

**Letter No. 2013-10**

**Date: April 29, 2013**

Fee-for-Service [9]    Experience-rated HMO [9]    Community-rated [8]

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**SUBJECT:    Management of Obesity in Adults**

Recent data indicates that nearly 75% of the US adult population is overweight or obese<sup>1</sup> when assessed using the body mass index (BMI) international standard. Adult obesity is strongly correlated with major health problems and higher health care costs<sup>2</sup>, prompting specific attention to obesity management within the FEHB program. Losing weight and increasing physical activity can prevent some complications of obesity, particularly type 2 diabetes. This carrier letter summarizes the management of adult obesity within the FEHB program. We request that each carrier review and update their medical policy accordingly.

**Background**

BMI is measured as an individual's weight (in kilograms) divided by height (in meters squared). The following classification applies:

- Overweight            BMI  $\geq 25$  to 29.9 kg/m<sup>2</sup>
- Obese                    BMI  $\geq 30$  kg/m<sup>2</sup>
  - Class I                    BMI 30-34.9 kg/m<sup>2</sup>
  - Class II                    BMI 35-39.9 kg/m<sup>2</sup>
  - Class III                    BMI  $\geq 40$  kg/m<sup>2</sup>

Recognizing obesity as a significant public health problem, the United States Preventive Services Task Force (USPSTF) published updated recommendations that all adults be screened and those with a body mass index of 30 kg/m<sup>2</sup> or higher be referred for intensive, multicomponent behavioral interventions.<sup>3</sup> USPSTF rated this recommendation as Grade B. As noted in Carrier Letter 2012-09, FEHB carriers are required to cover all Grade A and B USPSTF recommendations with no cost sharing.

**Diet, Exercise and Drug Therapy**

Diet and exercise are the preferred methods for losing weight. Accordingly, OPM first requested plans propose specific services to reduce the incidence of obesity in Carrier Letter 2011-05. The next year, Carrier Letter 2012-09 outlined OPM's expectation that FEHB plans offer programs to help patients attain and maintain a healthy weight. In response, many plans refined wellness activities, health coaching, nutrition counseling and disease management to achieve a greater focus on obesity.

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<sup>1</sup> <http://win.niddk.nih.gov/publications/PDFs/stat904z.pdf>, Weight Control Information Network, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health, October 2012

<sup>2</sup> Screening for and Management of Obesity in Adults: U.S. Preventive Services Task Force Recommendation Statement, *Ann Intern Med* 157, 373-378 (2012)

<sup>3</sup> Screening for and Management of Obesity in Adults: U.S. Preventive Services Task Force Recommendation Statement, *Ann Intern Med* 157, 373-378 (2012)

Additionally, drug therapy can assist obese adults who do not achieve weight loss goals through diet and exercise alone. The Food and Drug Administration (FDA) has approved several anti-obesity drugs, including two new ones in 2012. Complete prescribing information for Belviiq (Lorcaserin) and Qsymia (Phentermine/topiramate ER) is available at <http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm>

## **Bariatric Surgery**

For those with more severe obesity, surgical procedures to restrict the size of the stomach or induce malabsorption of ingested calories were first introduced in the 1950s. Three commonly performed bariatric surgical procedures are gastric bypass, adjustable gastric banding, and sleeve gastrectomy. The National Institutes of Health published criteria for surgical candidacy in 1992, which included a BMI of 40 kg/m<sup>2</sup> in patients who were unable to lose weight with lifestyle changes or drug therapy. Patients with a BMI of at least 35 kg/m<sup>2</sup> and serious coexisting medical conditions could also be considered. Over the ensuing 20 years, clinical trials documented that bariatric surgery can result in durable weight loss along with improvement of obesity related conditions such as diabetes. Surgical techniques are now more refined, improving the safety of these procedures.

Government agencies, medical specialty societies, professional associations and commercial insurers have issued updated guidelines and position statements regarding the effectiveness of bariatric surgery.<sup>4</sup> In February 2011, the FDA amended its 2001 approval of the LAP-BAND<sup>®</sup> System for gastric banding to include individuals with a lower BMI, dropping the threshold to BMI 30-34 kg/m<sup>2</sup> for those with obesity related co-morbidity.<sup>5</sup>

The strong association of obesity with diabetes was addressed by new clinical studies in 2012. One major study reported that bariatric surgery appears “markedly more efficient than usual care” to prevent type 2 diabetes in obese patients. During the study’s follow up period of 15 years, type 2 diabetes developed in 392 control group members (n= 1771) compared to only 110 surgery patients (n=1658).<sup>6</sup> Two other articles reported that bariatric surgery resulted in better glucose control for obese diabetic patients than what was achieved through medical therapy alone.<sup>7</sup>

Taken together, these updated standards and evidence-based guidelines strongly support considering bariatric surgery for patients with a BMI ≥40 kg/m<sup>2</sup> and for patients with a BMI ≥35 kg/m<sup>2</sup> plus one or more obesity-related chronic health conditions. OPM requests that plans promptly review recent clinical data and update coverage as needed to ensure that 2014 brochures reflect the most current information. Please include the following in your 2014 rate and benefit proposals:

**BMI Threshold:** BMI ≥ 40 kg/m<sup>2</sup> when members have no other health conditions and BMI ≥ 35 kg/m<sup>2</sup> when members have at least one co-morbidity. Higher thresholds require written justification. Lower

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<sup>4</sup> Examples include, but are not limited to, American Society for Metabolic & Bariatric Surgery (September 2012), *Position Statement on Bariatric Surgery in Class I Obesity*; American Diabetes Association (January 2012) *Standards of Medical Care in Diabetes*; Institute for Clinical Systems Improvement (April 2011), *Prevention and Management of Obesity*; American Association of Clinical Endocrinologists, The Obesity Society and American Society for Metabolic & Bariatric Surgery (2008) *Medical Guidelines for the Perioperative Nutritional, Metabolic and Nonsurgical support of the Bariatric Surgery Patient*

<sup>5</sup> [http://www.accessdata.fda.gov/cdrh\\_docs/pdf/p000008s017a.pdf](http://www.accessdata.fda.gov/cdrh_docs/pdf/p000008s017a.pdf)

<sup>6</sup> Bariatric Surgery and Prevention of Type 2 Diabetes in Swedish Obese Subjects, L. Carlsson, *New Engl J Med*, Vol 367: No 8: 695, August 2012

<sup>7</sup> Bariatric Surgery versus Conventional Medical Therapy for Type 2 Diabetes, Mingrone, G, *New Engl J Med*, 366:17, 1577-1585, April 2012 and Bariatric Surgery versus Intensive Medical Therapy in Obese Patients with Diabetes, Schauer, P, *New Engl J Med*, 367:17, 1567-1585, April 2012

thresholds may be appropriate under specific circumstances. Clarify any severity requirement that applies to co-morbidities.

Pre-surgical Waiting Period: Indicate the waiting period required. Waiting periods should be no longer than one year unless justified.

Pre-Authorization Criteria: Describe your pre-authorization or pre-certification process.

Procedure Selection: List specific bariatric surgical procedures covered under your plan.

Preferred Facilities: The Centers for Medicare & Medicaid Services (CMS) designates bariatric centers of excellence that meet accreditation standards set by the American College of Surgeons and American Society for Metabolic and Bariatric Surgery.<sup>8</sup> Some carriers also self-certify selected bariatric surgery facilities as eligible for payment. OPM strongly encourages all plans to consider referring surgical candidates to specialized centers to ensure high quality and maximize the value of their coverage.

Clinical Trials: Plans may receive requests for bariatric surgery on behalf of FEHB members who do not meet their criteria. Since some of these individuals might benefit, OPM encourages plans to refer appropriate members to ongoing clinical trials.

If you have any questions, please contact your contract specialist. We appreciate the commitment of FEHB plans to improve the health of federal employees and their families through optimized medical and surgical management of obesity.

Sincerely,

John O'Brien  
Director  
Healthcare and Insurance

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<sup>8</sup> CMS qualified facilities are listed at <http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/Bariatric-Surgery.html>