October 19, 2023

The Honorable Chiquita Brooks-LaSure, Administrator
U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

Dear Administrator Brooks-LaSure:

The undersigned organizations write in support of the request from the American Delirium Society, that causally specified delirium (F05, F1x.x21, F1x.231) be designated as a major complication or comorbidity (MCC), which would make its complexity designation consistent with toxic (G92) and metabolic (G93.41) encephalopathy (TME). Delirium, (currently specified as a complication or comorbidity (CC)) and encephalopathy are often used interchangeably and refer to a shared set of acute neurocognitive conditions that require additional resources to treat. They both describe core symptoms of impairment of level of consciousness and cognitive change caused by a medical condition or substance.

Delirium has well-validated diagnostic criteria that have allowed for the characterization of its complexity and numerous adverse outcomes, which are severe. There is robust literature detailing the impact of delirium on patient and caregiver distress, care complexity and costs, readmissions, rates of functional decline, institutionalization, cognitive decline, subsequent dementia diagnosis, and mortality.[1,2]

This change in status from complication or comorbidity to major complication or comorbidity is essential to recognizing the clinical importance of delirium and, crucially, the tremendous costs associated with it.[3,4] Placing delirium and encephalopathy on par with TME in terms of reimbursement is intended to facilitate systematic efforts to detect delirium as recommended across specialties and settings[5,6] thereby enhancing awareness of delirium and its dire impact on patients, their families, care delivery, and healthcare systems.[7] The ultimate goal of this change is to improve the clinical care and outcomes of cognitively vulnerable patients. We urge CMS to adopt this change.

Sincerely,
American Psychiatric Association
American Academy of Neurology

---

[1] Dziegielewski C, Skead C, Canturk T, et al. Delirium and Associated Length of Stay and Costs in Critically Ill Patients. Crit Care Res Pract. 2021;2021:6612187. Published 2021 Apr 24. doi:10.1155/2021/6612187

[2] Kinchin I, Mitchell E, Agar M, Trépel D. The economic cost of delirium: A systematic review and quality assessment. Alzheimers Dement. 2021 Jun: 17(6):1026-1041.doi: 10.1002/alz.12262.Epub 2021 Jan. PMID: 33480183.

[3] Slooter AJC, Otte WM, Devlin JW, et al. Updated nomenclature of delirium and acute encephalopathy: statement of ten Societies. Intensive Care Med 2020;46(5):1020-1022. DOI: 10.1007/s00134-019-05907-4.

[4] Oldham MA, Holloway RG. Delirium disorder: Integrating delirium and acute encephalopathy. Neurology 2020;95(4):173-178. DOI: 10.1212/WNL.0000000000009949.

[5] National Institute for Health and Clinical Excellence. Delirium: prevention, diagnosis and management in hospital and long-term care. (Clinical guideline) (https://www.nice.org/uk/guidance/cg103).

[6] American Geriatrics Society Expert Panel on Postoperative Delirium in Older A. American Geriatrics Society abstracted clinical practice guideline for postoperative delirium in older adults. J Am Geriatr Soc 2015;63(1):142-50. DOI: 10.1111/jgs.13281.

[7] Wilson JE, Mart MF, Cunningham C, et al. Delirium. Nat Rev Dis Primers 2020;6(1):90. DOI: 10.1038/s41572-020-00223-4.