Obesity and Morbid Obesity Management

Adjudication Guideline

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1.Abstract

1.1 For Members

Obesity is a condition involving abnormal or excessive body fat accumulation that poses a risk to health.

It is considered a multifactorial chronic disease influenced by a complex interaction of biological, genetic, environmental, and behavioral factors including sex, ethnicity, genetic susceptibility, developmental influences, physical activity and dietary habits.

Body mass index (BMI) is a simple index of weight-for-height that is commonly used to classify obesity in adults. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m2). The WHO defines obesity as BMI greater than or equal to 30 kg/m2.

1.2 For Medical Professionals

Individuals living with obesity are at greater risk of developing serious chronic conditions, including cardiovascular disease, stroke, type 2 diabetes mellitus, certain cancers, and non-alcoholic fatty liver disease.

Evidence demonstrates a positive association between increasing body weight and all-cause mortality across sexes and ethnic groups, with the risk of premature death rising progressively with greater obesity severity.

BMI should be interpreted with caution in adults with high muscle mass, as an elevated BMI may reflect increased lean body mass rather than excess adiposity. Similarly, in adults aged 65 years and older, BMI should be assessed carefully, as a modestly higher BMI may be associated with favorable health outcomes and improved survival compared with lower BMI ranges.

It is the responsibility of the treating physician to assess and discuss the patient’s weight management goals, provide realistic expectations regarding the degree of weight loss that can be achieved with specific interventions, and ensure that the proposed management plan is tailored to the patient’s individual preferences, treatment goals, and clinical circumstances.

2.Scope

This adjudication rule specifies the coverage details for medically necessary indications for Obesity and Morbid Obesity Management, and the Thiqa Pharmaceutical Obesity management as per the policy terms and conditions of each health insurance plan administered by Daman.

Classification of weight category by BMI for adults:

Category	Body Mass Index kg/m²
Underweight	<18.5
Normal weight	18.5 - 24.9
Overweight (pre-obese)	25.0 - 29.9
Obesity class I	30.0 - 34.9
Obesity class II	35.0 - 39.9
Obesity class III	≥40.0

3.Adjudication Policy

3.1 Eligibility / Coverage Criteria

Daman covers conservative obesity management for weight control only under health insurance plans that include this specific benefit.

Coverage for the surgical management of morbid obesity is available only under health insurance plans that include the relevant benefit and is subject to the coverage provisions specified in the Schedule of Benefits (SOB) for each plan.

- Criteria for eligibility of weight loss surgery for morbid obesity for adults (> 18 years):
- Criteria for eligibility of weight loss surgery for morbid obesity for young Adults (post-pubertal - 18 years):
- Preoperative workup for bariatric surgery will be covered according to international best practice.
- The major comorbidities which evidence suggests can be improved by losing weight include:
    - Type 2 Diabetes.
    - Dyslipidaemia.
    - Asthma.
    - Hypertension.
    - Ischemic heart disease.
    - Obstructive Sleep apnea syndrome.
    - Obesity syndrome hypoventilation (Pickwickian syndrome).
    - Disabling arthropathy.
    - Non-alcoholic fatty liver disease and steatohepatitis.
    - Gastro-oesophageal reflux.
    - Severe urinary incontinence.

- Venous stasis disease.
- Severely reduced quality of life. (To be determined by the bariatric MDT team); and 14. PCOS with infertility.

- The following comorbidities require additional assessment and referral from expert in the field of the comorbid disease:

1. Severe urinary incontinence
2. Disabling arthropathy
3. Venous stasis disease
4. PCOS with infertility

3.2 Requirements for Coverage

ICD and CPT codes must be coded to the highest level of specificity.

4. Non-Coverage

- Treatment of obesity is not covered for those health insurance plans where it is a general exclusion of their respective policies.
- Coverage will be restricted as per SOB for the plans in which obesity treatment coverage is restricted, regardless of the associated co-morbidities or failed treatment attempts e.g., gastric banding for morbid obesity only.
- Coverage for types of bariatric surgeries will be restricted as per SOB

5. Payment and Coding Rules

Please apply regulator payment rules and regulations and relevant coding manuals for ICD, CPT

1. Obesity or morbid should be coded with the appropriate ICD 10 CM codes designated as the principal diagnosis.

2. The principal code for obesity or morbid obesity should be accompanied by a secondary diagnosis code that defines the patient's BMI.

3. In case pre-op tests are required for bariatric surgery 3 ICD codes are required.

4. All patients should have received counselling from a multidisciplinary who are ALL DOH licensed.
    - This should include treating internal medicine or family medicine specialists / consultant, Surgeon.
    - Psychologist.
    - Clinical dietician

5. All candidates (Adults) need to go through the lifestyle modification unless the MDT team mentions that his co-morbidity is severe and that delaying the surgery would be life threatening.

6. The report should be structured and evidenced to show the different sessions of management plan (dietary and exercise or behavioural modification) and compliance of the patient. The weight loss journey needs to be documented.

7. Bariatric Surgery should only be undertaken by a consultant level surgeon with expertise in the field of bariatric surgery.

8. The below listed procedures are the current approved bariatric procedures:
    - Intra-Gastric balloon.
    - Adjustable gastric banding.
    - Biliopancreatic diversion with duodenal switch.
    - Biliopancreatic diversion without duodenal switch.
    - Revisional bariatric surgery.
    - Roux-en-Y gastric bypass.
    - Mini - gastric bypass.
    - Sleeve gastrectomy

9. Bariatric surgery facility must offer follow-up post-surgery with any member of multi-disciplinary team based on patient's need for a minimum of 2 years and ensure the following requirements are fulfilled:
    - Monitoring nutritional intake (including protein and vitamins) and mineral deficiencies; Monitoring for comorbidities and screening for complications.
    - Medication review.
    - Dietary and nutritional assessment, advice and support.
    - Physical activity advice and support.
    - Psychological support tailored to the individual.

10. Revisional bariatric intra-abdominal procedures include any procedure performed at any time frame following a previous surgical intervention performed for the treatment of morbid obesity.

    Indications for re-operative and revision surgery for adults (re-operations are likely for either one or a combination of the following factors):
    - Complications relating to their primary procedure.

- Post-surgical failure to lose weight or significant weight regain following initial success; Failure to improve or re-emergence of a co-morbidity.
- A combination of these factors.
- Rarely reversal is required for excessive weight loss, malnutrition, or intractable diarrhoea.

11. Failure of weight reduction and/or resolution of severe comorbidities:
Repeat surgery for failure of a primary obesity procedure may be due to failure to achieve sufficient or expected weight loss; the latter may be accompanied by failure of co-morbidities to resolve e.g. diabetes, obstructive sleep apnea. Revision surgery may be performed, to achieve weight loss that was not realized by the initial procedure. Long-term studies of obesity surgery show a gradual tendency, within 2 years to regain weight that was lost in the first few months after the operation or a failure to attain the expected average percentage of excess weight loss.

Pharmaceutical Management of Obesity

Pharmacologic treatment is considered appropriate for patients who have not achieved adequate weight loss or who have reached a plateau, despite adherence to a comprehensive lifestyle intervention. The decision to initiate such treatment should be made by a licensed physician following a thorough discussion with the patient. This discussion should include the potential benefits and limitations of the medication, its mechanism of action and possible adverse effects, as well as ongoing monitoring requirements and its expected impact on the patient's motivation.

Obesity medications:

Table: A

Obesity medications	Generic & Brand Name	Starting criteria	Stopping Criteria	Recommended Dose
GLP-1 receptor agonists	Tirzepatide (Mounjaro)	BMI of at least 30.0 kg/m2, and one or more weight-related comorbidities	Continue beyond 6 months only if the person has lost at least 5% of their initial body weight since starting the drug	Once weekly
	Semaglutide (Wegovy)			Once weekly
	Liraglutide (Saxenda)			Each pre-filled syringe for 6 days

Combination anorectic medication (e.g., phentermine and topiramate extended release)	Phentermine HCl/topiramate (Qsymia)	BMI of at least 35.0 kg/m2, and one or more weight-related comorbidities	Continue beyond 3 months only if the person has lost at least 5% of their initial body weight since starting the drug	Once daily
Lipase inhibitors (e.g. tetrahydrolipstatin - orlistat)	- Tetrahydrolipstatin - orlistat	Has a BMI of at least 30.0 kg/m2, OR a BMI of at least 28.0 kg/m2 with associated risk factors	Continue beyond 3 months only if the person has lost at least 5% of their initial body weight since starting the drug	3 times daily

Eligibility and Enrollment

To be eligible for obesity medications, patients must meet all the following criteria as outlined in the Thiqa Reimbursement Policy and the Standard for Non-Surgical Management of Obesity:

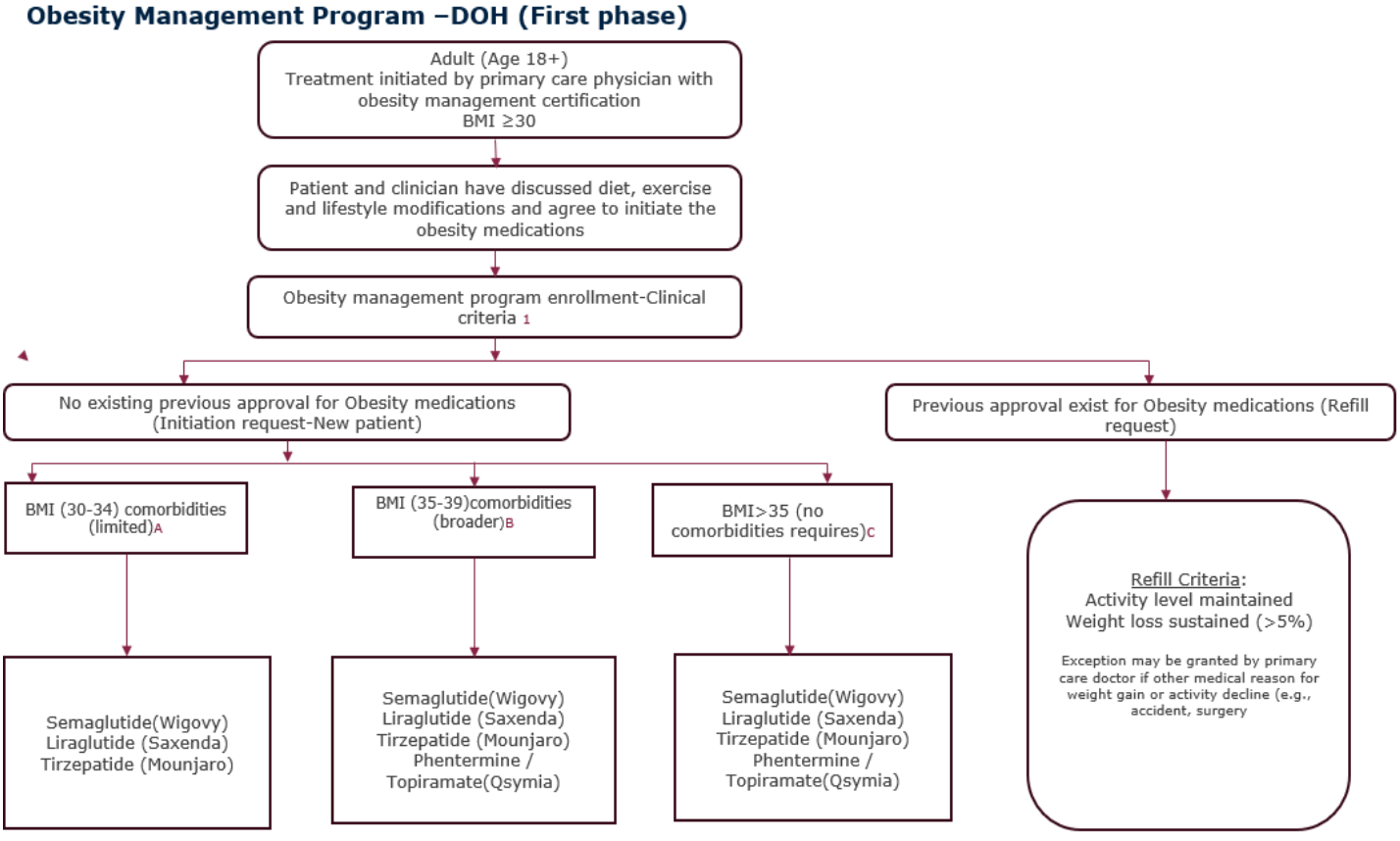
- **Thiqa plan categories C1, C2**
- **Age**: ≥ 18 years
- **BMI**: ≥ 30

Clinician Eligibility:

Treatment must be initiated by a primary care physician certified in obesity management. Acceptable certifications include those obtained through the World Obesity Federation or equivalent organizations. The following clinician categories are considered eligible:

- Endocrinologists (licensed by the Department of Health – DoH)
- Family and Internal Medicine physicians who have completed an obesity management training program recognized by the DoH, such as SCOPE certification or other internationally accredited courses

Medical Eligiblity:(Based on above Table A and below workflow and Table B)



Severe Comorbidities Qualifying for Medical eligibility criteria:

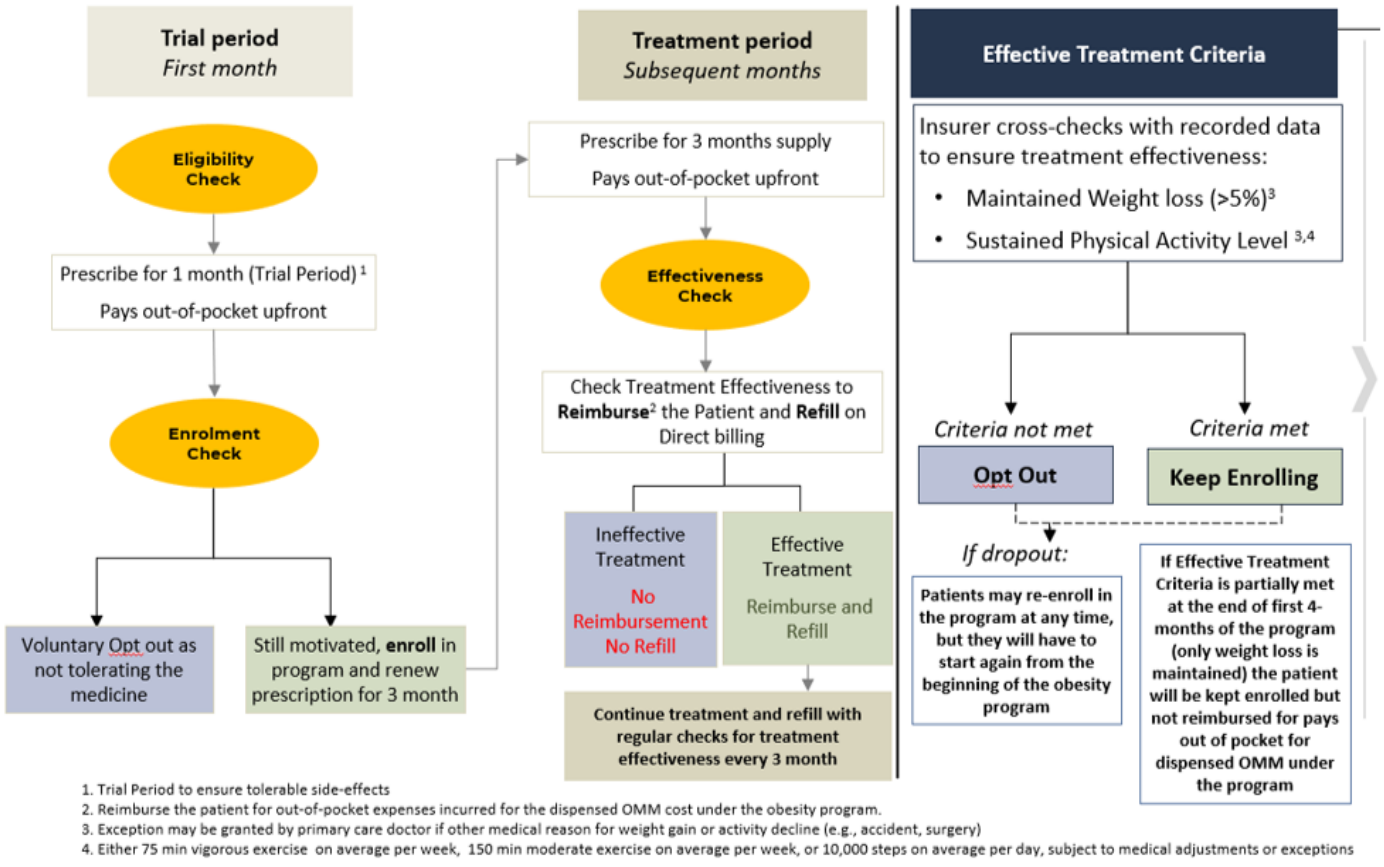
Table: B

Comorbidity	BMI 30.0-34.9 (A)	BMI 35.0-39.9 (B)	BMI40 ++ (C)
Asthma	Only severe cases qualify (Must be confirmed by Urologist/Urogynecologist)	All cases Qualify (Must be confirmed by rologist/Urogynecologist)	No comorbidity required
Arthropathy	Qualifies only if disabling	Qualifies only if disabling	
Cardiovascular & ischemic heart disease	All cases qualify	All cases qualify	
Dyslipidemia (severe, as demonstrated by high lipid levels)	Only severe cases qualify as demonstrated by high lipid levels ((Total cholesterol ≥ 7.8 mmol/L OR Triglycerides ≥ 5.6 mmol/L))	All cases Qualify	
Hypertension	All cases qualify	All cases qualify	
Non-alcoholic fatty liver disease and steatohepatitis	All cases qualify	All cases qualify	
Obstructive sleep apnea	Only severe cases qualify, as demonstrated by AHI > 30	All cases qualify	
Urinary incontinence	Only severe cases qualify (Must be confirmed by Urologist/Urogynecologist)	Only severe cases qualify (Must be confirmed by Urologist/Urogynecologist)	
Vascular disease	Only severe cases, e.g., cerebrovascular events, thrombosis, embolism or portal hypertension	All cases qualify	

Obesity Syndrome Hypoventilation (Pickwickian Syndrome)	All cases qualify	All cases qualify	
PCOS with infertility	All cases qualify (Must be confirmed by Gynecologist)	All cases qualify (Must be confirmed by Gynecologist)	

Biochemically defined for sever dyslipidemia as total cholesterol ≥ 7.8mmol/L or Triglycerides ≥ 5.6 mmol/l across multiple guidelines (ACC, AHAESC, EAS)

Enrollment process:



1. Trial Period to ensure tolerable side-effects
2. Reimburse the patient for out-of-pocket expenses incurred for the dispensed OMM cost under the obesity program.
3. Exception may be granted by primary care doctor if other medical reason for weight gain or activity decline (e.g., accident, surgery)
4. Either 75 min vigorous exercise on average per week, 150 min moderate exercise on average per week, or 10,000 steps on average per day, subject to medical adjustments or exceptions

Refill criteria for obesity medications: (Must meet all criteria)

1. Activity Level Maintained
2. Weight loss sustained (≥5%)

Red flag:

- Exceptions may be granted by primary care doctor if other medical reason for weight gain or activity decline (e.g..., accident, surgery)
- Patient can be unenrolled because of patient decision or medical condition (Pregnancy)or any other contraindications which should be reported
- Chronic kidney disease and gastroesophageal reflux (with or without esophagitis) are not considered qualifying obesity-related comorbidities

Scenarios:

1. Are diabetic patients who are taking GLP eligible to be enrolled in the Non-surgical Obesity program?

Yes, provided the eligibility criteria outlined in the Standard for Non-Surgical Management of Obesity are met and the effective treatment outcomes are achieved.

2. Can the patients switch between medication during the program?

Yes, they can switch between the listed medications, however upon initiating obesity management medication therapy; patients can switch to other medication (subject to medical necessity) as continuation of therapy.
Note: if patients opt out of the program they may re-enroll in the program at any time, but they will have to start again from the beginning of the obesity program

3. How many complications must the patient have to be eligible for enrollment?

Eligibility is determined based on BMI and list of complications as outlined in Thiqa Non-surgical Obesity policy
https://www.doh.gov.ae//media/CAFD4FAD88EE4D68B5610CFFE4024DAB.ashx

6.Appendices

Adjudication Examples:

Example 1:
Q: A patient diagnosed with obesity is unable to exercise due to back & knee pain and he/she has intolerance to weight loss pharmacology. Can the patient undergo bariatric surgery?

Answer:

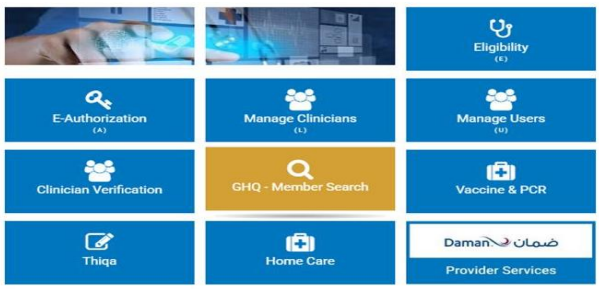
- Weight loss medication is not mandatory to proceed with surgery as per the standards.
- If the patient has knee pain, then what is dx of the condition. Referral to orthopaedic if they consider it as a comorbid condition in pt. with BMI less than 40. If patient has knee pain and not tolerant. The patient should visit a physiotherapist. They should offer a plan before or after surgery.
- Final approval for surgery will be based on MDT team recommendations.

Example 2:
Q: A physician is claiming that medical reports from the nutritionist stating that the patient tried lifestyle modification but failed to reduce their weight with no evidence that the patient followed any structured program.

Answer:

- Reject the case, if there is no evidence of structure program, no goal or objective written. The program should be structured with detailed plan of the treatment journey.

Medical Assessment questionnaire:
The medical assessment questionnaire is mandatory and can be accessed through the Disease Management section of the Daman Dashboard within the Provider Services module of the OpenJet



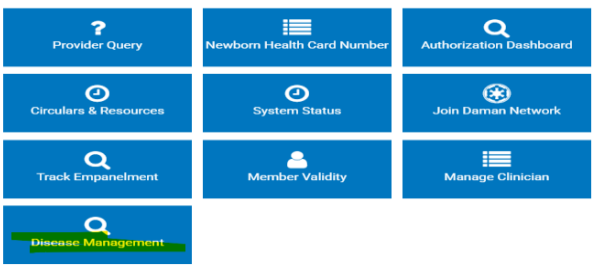


Table 1. Criteria for eligibility and documented evidence for approvals for Bariatric Surgery

Criterion	Requirements for Eligibility for Bariatric Surgery	Documentary evidence
Adults (18 or over)		
Clinical indicators	• BMI of 40* without comorbidities. • BMI of 35-39.9 with at least comorbidity ** (are expected to improve after surgical intervention). • BMI of 30-34.9 with uncontrolled type 2 diabetes mellitus can be considered in individual basis***. • BMI criterion may be the current BMI or previously maximum attained BMI of this severity. Note: Bariatric surgery is indicated in patients who had exhibited substantial weight loss through extensive lifestyle interventions but began to regain lost weight even if the required minimum indication weight for surgery has not been attained yet.	Medical report to include: • Patient information • BMI • List if investigation required for bariatric surgery according to international standards for care of obesity and obesity related diseases. • Evidence of the assessment of the comorbid condition and the severity and the necessity of surgery from all MDT members in accordance with their practice and capabilities.

Service/consultation	1. Weight loss attempts: • Must have been delivered by a DOH licensed professional who has the authorization by his/her scope of practice in weight management, • Patient must have failed to achieve or maintain adequate, clinically beneficial weight prior to surgery. 2. Counselling: • All patients must have received counselling and clearance for surgery from a multidisciplinary specialist team including a minimum of a: • Physicians trained on obesity care (This should include internal medicine or family medicine specialists / consultant"). • Surgeon. • Psychologist. • Clinical dietician. 3. The multi-disciplinary specialist team may consider earlier access to surgery if delay may increase the health risks of the patient.	Report from a DOH Licensed dietician who has authorization by his/her scope of practice in weight management Evidence of the delivery of a structured program for lifestyle intervention and With/out pharmacological intervention. Physician/nurse license number to be checked against DOH database. Report of support from a psychologist (psychiatrist if needed). Report from the bariatric surgeon with justifications for the requirement for bariatric surgery. Signed consent form including evidence of explanation of risks and benefits of bariatric surgery. Evidence of the designated specialized bariatric team who will undertake post-surgery follow-up.

	• Untreated major depression or psychosis; Uncontrolled and untreated eating disorders (e.g. Bulimia); • Current drug and alcohol abuse;	

Criterion	Requirements for Eligibility for Bariatric Surgery	Documentary evidence
Adolescents (below 18 years of age)		
Clinical indicators	Adolescent candidates for bariatric surgery must meet all of the following indicators: 1. Be morbidly obese (defined by the World Health Organization as a body mass index >40) AND, 2. Have comorbidities related to obesity that might be remedied with durable weight loss AND, 3. Shows skeletal and developmental maturity AND, 4. Have failed to lose weight through attempts of diet, exercise , behaviour modification with/out pharmacological intervention over at least 6 months AND, 5. All other attempts at behaviour modification have failed to achieve	1. Medical report / preparation assessment according to an updated best international practice. 2. Evidence of the delivery of a structured program for lifestyle modification.

	weight loss goals over a six-month period AND, 6. Express willingness to follow program requirements which include signing an Assent form, having the individual's legal guardian sign a consent form. 7. Agreed to avoid pregnancy for two years post operatively AND, 8. Agreed to adhere to nutritional guidelines postoperatively AND, 9. Has a supportive family environment AND, 10. Confirmation by a senior clinical psychologist with child/adolescent experience or consultant/specialist psychiatrist with child/ adolescent experience that the subject is sufficiently emotionally mature to comply with the clinical protocol and fully understands the short , medium and long-term implications of the surgery.	
Weight loss attempts	Evidence of Six months of a comprehensive, structured multi-disciplinary protocol including a structured behavior modification program****	Report from a DOH licensed dietician. Evidence of the delivery of a structured program for lifestyle intervention.

Service/consultation	1. Weight loss attempts: Must have been delivered by a DOH licensed specialist. 2. Counselling: The child must have had consultation and counselling from a multi-disciplinary team with expertise in childhood obesity, including as a minimum a DOH licensed: • Dietician • Behavioral specialist in pediatric and Adolescent care; • Pediatric medical advisor**** and a Pediatric bariatric surgeon or adult • Bariatric surgeon with expertise in Adolescent bariatric surgery and proven track record in adult bariatric surgery. 3. Assessment for surgery: Must only be made by a consultant level pediatric bariatric surgeon or adult bariatric surgeon with expertise in adolescent bariatric surgery and proven track record in adult bariatric surgery. 4. Consent Process must: • Be undertaken by the bariatric surgeon.	Report from a DOH Licensed dietician who has authorization by his/her scope of practice in weight management Evidence of the delivery of a structured program for lifestyle intervention and With/out pharmacological intervention. Physician/nurse license number to be checked against DOH database. Report of support from a psychologist (psychiatrist if needed). Report from the bariatric surgeon with justifications for the requirement for bariatric surgery. Signed consent form including evidence of explanation of risks and benefits of bariatric surgery. Evidence of the designated specialized bariatric team who will undertake post-surgery follow-up.

	• Fully explain the risks and benefits of bariatric surgery including the short, medium and long terms risks. • Bariatric Facility must offer follow-up post-surgery with a multidisciplinary team including as a minimum a DOH-licensed: • Specialist paediatric bariatric surgeon or • adult bariatric surgeon with expertise in adolescent bariatric surgery and proven track record in adult bariatric surgery. • Paediatric medial advisor. • Specialist paediatric bariatric nurse • Specialist paediatric bariatric dietician. • Specialist paediatric bariatric support service. 5. Adolescent bariatric surgery should be performed in a Bariatric Surgery Facility/Centre by a surgeon who fulfils the requirements of adult revision / high-risk surgeries. *****	

6.1 References

https://www.doh.gov.ae/-/media/CAFD4FAD88EE4D68B5610CFFE4024DAB.ashx
https://www.fda.gov/MedicalDevices/ProductsandMedicalProcedures/ObesityDevices/default.htm
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6.2 Revision History

Date	Change(s)
01/11/2011	V1.0 Release
01/11/2012	V2.0 Content Update
01/07/2013	V3.0 New template
15/07/2014	V4.0 • Disclaimer updated as per system requirements • AR content updated as per the latest HAAD standards • Pre-op investigations for bariatric surgery added
10/06/2018	V5.0 • AR content updated as per the latest HAAD standards
24/02/2025	V6.0 • General Content Update • Addition of Thiqa Pharmaceutical Obesity Management section • Template and reference Update
23/06/2025	V6.1 • Obesity management program-DOH
12/11/2026	V6.2 • Diagnosing Physician Requirements for Urinary Incontinence update.

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