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Editorial comment

Comment on: insurance-mandated preoperative diet and outcomes after bariatric surgery

Preoperative insurance-mandated medically supervised weight management (MSWM) before approval of any bariatric surgery for the treatment of morbid obesity has remained an insurance company requirement in the United States despite multiple published studies demonstrating no additional benefit for patients. Since the first study of this issue in 2006 [1] reported the lack of outcome benefit of insurance-mandated dietary counseling before bariatric surgery, multiple additional studies have been published [2–7], including at least 1 controlled trial [8] looking at the issue of insurance-mandated MSWM requirements and patient outcomes. In the current issue of *Surgery and Obesity Related Diseases*, Keith et al. [9] present yet another study of this topic. It is noteworthy that this present study and, in fact, all published studies have confirmed the findings that insurance-mandated MSWM programs did not confer additional benefits compared with standard preoperative bariatric surgery protocols. Despite publications leading to a comprehensive American Society for Metabolic and Bariatric Surgery position statement [10] strongly opposing insurance company–mandated completion of a MSWM program, commercial insurance payors have continued to require completion of these programs and have sequentially increased the time requirement from 3 to 6 months, some going to 9 months, and in some cases the requirement has increased to 1 year. We cannot ignore the fact that efforts to reverse this practice through the publication of peer-reviewed studies have fallen on deaf ears.

Insurance-mandated MSWM requirements have had a deleterious effect on patient access to care, often increasing the individual patient costs required to complete the program and contribute to drop-out rates secondary to inability or failure to complete the multiple appointments and requirements distributed over an unreasonable length of time.

Mandatory MSWM as described by insurance company policies is an amorphous and poorly defined requirement. Insurance company requirements typically establish no curriculum of educational goals and are focused on monthly weigh-ins and notations of participation in a program that has vague goals, a complete lack of educational content, and no justification for delaying surgery to meet undefined exercise requirements. In the overwhelming majority of policies, these programs and their associated requirements amount to no subjective or objective accomplishments that could possibly play a role in improving a patient's outcome or in decreasing complications. The plan language of multiple insurance payors is consistently vague in this regard, lacking any standardized goals regarding what must be accomplished during the time period required to complete it. Few payors define what the requirement for MSWM is supposed to accomplish, including what or how any educational goals are to be implemented. Each payor requires a set number of days in which the attempt at MSWM must be completed, but provides no standardized milestones that the practice must document as achieved. As a result the requirement for MSWM has become largely a prolonged waiting period interrupted by a few appointments to obtain the necessary paperwork to demonstrate an attempt has been made. In some 6-month programs, requirement could be satisfied with as little as 2 appointments with a dietician, monthly weights, and a statement describing an exercise program of daily walking and a pedometer record as proof. These long waiting programs lead to patients experiencing discouragement, financial hardship, and ultimately a high rate of attrition.

Unfortunately, there is no evidence that any of the efforts attempted by bariatric surgery healthcare professionals in the United States, including work done by American Society for Metabolic and Bariatric Surgery, have had any significant success in changing these insurance policy requirements, which result in fewer patients being treated for morbid obesity.

In this editorial, we suggest a change in strategy to address the issue of MSWM as an insurance requirement for bariatric surgery. We feel it is unlikely that continued efforts to convince insurance payors to eliminate these requirements will succeed. There are many reasons behind this failure, and these must be taken into consideration if our specialty hopes to reverse the trend, which has led us to see insurance companies increasing, not decreasing, their mandates for MSWM to 6 months and beyond. Most major insurance companies justify implementing MSWM requirements as satisfying recommendations put forth by other medical societies. Blue Shield of California recently revised its benefits of coverage and included rationale justifying the approach to include medically supervised weight management programs as a prerequisite. Referencing a 2016 comprehensive clinical practice guideline, which was jointly published by the American Association of Clinical Endocrinologists and the American College of Endocrinology, Blue Shield of California incorporated the clinical practice recommendation into the requirement for documenting failure at conservative medical management of obesity. The 2016 publication modified the previous 2013 recommendations for bariatric surgery to include the following recommendation:

> *Recommendation 35: "Patients with obesity ([body mass index] BMI ≥30 kg/m^2) and diabetes* ***who have failed to achieve targeted clinical outcomes following treatment with lifestyle therapy and weight loss medications may be considered for bariatric surgery,*** *preferably Roux-en-Y gastric bypass, sleeve gastrectomy, or biliopancreatic diversion." (Intermediate recommendation, Strong evidence).*

In addition Blue Shield Medical Policy also referenced the American College of Cardiology and the American Heart Association and the published guidelines from the Obesity Society to justify the requirement to document failure of medical management. The guidelines make the following recommendations related to bariatric surgery:

> *Advise adults with a BMI ≥40 kg/m^2 or BMI ≥35 kg/m^2 with obesity-related co-morbid conditions who are motivated to lose weight and* ***who have not responded to behavioral treatment with or without pharmacotherapy with sufficient weight loss to achieve targeted health outcome goals*** *that bariatric surgery may be an appropriate option to improve health and offer referral to an experienced bariatric surgeon for consultation and evaluation. NHLBI Grade A (Strong).*

Finally, Blue Shield cites Medicare and Centers for Medicare and Medicaid Services statements as justification for documentation of participation in medically managed 3-month programs:

> *Medicare has published a national coverage decision on bariatric surgery that concludes "The Centers for Medicare and Medicaid Services (CMS) has determined that the evidence is adequate to conclude that open and laparoscopic Roux-en-Y gastric bypass (RYGBP), laparoscopic adjustable gastric banding (LAGB), and open and laparoscopic biliopancreatic diversion with duodenal switch (BPD/DS), are reasonable and necessary for Medicare beneficiaries who have a body mass index (BMI) ≥35, have at least one co-morbidity related to obesity,* ***and have been previously unsuccessful with medical treatment for obesity****."*

Implementation of wait times before surgical treatment as a "stall tactic" also likely addresses payor concerns about patients undergoing procedures with little to no workup or preoperative education. Some insurance companies suggest that their internal data before implementation of MSWM requirements demonstrated higher complication rates, readmissions, and reoperations.

We propose to develop a best practice strategy for preoperative preparation of patients before bariatric surgery with clear goals and milestones that must be accomplished by patients seeking surgical treatment. In the setting of no existing evidence for outcome improvements with the current insurance-mandated MSWM programs, we propose to develop a presurgery program that we can expect to provide benefit and improved outcomes for patients, and then to study it to confirm benefit and to further refine the process over time based on data, not theory.

We propose calling upon the American Society for Metabolic and Bariatric Surgery to use the resources, knowledge, skills, and talent available in our national organization, along with data collected under the auspices of the Metabolic Bariatric Surgery and Quality Improvement Program, to develop a process that will derail the current useless MSWM model and replace it with a preoperation preparation process consisting of a comprehensive, educational-based curriculum. Characteristics of such a program would not be primarily based on time as the endpoint but rather successful demonstration of the acquisition of important knowledge by patients in the areas of nutrition, behavior, weight loss strategies, and the various surgical procedures themselves. While premature to describe such a program before the intense review of evidence required to develop it, demonstration of patient compliance by requiring patients to demonstrate improved