Medicare Expands Bariatric Surgery Coverage

Several types of procedures are covered for all ages, but only if they're done at certified surgical facilities.

BY JENNIFER LUBELL
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Medicare has expanded its coverage of bariatric surgery to its beneficiaries of all ages—provided that those patients seek care in facilities certified by the American College of Surgeons or the American Society for Bariatric Surgery.

The Centers for Medicare and Medicaid Services had originally proposed to exclude patients aged 65 years and older from coverage for bariatric surgery, based on the significant surgical risks seen in studies of this population.

But in reviewing new data and analyses, the agency determined that similar outcomes could be obtained in patients of all ages—provided that the surgery be performed in facilities capable of handling large numbers of these procedures and that it be performed only by highly qualified surgeons.

In its national coverage decision, CMS said it had evaluated the certification programs of the American College of Surgeons and the American Society for Bariatric Surgery and determined that facilities deemed Centers of Excellence by either organization would be able to produce the best surgical results.

The ACS devised its standards "for anybody performing this surgery in adults of any age," Dr. R. Scott Jones, the ACS's director of the division of research and optimal patient care, said in an interview. "We've got a big problem with obesity, so it's important for the public to know that they can go to a hospital that meets standards that are subject to scrutiny."

In announcing the national coverage decision, CMS Administrator Dr. Mark B. McClellan said, "Bariatric surgery is not the first option for obesity treatment, but when performed by expert surgeons, it is an important option for some of our beneficiaries.

"While we want to see more evidence on the benefits and risks of this procedure, some centers have demonstrated high success rates, and we want to ensure access to the most up-to-date treatment alternatives for our beneficiaries."

CMS's original proposal, issued late last year, would have excluded coverage for patients older than 65 years, except in clinical trials.

Evidence regarding the benefits of the surgery is more limited for the over-65 population, Cynthia A. Brown, director of advocacy and health policy at ACS, said in an interview.

'We've got a big problem with obesity, so it's important for the public to know that they can go to a hospital that meets standards that are subject to scrutiny.'

Nevertheless, she noted "the procedure is valuable, and ought to be covered as part of the process that includes data collection and quality monitoring. And that's what CMS is doing."

The College started its certification program "because of concerns on what happens when new technology gets disseminated into the community and used in specialized facilities," Ms. Brown said.

"Our certification program addresses those issues, as well as data collection, to monitor outcomes."

The national coverage decision also expands the types of bariatric procedures Medicare covers for its beneficiaries. Previously, only gastric bypass surgery was covered; now the list also includes open or laparoscopic Roux-en-Y bypass, laparoscopic adjustable gastric banding, and open or laparoscopic biliopancreatic diversion with duodenal switch.

Although Medicare's bariatric coverage has expanded regarding patient age and types of procedures, limitations do remain. Coverage is still restricted to obese patients who have one or more comorbidities, such as hypertension, type 2 diabetes, osteoarthritis, or coronary heart disease, according to CMS. ■

More information on the American College of Surgeons' bariatric surgery certification program is available at www.facs.org/cqi/bscn/index.html. Medicare's coverage decision can be found at www.cms.hhs.gov/center/coverage.asp.

Obesity, Hypertension, Apnea Confound Diagnosis of PAH

BY BRUCE K. DIXON
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MONTREAL — Obese patients often have a constellation of physiological problems that together can lead to a mistaken diagnosis of pulmonary artery hypertension, according to researchers at Duke University Medical Center in Durham, N.C.

The presence of exertional dyspnea in these patients often leads to an echocardiogram and a finding of elevated right ventricular systolic pressure.

"Often, the pressure is just mildly elevated, and these patients don't really have pulmonary arterial hypertension but are referred for evaluation anyway," Dr. Terry A. Fortin said at the annual meeting of the American College of Chest Physicians. "The etiology of their mild pulmonary hypertension often is multifactorial and can present a diagnostic dilemma."

To assess diagnostic strategies for pulmonary arterial hypertension (PAH) in this often very symptomatic population, Dr. Fortin and her colleagues retrospectively assessed consecutive cardiac catheterization data on patients referred for suspected PAH.

Suspected PAH was defined as mean pulmonary arterial pressure (mPAP) greater than 25 mm/Hg, pulmonary capillary wedge pressure (PCWP) less than 15 mm/Hg, and pulmonary vascular resistance (PVR) greater than 3 Wood units.

Patients with left ventricular systolic dysfunction, pulmonary hypertension (PH) clearly associated with a known syndrome, or significant valve or lung disease of sufficient severity to explain PH were excluded. That left 78 obese patients with mild PH and with mPAP greater than 25 mm/Hg and PVR less than 5 Wood units, said Dr. Fortin of Duke University Medical Center.

Of those 78 patients, 40 had baseline syndromes or conditions that the investigators believed adequately explained the patients' PH after workup. Those conditions included connective tissue disease, congenital heart disease, chronic thromboembolic disease, portopulmonary disease, severe lung disease, high-output arteriovenous shunts, and left-sided valve disease.

Eliminating these patients left 38 patients with elevated mPAP associated with a constellation of factors that together resulted in PH, although maybe not PAH, she said.

'It should not be assumed that patients with an elevated right ventricular systolic pressure by echo have pulmonary arterial hypertension. Pulmonary capillary wedge pressure and diastolic dysfunction may be causative.'

Most were women with a mean age of 60 years. All were hypertensive, and virtually all had a body mass index greater than 30; half had a body mass index (BMI) greater than 40. Nearly two-thirds had diabetes and/or a sleep disorder.

"The precatheterization diagnostic tests often showed elevated right ventricular systolic pressures on referral cardiac echo, and that was typically the reason that the patients were sent to us," Dr. Fortin explained.

Many of the patients did have increased artery sizes, and their right atrium size or decreased contractility in the right ventricle was of concern. About half the patients were hypoxemic, and some were hypercarbic, "which is not necessarily what we would expect in pulmonary hypertension," she added.

Low lung volume was common, and many patients had reduced diffusion capacity of carbon monoxide (DLCO). Two patients had only increased right ventricular systolic pressures.

"Looking at the cardiac cath data, PVRs were not quite 3 [Wood units] in most patients, and if you break them down into those with enlarged and normal right ventricles, they're slightly different, but not statistically so," Dr. Fortin said.

In addition, the study investigators found a slight but statistically nonsignificant difference in mean pulmonary pressures, with a predominance of elevated pressures—as expected in bigger right ventricles. Overall, the patients had normal cardiac indices and were not very sick.

Only one patient had pulmonary arterial hypertension based upon a PCWP less than 15 mm/Hg and a PVR greater than 3, Dr. Fortin said. Hypoxemia, hypercarbia, low total lung capacity, and DLCO were all related to obesity, hypoventilation, and sleep disorders, she added.

"Lest you think that obese people do not ever have pulmonary hypertension, I was quickly able to glean 13 patients who were morbidly obese with BMIs greater than 40 who were seen in our clinic," Dr. Fortin observed. "All had mPAPs greater than 25 with elevated pulmonary vascular resistances. In fact, their average pulmonary artery pressure was 60, and their PVR was 12, while their cardiac indices were very low; these were very sick patients."

The study's researchers concluded that a number of factors can contribute to a mistaken diagnosis of PAH. These include systemic hypertension, obesity, sleep-disordered breathing and hypoventilation, and elevated pulmonary capillary wedge pressure.

"It should not be assumed that patients with an elevated right ventricular systolic pressure by echo have pulmonary arterial hypertension," Dr. Fortin cautioned. "Pulmonary capillary wedge pressure and diastolic dysfunction may be causative."

Aggressive management of weight, sleep disorders, hypertension, hypoxemia, and diabetes may limit the development of diastolic dysfunction and secondary pulmonary hypertension, though that's easier said than done, she added.

"Patients with this complex of disorders often have findings similar to those in full-blown PAH, and thus cardiac catheterization is necessary to help sort this out," Dr. Fortin said. "I think that diagnostic testing also should definitely include sleep studies, as 70% of these patients had sleep disorders that were not necessarily diagnosed at the time of presentation."

It is not necessary to proceed directly to performing a diagnostic test, Dr. Fortin noted, "as long as you're following the patient carefully; try to fix these other factors first before going to cardiac catheterization." ■