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 prior to bariatric surgery. In this statement, available data is summarized regarding the efficacy of required preoperative diet attempts and is based on current knowledge, expert opinion, and 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 provide recommendations based on the current evidence. The statement may 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 of time (e.g., typically between 6 to 18 months) before authorization to pay for bariatric surgery services. In reviewing the medical literature for information about this topic, it is clear that most studies of weight loss before bariatric surgery focus on a different weight
management initiative than is the purpose of this review, i.e., physician-mandated weight loss. Physician-mandated weight loss may be undertaken in individual patients to evaluate a patient’s ability to adhere to dietary changes and to comply with treatment, to decrease 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 pre-surgical diet management practices will be reviewed in the current 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 to 12 months or more 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 commonly without any expectation for successful weight loss. Such policies typically ignore the patient’s health circumstances related to morbid obesity and the status of potentially life-threatening comorbid 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 re-initiate the entire process. This process can be financially onerous, frustrating, and time-consuming for many patients. Medicare and many other payers 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 insurance carriers’ requirements.

Available Data

Almost all severely obese patients have been through numerous weight-loss programs over many years, without long-term efficacy.\(^{(2, 3)}\) There are only rare cases of successful long-term weight loss beyond 5 years for severely obese patients.\(^{(4)}\)

There are no Class I large, adequately powered randomized, prospective trials or meta-analyses to validate the hypothesis that preoperative diet attempts improve bariatric surgery outcomes. One small prospective study randomized 50 patients to lose 10% excess weight preoperatively versus 50 patients who had no such requirement. Sixty-one patients ultimately underwent surgery and patients assigned to the weight loss group had shorter operative times and enhanced weight loss at three months. There were no differences in complication rates between groups and, at six months, the excess weight loss was equivalent.\(^{(5)}\) Results of the same study at one year demonstrated no differences in weight, BMI, excess weight loss, or comorbidity reduction between 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 with no weight loss or weight gain preoperatively. Additionally, the requirement for a 6 or 12 month pre-operative dietary management prior to bariatric surgery delays surgical care\(^{(7)}\) and can reduce the number of patients who ultimately undergo bariatric surgery through attrition.\(^{(3, 8-12)}\)
There are some Class III studies (clinical series or case reviews) that support a 5 to 10% diet-induced acute weight loss immediately (a month or two) prior to bariatric surgery in order to decrease the size of the liver and visceral adipose tissue. This rapid preoperative weight loss can facilitate the laparoscopic approach to the upper stomach and esophagus and may shorten operative time.\(^{13-18}\) There is also some retrospective evidence that patients who lose 5-10% excess body weight prior to surgery have a higher probability of a shorter hospital stay, may achieve more rapid postoperative weight loss, \(^{(13)}\) and have fewer complications.\(^{(19)}\) A few small studies have suggested that preoperative weight loss may lead to a better short-term weight loss outcomes\(^{(5,16)}\) but these effects have not been demonstrated beyond one 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 the length of stay and did not affect the mean net postoperative weight loss nor the percent excess weight loss at one year. However, the group that had lost more than 10 pounds had fewer complications.\(^{(10)}\) Another study that retrospectively analyzed 539 patients found no relationship between preoperative weight changes and excess weight loss 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 prior to 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 states that mandated weight loss prior to indicated bariatric surgery is without evidence-based support, is not medically necessary, and that the risks of delaying bariatric surgery are
real and measurable.\(^{(21)}\) In this regard, there are now numerous studies documenting the
efficacy of bariatric surgery to decrease many severe obesity-related co-morbidities,
including type-2 diabetes mellitus.\(^{(22-24)}\) There are 8 studies that document a decreased
mortality after bariatric surgery when compared to cohorts who have not undergone a
bariatric operation; two 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 ½ to 5 years after the
operation; a benefit that almost no other surgical procedure provides.\(^{(33-35)}\)

**Summary and Recommendations**

1. There are no Class I studies or evidence-based reports that document the benefits of, or
the need for, a 6 to 12 month pre-operative 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 there may be benefits to acute preoperative weight loss in the weeks before
bariatric surgery, the available Class II-IV data regarding acute weight loss prior to
bariatric surgery are indeterminate and provide conflicting results leading to no clear
consensus at this time. Preoperative weight loss that is recommended by the surgeon
and/or the multi-disciplinary bariatric treatment team due to an individual patient’s needs
may have value for the purposes of improving surgical risk or evaluating patient
adherence, but is supported only by low-level evidence in the literature at the present
time.
2. One effect of mandated preoperative weight management prior to bariatric surgery is attrition of patients from bariatric surgery programs. This barrier to care is likely related to patient inconvenience, frustration, healthcare costs and lost income due to the requirement for repeated physician visits that are not covered by health insurance.

It is the position of the ASMBS that the requirement for documentation of prolonged preoperative diet efforts before health insurance carrier approval of bariatric surgery services is inappropriate, capricious, and counter-productive 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, as have been proven 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 based on the specific needs and circumstances of the patient.

**Pre-operative Dietary Weight Loss Requirement Prior to 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, there are various appropriate treatment modalities 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 are 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. To the contrary, a conscientious physician may 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.

References


