ASMBS Position Statement on Preoperative Supervised Weight Loss Requirements

Preamble

The following position statement is issued by the American Society for Metabolic and Bariatric Surgery in response to numerous inquires made to the Society by patients, physicians, society members, hospitals, health insurance payors, the media, and others, regarding the need for a preoperative weight loss requirement before bariatric surgery. In this statement, the available data are summarized regarding the efficacy of the required preoperative diet attempts and is based on current knowledge, expert opinion, and the published peer-reviewed scientific evidence available at this time. The intent of issuing such a statement is to provide objective information about the need for this requirement and to provide recommendations from the current evidence. The statement could be revised in the future as additional evidence becomes available.

Scope

The purpose of this position statement is to provide an evidence-based review of the medical literature regarding the common healthcare insurance requirement for patients to provide documentation of supervised diet attempts for various periods (e.g., typically 6–18 mo) before providing authorization to pay for bariatric surgery services. In reviewing the published medical data for information about this topic, it is clear that most studies of weight loss before bariatric surgery have focused on a different weight management initiative than is the purpose of this review (i.e., physician-mandated weight loss). Physician-mandated weight loss can be undertaken by individual patients to evaluate a patient’s ability to adhere to dietary changes and to comply with treatment, to decrease the surgical risk, and/or to reduce the size of the liver and visceral fat load. For the sake of clarity, the level of evidence available for both preoperative diet management practices will be reviewed in the present document.

Background

Medicare requires a period of preoperative dietary treatment for severe obesity before a patient is approved for bariatric surgery [1]. Most health insurance carriers, including those who administer the Medicare program, require ≥6–12 months of recent documentation of diet attempts before authorization is granted to provide coverage for bariatric surgery services. This is mandated in the absence of any regard for the individual patient’s history of past efforts and often without any expectation of successful weight loss. Such policies typically ignore the patient’s health circumstances related to morbid obesity and the status of potentially life-threatening co-morbid conditions. Most policies require rigorously documented physician encounters, including monthly chart entries conforming to a specific format. Carriers often penalize patients who miss a single monthly visit by forcing them to reinitiate the entire process. This process can be financially onerous, frustrating, and time-consuming for many patients. Medicare and many other payors do not pay for dietary treatment, and patients must take time off from work or family responsibilities to visit their physician. Programs, such as Weight Watchers and Slim-Fast, typically do not meet the insurance carriers’ requirements.

Available data

Almost all severely obese patients have been through numerous weight loss programs for many years, without long-term efficacy [2,3]. Only rare cases of successful long-term weight loss for >5 years for severely obese patients have been reported [4].

No class I large, adequately powered, randomized, prospective trials or meta-analyses to validate the hypothesis that preoperative diet attempts improve bariatric surgery...
outcomes have been performed. One small prospective study randomized 50 patients to lose 10% of their excess weight preoperatively versus 50 patients who had no such requirement. Of the 100 patients, 61 ultimately underwent surgery. The patients assigned to the weight loss group had shorter operative times and enhanced weight loss at 3 months. However, no differences were found in the complication rates between the 2 groups, and, at 6 months, the excess weight loss was equivalent [5]. The results of the same study at 1 year demonstrated no differences in weight, body mass index, excess weight loss, or co-morbidity reduction between the 2 groups [6].

Class II comparative studies have consistently demonstrated that patients who achieve preoperative weight loss, regardless of the magnitude, do not have better long-term weight loss after bariatric surgery compared to groups without weight loss or weight gain preoperatively. Additionally, the requirement for a 6- or 12-month preoperative dietary management before bariatric surgery delays surgical care [7] and can reduce the number of patients who ultimately undergo bariatric surgery through attrition [3,8–12].

The evidence from some class III studies (clinical series or case reviews) has supported a 5–10% diet-induced acute weight loss immediately (1 or 2 months) before bariatric surgery to decrease the liver size and visceral adipose tissue. This rapid preoperative weight loss can facilitate the laparoscopic approach to the upper stomach and esophagus and can facilitate the laparoscopic gastric bypass to decrease the liver size and visceral adipose tissue.

Class III evidence has shown that patients who lose 5–10% of their excess body weight before surgery have a greater probability of a shorter hospital stay, might achieve more rapid postoperative weight loss [13], and have fewer complications [19]. The results from a few small studies have suggested that preoperative weight loss might lead to better short-term weight loss outcomes [5,16]; however, these effects have not been demonstrated beyond 1 year of follow-up. A retrospective review of 353 patients after laparoscopic gastric bypass showed that preoperative weight loss did not decrease the operative time or length of stay and did not affect the mean net postoperative weight loss nor the percentage of excess weight loss at 1 year. However, the group that had lost >10 lb had fewer complications [10]. Another study that retrospectively analyzed the data from 539 patients found no relationship between the preoperative weight changes and excess weight loss at 48 months after surgery, regardless of the surgical procedure performed, patient gender, or preoperative body mass index [20].

The California Department of Managed Health Care recently conducted a review of weight loss before bariatric surgery and concluded that “there is no literature presented by any authority that mandated weight loss, once a patient has been identified as a candidate for bariatric surgery, is indicated.” This comprehensive review has stated that mandated weight loss before indicated bariatric surgery is without evidence-based support and is not medically necessary and that the risks of delaying bariatric surgery are real and measurable [21]. Thus, numerous studies have now documented the efficacy of bariatric surgery to decrease many severe obesity-related co-morbidities, including type 2 diabetes mellitus [22–24]. Also, 8 studies have documented decreased mortality after bariatric surgery compared with cohorts who had not undergone a bariatric operation; 2 of these studies would be classified as class I under the Evidence-Based Medicine guidelines [25–32]. Furthermore, 3 studies have shown that bariatric surgery is cost-effective and pays for itself within 2.5–5 years postoperatively: a benefit that almost no other surgical procedure provides [33–35].

Summary and recommendations

First, no class I studies or evidence-based reports has documented the benefits of, or the need for, a 6–12-month preoperative dietary weight loss program before bariatric surgery. The current evidence supporting preoperative weight loss involves physician-mandated weight loss to improve surgical risk or to evaluate patient adherence. Although many believe benefits could result from acute preoperative weight loss in the weeks before bariatric surgery, the available class II–IV data regarding acute weight loss before bariatric surgery are indeterminate and provide conflicting results, leading to no clear consensus at this time. The preoperative weight loss recommended by the surgeon and/or the multidisciplinary bariatric treatment team because of an individual patient’s needs might have value for the purposes of improving surgical risk or evaluating patient adherence. However, it is supported only by low-level evidence in the published data at present.

One effect of mandated preoperative weight management before bariatric surgery is the attrition of patients from bariatric surgery programs. This barrier to care is likely related to patient inconvenience, frustration, healthcare costs, and the lost income resulting from the requirement for repeated physician visits not covered by health insurance.

It is the position of the American Society for Metabolic and Bariatric Surgery that the requirement for documentation of prolonged preoperative diet efforts before health insurance carrier approval of bariatric surgery services is inappropriate, capricious, and counterproductive, given the complete absence of a reasonable level of medical evidence to support this practice. Policies such as these that delay, impede, or otherwise interfere with life-saving and cost-effective treatment, which has been proved to be true for bariatric surgery to treat morbid obesity, are unacceptable without supporting evidence. Individual surgeons and programs should be free to recommend preoperative weight loss according to the specific needs and circumstances of the patient.
Preoperative dietary weight loss requirement before bariatric surgery position statement and standard of care

This Position Statement is not intended to provide inflexible rules or requirements of practice and is not intended, nor should it be used, to state or establish a local, regional, or national legal standard of care. Ultimately, various treatment modalities are appropriate for each patient, and surgeons must use their judgment in selecting from among the different feasible treatment options.

The American Society for Metabolic and Bariatric Surgery cautions against the use of this Position Statement in litigation in which the clinical decisions of a physician have been called into question. The ultimate judgment regarding the appropriateness of any specific procedure or course of action must be made by the physician in light of all the circumstances presented. Thus, an approach that differs from the Position Statement, standing alone, does not necessarily imply that the approach was below the standard of care. A conscientious physician could responsibly adopt a course of action different from that set forth in the Position Statement when, in the reasonable judgment of the physician, such a course of action is indicated by the condition of the patient, the limitations of available resources, or advances in knowledge or technology. All that should be expected is that the physician will follow a reasonable course of action on the basis of current knowledge, available resources, and the needs of the patient to deliver effective and safe medical care. The sole purpose of this Position Statement is to assist practitioners in achieving this objective.

Disclosures

Dr. Brethauer, Clinical Issues Committee, Chair, has been a speaker and has received honorarium and consulting fees for research from Ethicon Endo-Surgery.

References


