et al.,* "When, why, and how to stop HRT: women and clinicians need more evidence." *British Journal of General Practice* 75:756 (2025) 292-294. DOI**:** https://doi.org/10.3399/BJGP.2025.0300.

[33] Dr Helen Webberley, "The Danger of Withdrawing Hormones from Trans People: A Frank Reality Check," *GenderGP* (January 27, 2025). https://www.gendergp.com/the-danger-of-withdrawing-hormones-from-trans-people/#:~:text=For%20post%2Doperative%20trans%20people,political%20statement%2C%20it's%20medical%20malpractice.

[34] Kinnon R. MacKinnon, et al.," What is Detransition?" *DeTrans Support.* https://detransinfo.com/what-is-detransition/#:~:text=A%20detransition%20can%20be%20medical,back%20or%20change%20their%20name. Last visited November 4, 2025.

[35] Hannah Grossman & Ashley Carnahan, "Detransitioned boy who was castrated warns about the dangers of 'gender-affirming care,'" *Fox News* (Published July 21, 2023). https://nypost.com/2023/07/21/detransitioned-boy-who-was-castrated-warns-about-the-dangers-of-gender-affirming-care/#!.

morally justified for a male seeking to transition to female. Thus, it is critical that there be accurate diagnoses to enable the proper treatment of those made to suffer through sex-rejecting interventions.

Summary

The National Catholic Bioethics Center (NCBC), the Catholic Medical Association (CMA), the National Association of Catholic Nurses, USA (NACN-USA), and the National Catholic Partnership on Disability (NCPD) write in support of the need for edits/additions to the current diagnostic classification system, ICD-10-CM[36] to identify and address the growing needs of those who regret undergoing sex-rejecting interventions to address their gender dysphoria. As a number of these youths mature, they experience extreme regret, seeking restorative treatment. This has been substantiated, not only by individual cases we have identified, but also by the study of thousands of persons subjected to sex-rejecting interventions which concluded that: "Severe psychiatric morbidity is common among gender-referred adolescents and appears to be more prevalent in those referred after the recent surge in referrals. Psychiatric needs do not subside after medical gender reassignment."[37] However, there is no mechanism to identify the diagnostic need for providing and reimbursing restorative treatments. The number of persons trapped in this dilemma is growing, and increasingly victims of these sex-rejecting interventions are stepping forward publicly to tell their stories. Moreover, increasingly detransitioners are forced to pay out of pocket, or rely on charity, even when they have insurance. This sets the stage for the refusal by health care professionals to help them. This is a serious injustice.

By misrepresenting so-called gender affirming interventions, those who advanced them created a whole new category of unaddressed diagnoses and corresponding therapeutic needs. More precise codes will fill significant gaps not only in health care but critically needed research. Furthermore, health care professionals who provide care to address these needs face challenges in identifying them in a manner that will allow these victims to secure insurance coverage as they seek care. Thus, again, we recommend:

Establish "in remission" diagnostic classification (desistance), and "Posttransition Distress;" thus, add the following ICD-10 codes:
F64.A Gender identity disorder, in remission (desistance) [We are grateful for CDC's recognition of this need]
F64.B Posttransition distress

Distinguish social, medical, and surgical "sex reassignment"/"gender transition" & note complications. Maintain and edit as an "inclusion term" the current code Z87.890, edited as "Personal history of gender transition," and then distinguish social, medical, and surgical sex reassignment/gender transition, among these and from intersex surgery:
Z87.890 Personal history of gender transition
Z87.8901 Personal history of social gender transition
Z87.8902 Personal history of medical gender transition: Creates an inclusion code; need to capture personal history of pharmaco (hormonal) gender transition.
Z87.8903 Personal history of surgical gender transition

[36] World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research* (Geneva: World Health Organization, 1993).
[37] Supra, note 11.

Z87.8904 Personal history of intersex surgery
Z87.8909 Personal history of unspecified gender transition

And add and account for personal history of detransition & note complications:
Z87.893 Personal history of gender detransition

There is a growing need to meet the needs of persons who regret having been led into sex-rejecting interventions, now seeking restorative wellness. The federal government must be a party in promoting remedies to address the lasting consequences of sex-rejecting interventions on suffering children and adults now seeking restorative wellness. Such remedies can be advanced, in part, by providing a mechanism for true health care, and its availability through insurance coverage, which a revision of the ICD-10 codes will advance.

Thank you for this opportunity to provide you with our collective expert opinion on what has been an outright catastrophe in addressing gender dysphoria, with proposals for how, in part, to relieve the suffering of those who have been subjected to it.

Sincerely yours,

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