



SPA PCP Treatment & Referral Guidelines
Bariatric Surgery

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Weight loss management is a challenging problem for both patients and providers. Rarely does a simple intervention (i.e. medications) or invasive interventions (i.e. surgery) provide the answer unless the patient is committed to a life-long behavioral change. As with any other behavior modification approaches, most goals are successful with combined with counseling, education, behavioral therapy, and on-going support.

Physicians may consider:

- A) Patient-friendly educational materials
- B) Exercise prescriptions
- C) Nutritional counseling (consider referral to SMF Nutritional Program)

Group-clinic model (DIGMAs) for weight loss and weight management or community programs such as Overeaters Anonymous or one of the commercial product programs.

I. Background and Review of Benefits

Almost all health care plans exclude coverage for services specifically related to treatment of obesity and weight control, including medications. Remind patients that this program may be an out of pocket expense. Some plans will cover medications or physician-supervised weight loss programs under the medical benefit for the following conditions:

- A) Patient has demonstrated the discipline in following a physician supervised dietary program for at least (3) months.
Documentation of ≥ 3 consecutive months of adherence to a professionally supervised weight loss program must be provided. (Acceptable documentation includes):
 - 1. Actual Physician office notes from the physician who provided the supervision during the weight loss program. (or)
 - 2. Concurrent progress notes or program notes documenting each visit to a reputable community weight loss program, such as Weight Watchers, local hospital sponsored program, or other.A summary letter from the treating doctor or supervising entity will NOT suffice.
- B) Patient has a BMI (body mass index) ≥ 40 , OR
- C) Patient has a BMI ≥ 35 with one or more of the following comorbidities:
 - a) High blood pressure, HTN, or
 - b) Lab values with ONE:
 - 1. LDL ≥ 160 mg/dl, or
 - 2. HDL < 35 mg.dl, or
 - 3. TG ≥ 400 mg.dl
 - c) Coronary artery disease (CAD), or
 - d) Type 2 diabetes mellitus, or
 - e) Documented sleep apnea, or
 - f) Debilitating lower extremity joint disease

Patient's who meet the morbid obesity parameters may be referred to a network contracted bariatrician for the supervised dietary program if the service cannot be provided by the patient's primary care physician.

At the discretion of either the medical or surgical bariatric physician, the patient may be referred for pre-bariatric surgery psychological consultation and evaluation.

BMI may be calculated by: $\text{weight (kg)} / \text{height (m)}^2$. Refer to the attached table for quick calculation. (Table I)

At this time, there is no literature that adequately supports the safety or efficacy for weight reduction medications. Several systematic reviews of the literature support combination of diet/exercise advice from the physician with a combination of behavior therapy are probably more effective than diet, exercise, or medications alone.

NOTE: Surgeons are stating that anything less than BMI of 40 is being denied by insurance.

II. Approach to Weight Reduction Interventions

(Table III– algorithm)

Materials taken from *Guidance for Treatment of Adult Obesity*, Shape Up America!

In addition, the American Obesity Association: 1998.

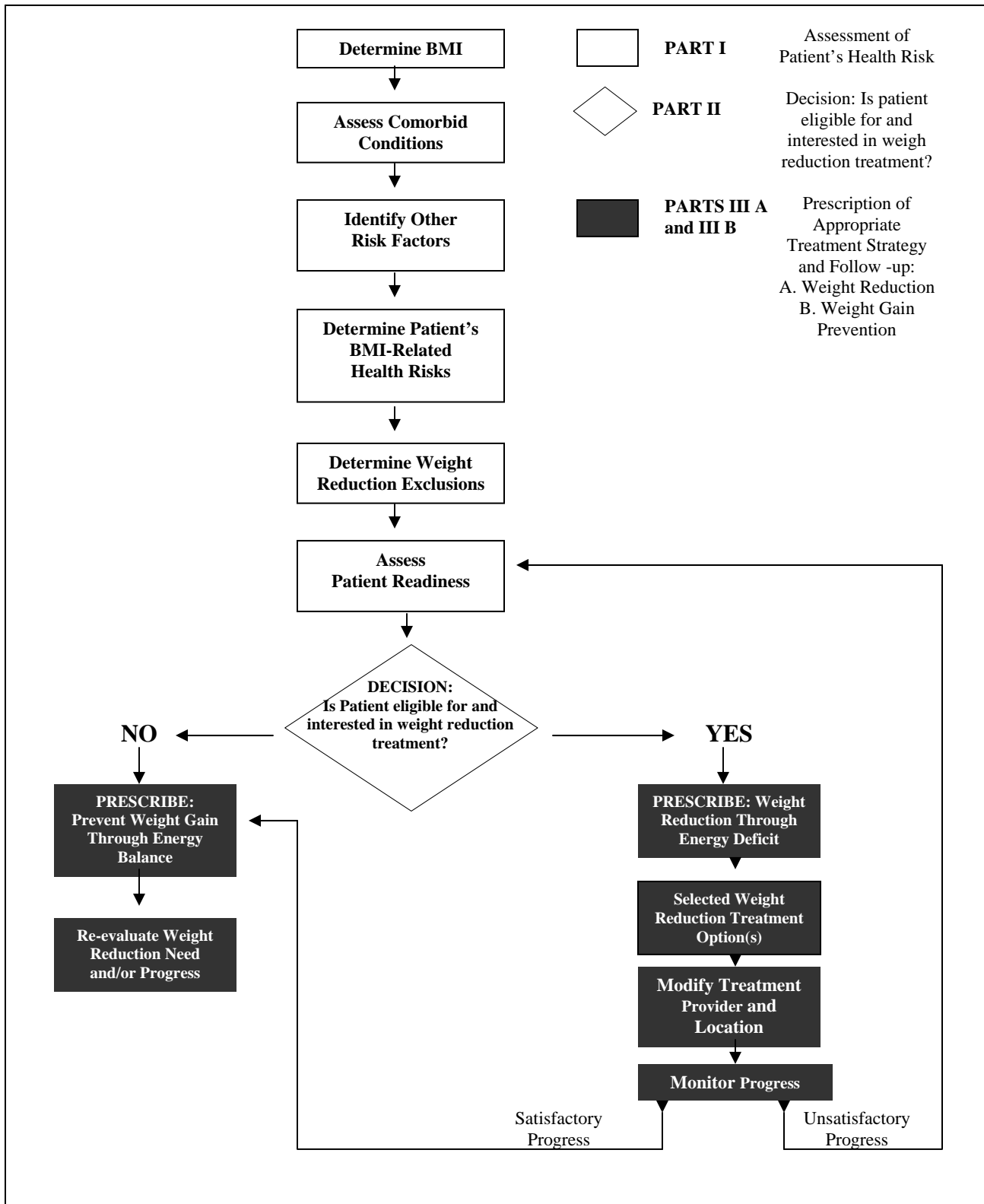
III. How to Determine BMI

Height (Feet and Inches)

	5'0"	5'1"	5'2"	5'3"	5'4"	5'5"	5'6"	5'7"	5'8"	5'9"	5'10"	5'11"	6'0"	6'1"	6'2"	6'3"	6'4"
100	20	19	18	18	17	17	16	16	15	15	14	14	14	13	13	12	12
105	21	20	19	19	18	17	17	16	16	16	15	15	14	14	13	13	13
110	21	21	20	19	19	18	18	17	17	16	16	15	15	15	14	14	13
115	22	22	21	20	20	19	19	18	17	17	17	16	16	15	15	14	14
120	23	23	22	21	21	20	19	19	18	18	17	17	16	16	15	15	15
125	24	24	23	22	21	21	20	20	19	18	18	17	17	16	16	16	15
130	25	25	24	23	22	22	21	20	20	19	19	18	18	17	17	16	16
135	26	26	25	24	23	22	22	21	21	20	19	19	18	18	17	17	16
140	27	26	26	25	24	23	23	22	21	21	20	20	19	18	18	17	17
145	28	27	27	26	25	24	23	23	22	21	21	20	20	19	19	18	18
150	29	28	27	27	26	25	24	23	23	22	22	21	20	20	19	19	18
155	30	29	28	27	27	26	25	24	24	23	22	22	21	20	20	19	19
160	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20	19
165	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21	20
170	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21	21
175	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22	21
180	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	22	22
185	36	35	34	33	32	31	30	29	28	27	27	26	25	24	24	23	23
190	37	36	35	34	33	32	31	30	29	28	27	26	26	25	24	24	23
195	38	37	36	35	33	32	31	31	30	29	28	27	26	26	25	24	24
200	39	38	37	35	34	33	32	31	30	30	29	28	27	26	26	25	24
205	40	39	37	36	35	34	33	32	31	30	29	29	28	27	26	26	25
210	41	40	38	37	36	35	34	33	32	31	30	29	28	28	27	26	26
215	42	41	39	38	37	36	35	34	33	32	31	30	29	28	28	27	26
220	43	42	40	39	38	37	36	34	33	32	32	31	30	29	28	27	27
225	44	43	41	40	39	37	36	35	34	33	32	31	31	30	29	28	27
230	45	43	42	41	39	38	37	36	35	34	33	32	31	30	30	29	28
235	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30	29	29
240	47	45	44	43	41	40	39	38	36	35	34	33	33	32	31	30	29
245	48	46	45	43	42	41	40	38	37	36	35	34	33	32	31	31	30
250	49	47	46	44	43	42	40	39	38	37	36	35	34	33	32	31	30

IV. THE TREATMENT MODEL

*TO REDUCE HEALTH RISK AND DISEASE BURDEN
 THROUGH WEIGHT REDUCTION AND PREVENTION OF WEIGHT GAIN*



Summary of the Treatment Model

The management of obesity is not an easy task. SPA has tried to make it as easy for you by providing this Treatment Model and associated guidance. The goal of this document is to encourage intervention with the adult overweight and obese patients and to provide practical information and guidance for such intervention.

This Treatment Model has three fundamental components.

- A) Assessment of the Patient's Health Risk
- B) Decision: Is the Patient Eligible for and Interested in Weight Reduction?
- C) Prescription of Appropriate Treatment and Follow-up

The goal is reduce the health risk associated with an elevated body mass index (BMI) by prescribing either 1) weight reduction treatment and maintenance of weight loss or 2) treatment that prevents weight gain.

V. **Assessment of Patient's Health Risk**

- A) Determine Body Mass Index (BMI)
 - a) Measure height (in inches)
 - b) Weigh patient (in pounds)
 - c) Use BMI table

The BMI table is not to be used in assessing patients who are competitive athletes or body builders, (i.e., patients whose BMI is high due to relatively great muscle mass) and/or in women who are pregnant and/or lactating. This guideline is not intended for use in growing children or elderly patients who are both frail and sedentary.

- B) Assess Comorbid Considerations

Does your patient have any of the following conditions?

- a) Hypertension
- b) Cardiovascular disease
- c) Dyslipidemia
- d) Type 2 diabetes
- e) Sleep apnea/obesity hypoventilation syndrome
- f) Osteoarthritis
- g) Infertility
- h) Other conditions, including:
 - 1) Idiopathic intracranial hypertension
 - 2) Lower extremity venous stasis disease
 - 3) Gastro-esophageal reflux
 - 4) Urinary stress incontinence

These conditions are associated with obesity and usually worsen as the degree of obesity increases and improve as the obesity is successfully treated. Presence of one or more conditions raises the health risk that is associated with BMI alone.

- C) Identify other risk Factors

Does your patient have any of the following additional risk factors?

- a) Waist-to-hip ratio >1.0 in males or >0.8 in females
- b) Waist circumference \geq 40 inches (102 cm) in males or \geq 35 inches (88 cm) in females
- c) Factors requiring clinical judgment:
 - 1) Progressive weight gain since adolescence
 - 2) Individual history of obesity
 - 3) Family history of obesity
 - 4) Bulimia nervosa
 - 5) Binge eating disorder
 - 6) Depression, anxiety, and stress
 - 7) Physical inactivity
 - 8) Smoking cessation
 - 9) Relevant medical or physical conditions, including:
 - Hyperinsulinemia
 - Breast, colon or endometrial cancer
 - Menopause
 - Overall disease burden
 - 10) History of physical or sexual abuse or trauma

Increased risk for obesity-related comorbidities is associated with an increased waist-to-hip ratio or waist circumference. The other clinical conditions and individual considerations listed above may also affect and possibly increase risk for further weight gain. An individual evaluation and clinical judgment to evaluate whether adjustments to the patient’s health risk based on BMI alone, is warranted.

D) Determine Patient’s BMI-Related Health Risk

What is the patient’s BMI-related health risk? How is that risk modified by the presence of comorbid conditions and/or other risk factors?

BMI Category	Health Risk Based on BMI	Risk Adjusted for Presence of Comorbid conditions and/or other Risk Factors
<25	Minimal	Low
25-<27	Low	Moderate
27-<30	Moderate	High
30-<35	High	Very High
35-<40	Very High	Extremely High
\geq 40	Extremely High	Extremely High

Health risk assessment:

- a) Identify patients who may benefit from intervention
- b) Determine if weight reduction treatment is warranted
- c) Identify the treatment option(s) for which the patient is eligible

- E) Determine Weight Reduction Exclusions
Does the patient have any conditions that warrant a temporary or permanent exclusion from weight reduction treatment?

- F) Treatment Exclusions:
 - a) Pregnancy
 - b) Lactation
 - c) Unstable mental illness
 - d) Unstable medical conditions

- G) Possible Exclusions (requires clinical judgment):
 - a) Cholelithiasis
 - b) Osteoporosis

- H) Permanent Exclusions:
 - a) Anorexia nervosa
 - b) Terminal illness

Weight reduction treatment is not recommended for patients with unstable mental or medical conditions. Since osteoporosis and cholelithiasis can be aggravated by weight loss, the risks and benefits of weight reduction need to be assessed on a case-by-case basis for these patients. Patients with anorexia nervosa or a terminal illness should be permanently excluded.

- I) Assess Patient Readiness
Is the patient **READY** to lose weight?
Lack of patient interest or readiness is an indication that weight reduction treatment is not appropriate – even if such treatment is warranted based on the patient’s health risk. For these patients, prevention of weight gain should be the treatment goals. If the patient declines treatment, it is important to ensure an “informed refusal.”

VI. Decision: Is Patient Eligible For and Interested in Weight Reduction Treatment?

- A) If yes, proceed to weight reduction section of the model
- B) If no, proceed to prevention of weight gain section of the model

VII. Prescription of Appropriate Treatment Strategy and Follow Up

- A) Weight Reduction
If weight reduction treatment is appropriate, the process is as follows:
 - a) Prescribe: Weight Reduction through Energy Deficit

What is fundamental to weight reduction treatment?

- a) Select an appropriate target BMI
- b) Create an energy deficit
- c) Establish permanent changes in lifestyle

For most patients – especially those with a BMI \geq 30 – a target BMI that is 2 BMI units below their current one is a realistic and practical goal. A 5-10% weight loss from the patient’s initial weight is a realistic first weight goal, which has been demonstrated for health improvement.

An energy deficit can only be achieved by consistently expending more energy than consumed in food. Treatment options that support such a strategy include attention to

diet, increased physical activity, pharmacological intervention, and surgery. Each of these options is described in detail in the guidance document. *Lifestyle change strategies should be routinely used in combination with any other treatment option.*

B) Select Weight Reduction Treatment Option

Based on health risk, what treatment options are available for the patient?

<u>Health Risk</u>	<u>Treatment Option(s) Available</u>
Minimal and Low	Healthful eating and/or moderate deficit diet Increased physical activity Lifestyle change strategies
Moderate	All of the above plus low calorie diet
High and Very High	All of the above plus pharmacotherapy All of the above plus very low calorie diet
Extremely High	All of the above plus surgical intervention

The treatment options available to each patient are based on his/her health risk.

Any comprehensive treatment plan should include healthy eating and/or a moderate deficit diet combined with increased physical activity and lifestyle change strategies. Additional treatment options can be combined with this foundation, and the treatment option analysis chart can assist the physician and the patient study the merits, risks, and costs for each option.

C) Identify Treatment Provider and Location

When do weight reduction treatment programs or services meet the patient’s treatment needs?

<u>Treatment Option</u>	<u>Who May Provide</u>
Moderate deficit diet, Physical activity, + Lifestyle change	Self-help Non-clinical programs Health care professionals

Low-calorie diet (LCD), Physical activity, + Lifestyle change	As above (Professional monitoring may be needed for LCD)
Very low calorie diet, Physical activity + Lifestyle change	As above + physician Clinical program + physician
Above + pharmacotherapy	As above
Surgery, individually Prescribed diet, Physician activity + Lifestyle change	Surgical clinical program

Consider which treatment programs and services available within the community would be appropriate for the patient’s treatment plan AND best meet the patient’s individual weight reduction needs

D) Monitor Progress

Is the patient losing weight? What are the next steps?

E) Satisfactory Progress (Patient is losing weight.)

- a) Encourage and recognize success
- b) Begin prevention of weight-gain strategy.

F) Unsatisfactory Progress (Patient is not losing weight or is gaining weight)

- a) Reassess patient readiness. Then decide whether to:
 - 1) Begin prevention of weight gain strategy?
 - 2) Re-evaluate weight reduction treatment option?
 - 3) Re-evaluate service provider?

VIII. Prevention of Weight Gain

If BMI-related health risk does not warrant weight reduction, treatment, or it does but the patient is not ready for or interested in treatment, a strategy to prevent weight gain is appropriate (discussed below). The following section is appropriate for individuals who have successfully lost weight and are ready to maintain the weight loss.

A) Prescribe: Prevent Weight Gain Through Energy Balance

- a) In partnership with the patient, select a target BMI that the patient is willing to maintain.
- b) Create an energy balance between energy consumed in food and daily physical activity.
- c) Establish permanent lifestyle change strategies

- B) Re-evaluate Weight Reduction Need and/or Progress
 - a) If the patient is temporarily excluded until a condition stabilizes or resolves, re-evaluate in three to six months.
 - b) If patient is not ready or interested in weight reduction treatment, re-evaluate in six to 12 months or if the patient initiates the request prior to 12 months. Obesity-related health risk should be recalculated at interval visits or in six to 12 months if there are no interval visits related to other health concerns.
 - c) If the patient has reached the goal, re-evaluate periodically as for any other chronic medical condition. Continue to recognize and support any period of weight maintenance, as it is far more difficult to sustain weight loss than it is to lose weight.

IX. Considerations for Bariatric Surgery

Bariatric procedures are directed at reduction of caloric intake and may be done as either open (laparotomy) or closed (laparoscopically). These procedures are not without risk and should not even be considered unless there have been consistent failed attempts at conservative therapy for no less than 12 months.

Risks include:

- A) Psychological stress
- B) Wound infections, dehiscence or seroma
- C) Hernia
- D) Intractable vomiting secondary to GE reflux
- E) Gastric outlet obstruction
- F) Ulceration of the stoma
- G) Anorexia
- H) Anemia
- I) Osteoporosis
- J) Nutritional deficiencies secondary to malabsorption
- K) Ongoing abdominal pain
- L) Pulmonary embolus
- M) Death

Basic criteria must be met PRIOR to discussions whether or not this may or may not be an appropriate intervention. If the patient does not meet criteria for surgery or is not a surgical candidate, then the patient should be enrolled in a weight management program (see section on non-surgical candidate).

X. Pre-bariatric Surgery Work-up

Section XI lists a number of potential evaluations to identify and manage comorbid conditions related to the bariatric procedure. These studies may be necessary for the patient prior to surgery, but depends on the clinical presentation and history. Many of these procedures require PCP authorization, and it is most useful for the PCP to first review if these tests have recently been done, before the “blanket approach” work-up is initiated. The patient must be clinically appropriate for surgery and meet the authorization requirements set by their health plan. Attached is a summary of commonly ordered tests prior to bariatric surgery.

XI. Preoperative Studies for Bariatric Surgery

TEST	POTENTIAL INDICATIONS
EKG	History of CAD, HTN, history of cardiac arrhythmia, history of chest pain
Treadmill	History of CAD, history of chest pain, dyspnea with exertion, known cardiac risk factors for CAD, hyperlipidemia
Chest X-ray	Dyspnea, chronic cough, known pulmonary disease, documented hypoxia
Echocardiogram	History of valvular disease, past history of Phen-fen use, orthopnea, PND, history or known atrial fibrillation, exam finding suspicious for valvular disease or CHF
Upper GI	History of significant reflux symptoms not relieved in therapy
Lab studies (Blood Sugar, CBC, Thyroid studies, lipids, renal panel, liver panel, endocrine studies, pregnancy test)	As clinically indicated
Lab studies (Helicobacter Pylori and A1c)	Required studies
Pulmonary Function Tests	History of Asthma or COPD, history of wheezing or dyspnea
Physical Therapy	Needed evaluation for musculo-skeletal symptoms related to exercise program
Registered Dietician	Unable to identify dietary needs, has specific dietary restrictions, i.e. Diabetes, hyperlipidemia; assistance needed with post-surgery dietary planning
Psychiatric Evaluation	History of major depression – not responding to treatment, history of eating disorder, history of substance abuse – likely to interfere with diet and/or treatment plan

Source: Sweitzer, B; *Handbook of Preoperative Assessment and Management*, Lippincott, 2000. pg. 351-354

XII. Post Bariatric Follow-Up

A) First postoperative year

- a) Routine visits to the bariatric medical specialist should occur every 6 weeks as determined by the bariatric medical specialists, on a case-by-case basis.

- b) A registered dietician should see the patient no less than 3 times within the first postoperative year as determined by the dietician, on a case-by-case basis.
 - 1) Nutritional counseling (this is NOT approved by insurance).
- B) Second postoperative year
 - a) Routine visits to the bariatric medical specialist will occur every 12 weeks.
 - b) A registered dietician should see the patient at least one time during the second postoperative year.
 - 1) Continued nutritional counseling (this is NOT approved by insurance).
- C) 6-8 Weeks - Postoperative Labs
 - a) CBC, TIBC/Iron level, comprehensive metabolic panel, lipid panel, screening levels for B12, B1, and B6.
- D) Additional Labs based on other comorbidities:
 - a) HgbA1C (for Diabetic), lipid panel (for heart disease & hyperlipidemia), TSH (for thyroid disease).
 - b) Repeat Post op labs 12-18 months after surgery.
- E) Additional monitoring
 - a) Monitor patient for energy level, endurance level, and conditioning.
 - b) Monitor post op prescribed medications.
 - c) Ongoing behavioral support if needed provided by a LCSW.
 - d) BMI – should be calculated at each follow up visit.
 - e) Personalized exercise program put together by a certified fitness instructor.
 - f) Psychological assessment
 - 1) Depression, anxiety, and psychosocial stressors (frequently occur in post op patients).

XIV. Non-Surgical Weight Management Program

- A) This program consists of education, counseling, and treatment involving nutrition, exercise, and behavioral modification.
 - a) Medications will be used when appropriate in selected patients.
 - b) 12-week program that is tailored to each individual patient.
 - c) Labs and additional studies will be requested as necessary.
- B) The non-surgical program will encompass the same basic principles and protocols also tailored for the individual interested in pursuing bariatric surgery.
 - a) Initial evaluation to determine patient readiness and screening for comorbidities.
 - b) Individualized treatment program developed, outlined and supervised by the treating bariatric medical specialist.
 - c) Nutritional assessment and counseling conducted by a registered dietician.
 - d) Behavioral counseling and assessment conducted by a licensed psychologist or LCSW as needed.
 - e) Exercise instruction provided by educational materials, community resources or recommendations for an exercise evaluation and instruction by an exercise

- physiologist or personal fitness instructor.
- f) All program participants will receive instruction on setting realistic weight loss goals and expectations, exercise information, and behavior modification strategies. The program will be directed on helping participants learn to focus on “fitness NOT fatness” as they strive to improve their health.
- C) Patients involved with the non-surgical program will be enrolled in a 12-week program as follows:
- a) Week 1: Initial assessment and evaluation by the bariatric medical specialist.
- b) Week 1-4: Initial assessment and evaluation by the registered dietician; referral for behavioral counseling, psychological evaluation, exercise evaluation and instruction will be made on an individual basis.
- c) Week 4-8: Follow-up visit with the bariatric medical specialist and dietician.
- d) Week 8-12: Follow-up visits with the bariatric medical specialist and dietician for program assessment, and determine the course of future follow-up visits.

APPROVAL:



SPA/SMF Medical Director

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Date

Approval / Revision Summary:

SMF QM Committee

SPA Steering Committee

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FYI Only