

Bariatric surgery complications rates following restricting coverage to higher-quality centers

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In an analysis of data on patients who underwent bariatric surgery 2004-2009, there was no significant difference in the rates of complications and reoperation for Medicare patients before vs. after a 2006 Centers for Medicare & Medicaid Services policy that restricted coverage of bariatric surgery to centers of excellence, according to a study appearing in the February 27 issue of *JAMA*.

"Prompted by concerns about perioperative safety with [bariatric surgery](#), the Centers for Medicare & Medicaid Services (CMS) issued a national coverage decision in 2006 that limited coverage of weight loss surgery to centers of excellence (COEs)," according to background information in the article. These COEs were accredited by a surgical professional organization. "In addition to other structural measures and processes of care, the accreditation was based on a hospital volume threshold (>125 cases/year). Whether the CMS restriction of bariatric surgery to COEs is associated with improved outcomes remains uncertain."

Justin B. Dimick, M.D., M.P.H., of the University of Michigan, Ann Arbor, and colleagues compared outcomes in Medicare patients before and after implementation of the CMS policy to determine whether the policy was associated with improved outcomes (rate of complications, reoperations). The study included 2004-2009 hospital discharge data from 12 states (n = 321,464 patients) and analyzed changes in outcomes in Medicare patients undergoing bariatric surgery (n = 6,723 before and

n = 15,854 after implementation of the policy). A difference-in-differences analytic approach was used to evaluate whether the national coverage decision was associated with improved outcomes in Medicare patients above and beyond existing time trends in non-Medicare patients (n = 95,558 before and n = 155,117 after implementation of the policy).

The researchers found that bariatric surgery outcomes improved during the study period in both Medicare and non-Medicare patients; however, this change was already underway prior to the CMS coverage decision. "After accounting for patient factors, changes in procedure type and pre-existing trends toward improved outcomes, there were no measurable improvements in outcomes after (vs. before) implementation of the CMS national coverage decision for any complication (8.0 percent after vs. 7.0 percent before the policy), serious complications (3.3 percent vs. 3.6 percent), and reoperation (1.0 percent vs. 1.1 percent)."

In a direct comparison of outcomes at COEs (n = 179) vs. non-COEs (n = 519), COEs did not result in better outcomes than non-COEs. "After accounting for patient factors, procedure type, and the year of operation, patients undergoing bariatric surgery at hospitals with the COE designation (vs. hospitals without the COE designation) did not have significantly different rates for any complication (5.5 percent vs. 6.0 percent), serious complications (2.2 percent vs. 2.5 percent), and reoperation (0.83 percent vs. 0.96 percent)."

Also, the authors found no relationship between hospital COE designation and adverse outcomes in a sensitivity analysis that evaluated [Medicare](#) and non-[Medicare patients](#) separately.

"Rather than the CMS policy restricting bariatric surgery to COEs, we found that the improvement in outcomes over time could be explained in part by the evolution away from higher risk toward lower risk procedures," the researchers note. They add that procedure mix changed

in 2 important ways: first, there was a general shift away from open to laparoscopic surgery, which is consistent with broader trends in surgery toward less invasive procedures with more favorable safety profiles; and second, there was a dramatic increase in the use of laparoscopic gastric banding, a safer but less effective procedure.

The authors write that the "CMS policy restricting coverage to COEs has not been associated with improved outcomes for bariatric surgery, but may have had the unintended consequence of reducing access to care [because of potentially increased travel distance to undergo the procedure]. These findings suggest that the CMS should reevaluate this policy."

In an accompanying editorial, Caprice C. Greenberg, M.D., M.P.H., of the University of Wisconsin Hospitals and Clinics, Madison, writes that because of the results of studies such as Dimick et al, the CMS is currently re-evaluating the need for bariatric surgery COEs.

Dr. Greenberg notes that COE accreditation relies on measures of structure and processes of care that duplicate accreditation functions of the Joint Commission. Measuring outcomes is difficult when relying on manual collection of information, delaying interventions when there is a need for improvement.

"As the CMS and the surgical societies re-examine the COE policy in bariatric [surgery](#), there is an opportunity for them to be creative; to catapult surgical outcomes science forward through scalable approaches to data sharing, measurement, collaborative networks, and CER; and to design a program that can not only identify high-quality hospitals, but also provide a sustained mechanism for quality improvement."

More information: *JAMA*. 2013;309(8):792-799; *JAMA*. 2013;309(8):827-828.

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