OMNIA HEALTH · NEWNAN, GEORGIA

# Your Weight-Loss Surgery Decision Guide

What the procedures actually do, what the published outcomes really say, how insurance works, and the questions worth asking before you commit to anything.

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START HERE

# You are not failing. Your body is defending a set point.

If you have lost weight and regained it, the most useful thing to understand is that this is the expected physiological outcome, not a character flaw.

When you lose a meaningful amount of weight, your body responds as though it is under threat. Appetite hormones shift toward hunger, satiety signals weaken, and resting energy expenditure falls. The uncomfortable part is how long it lasts. In one well-known study, these hormonal changes were still measurable **a full year after** the weight was lost, in people who had kept the weight off.[1]

That is why the honest question is not "can I lose weight." Most people can. The question is **what changes the set point your body keeps returning to**. Only two categories of treatment reliably do that: GLP-1 medications, which change the hormonal signal while you take them, and bariatric surgery, which changes it structurally and durably.

> THE PRACTICAL IMPLICATION
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> Any plan that relies on sustained willpower against a hormonal headwind is a plan with an expiration date. This is the single most important idea in this guide, and it is the reason obesity is treated as a chronic disease rather than a temporary problem.

## What actually predicts long-term success

- A treatment that addresses the biology, not just the calories.
- Follow-up that continues for years, not weeks. This is where most programs quietly fail.
- Protein and resistance training during weight loss, so what you lose is fat and not muscle.
- Treating the conditions that travel with weight: sleep apnea, reflux, type 2 diabetes.
- A plan that can change. Medication first and surgery later is a legitimate path, and so is the reverse.

## Do you meet the usual criteria?

Most patients are candidates for bariatric surgery at a **BMI of 35 or higher**, or at a **BMI of 30 or higher** when a weight-related condition such as type 2 diabetes is present. Medical weight-loss programs generally start at a BMI of 27 or higher. These are starting points for a conversation, not a verdict: the real assessment includes your history, your conditions and your previous attempts.

COMPARE

# Four operations, four different jobs

There is no single best procedure. There is a best procedure for your anatomy, your conditions and your goals, and that is a decision made with a surgeon after a proper workup.

| PROCEDURE | WHAT IT DOES | OFTEN CHOSEN WHEN | TRADE-OFFS TO WEIGH |
|---|---|---|---|
| **Gastric sleeve** | Removes most of the stomach, leaving a narrow sleeve. Reduces capacity and lowers hunger hormones. | The most common first procedure. Strong results with a simpler operation. | Can worsen or unmask reflux in some patients. |
| **Gastric bypass** | Creates a small stomach pouch and reroutes a portion of the small intestine. | Higher BMI, type 2 diabetes, or significant reflux, which it often improves. | More complex. Requires lifelong vitamin supplementation and monitoring. |
| **SADI-S / duodenal switch** | Combines a sleeve with a longer intestinal bypass for a stronger metabolic effect. | Higher BMI or difficult metabolic disease where more effect is needed. | The most powerful option and the most demanding on nutritional follow-up. |
| **Revision surgery** | Converts or repairs a previous weight-loss operation that is no longer working. | Regain after a prior procedure, or a complication such as new reflux. | Technically harder than a first operation. Requires a surgeon who does them regularly. |

A QUESTION WORTH ASKING ANY SURGEON

"If I were your family member, which of these would you recommend for me, and what is the single strongest argument against it?" A surgeon who answers both halves is a surgeon giving you a real assessment rather than a preference.

## What all four have in common

- Performed laparoscopically or robotically in almost all cases, through small incisions.
- Typically one night in the hospital, sometimes two, depending on the procedure and your health.
- A staged diet progression afterward: liquids, then soft foods, then a durable eating pattern.
- Most patients are back to desk work in about two weeks, and to full activity in four to six.
- Lifelong follow-up. This is not optional, and it is the part that protects your result.

THE REAL COMPARISON

# GLP-1 medications versus surgery, honestly

Omnia offers both, which means we have no reason to steer you. Here is the comparison as the published evidence actually presents it.

| | GLP-1 MEDICATION | BARIATRIC SURGERY |
|---|---|---|
| **Typical weight loss in trials** | About 15% of body weight with semaglutide 2.4 mg at 68 weeks.[2] About 21% with tirzepatide 15 mg at 72 weeks.[3] | Commonly 25% to 30% of body weight, with the largest effect from bypass and SADI-S. |
| **What real-world data shows** | Lower than trials. One large real-world analysis found roughly 8% at one year on semaglutide and 15% on tirzepatide among patients who stayed on treatment.[4] | Durable at 5 and 10 years in registry data, with some regain expected over time. |
| **If you stop** | Weight is commonly regained, because the hormonal signal the drug was supplying stops. | The anatomic change persists. Habits and follow-up still determine the long-term result. |
| **Effect on type 2 diabetes** | Substantial improvement in glucose control while on treatment. | Frequently drives remission, sometimes within days of surgery, before much weight is lost. |
| **Commitment** | A weekly injection, ongoing cost, and side effects that are usually manageable but real. | One operation, a recovery period, and lifelong follow-up and supplementation. |

HOW TO READ THIS

Medication is a serious, legitimate treatment, and for many patients it is the right first step. Surgery produces more weight loss and holds it better. The wrong framing is surgery versus medication as rivals. The right framing is which one fits where you are now, with the option to change course later. Individual results vary in both directions.

## One thing to be careful about

If you pursue GLP-1 therapy, insist on **branded, FDA-approved medication**. Compounded GLP-1 products do not go through the same verification of identity, potency and purity, and dosing errors with them have caused real harm. Omnia Health prescribes branded medication only.

MONEY, PLAINLY

# What to ask your plan, in the order that matters

Coverage is rarely a simple yes or no. It is a list of conditions, and knowing the list early saves months. Call your insurer and ask these, in this order.

- [ ] **Is bariatric surgery a covered benefit on my specific plan?**
  Not on my insurer's plans generally. Mine. Employer plans often carve this out entirely, and that answer changes everything that follows.
- [ ] **What BMI and comorbidity criteria apply?**
  Get the actual thresholds, and whether a documented condition changes them.
- [ ] **Is a supervised weight-management period required first, and for how long?**
  Three and six month requirements are both common. Starting this clock early is the single biggest time saver.
- [ ] **What documentation do you require?**
  Typically some combination of a psychological evaluation, a nutrition consult, and weight history records.
- [ ] **Which procedures are covered?**
  Some plans cover sleeve and bypass but exclude SADI-S or revisions.
- [ ] **Is my surgeon and my hospital in network?**
  Both, separately. In-network surgeon at an out-of-network facility is a common and expensive surprise.
- [ ] **What is my deductible, coinsurance and out-of-pocket maximum for this year?**
  Timing a procedure relative to your plan year can change what you pay meaningfully.
- [ ] **How long does prior authorization take?**
  Ask for a typical timeline so you can plan time off work.

> IF YOUR PLAN SAYS NO
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> A denial is often a missing requirement rather than a final answer, and those are frequently fixable. If it is genuinely final, ask for a written self-pay quote and financing options. Be skeptical of any practice that quotes a single headline price without knowing your case.

## What we do on our side

- We verify your specific benefits before you commit to anything.
- We tell you your deductible and coinsurance exposure in real numbers.
- If you are paying yourself, you get a written quote, not a figure that moves later.
- If your plan denies coverage, we explain exactly why and what can still be done.

BRING THIS WITH YOU

# Twelve questions that separate a good program from a busy one

- [ ] How many of these procedures do you personally perform each year?
- [ ] Will you be the surgeon in the room, and will I see you at follow-ups?
- [ ] Is the hospital accredited for bariatric surgery, and by whom?
- [ ] What is your complication rate, and how do you handle one if it happens?
- [ ] Based on my history, which procedure would you recommend and why not the others?
- [ ] What does follow-up look like at one year and at five years?
- [ ] Who manages my nutrition, and are they part of your practice?
- [ ] How do you handle regain if it happens later?
- [ ] Do you also offer medical weight loss if surgery is not right for me?
- [ ] What happens to my reflux, diabetes or sleep apnea after this procedure?
- [ ] What is the realistic range of results for someone with my starting point?
- [ ] What would make me a poor candidate, and am I one?

## References

1. Sumithran P, et al. Long-term persistence of hormonal adaptations to weight loss. *N Engl J Med.* 2011;365(17):1597-1604.
2. Wilding JPH, et al. Once-weekly semaglutide in adults with overweight or obesity (STEP 1). *N Engl J Med.* 2021;384(11):989-1002.
3. Jastreboff AM, et al. Tirzepatide once weekly for the treatment of obesity (SURMOUNT-1). *N Engl J Med.* 2022;387(3):205-216.
4. Rodriguez PJ, et al. Semaglutide vs tirzepatide for weight reduction in a real-world population. *JAMA Intern Med.* 2024.

**Important.** This guide is general medical education, not medical advice, and it does not create a doctor patient relationship. Individual results vary: the figures above are population averages from published studies, not predictions about you. Surgical and medical treatments both carry risks that must be discussed with a physician who has reviewed your history.

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