

## Growth Hormone Deficiency: Perspectives from the Clinician and Payer Communities

Ron Rosenfeld, MD

This Special Report supplement to *The American Journal of Managed Care* features highlights of the Consultants' Conference, "Growth Hormone Deficiency: Perspectives from the Clinician and Payer Communities," held March 18 to 20, 2000, in Phoenix, Arizona. The symposium panel included experts in pediatric and adult endocrinology, pediatrics, and neuroendocrinology, as well as pharmacists, physicians, and other healthcare professionals representing the payer community.

The impetus for this conference was the following scenario. A child exhibited significant growth failure, evidenced by growth curves. However, the child had "passed" a provocative growth hormone test with a peak growth hormone level of 11 ng/mL. Thus, the insurance company denied reimbursement for growth hormone replacement therapy for that child. From a clinical perspective, the growth curves indicating that the child had been growing very poorly for at least 1 year were reason enough to prescribe growth hormone. Nevertheless, the insurance company based its decision to deny reimbursement on the test results, which are considered by many pediatric endocrinologists and cited in numerous textbooks and journals as "definitive" for the diagnosis of growth hormone deficiency.

Examination of this incident reveals several issues. First, improved communication between clinicians and payers—the 2 groups that are

critically involved in the care of children with hormone deficiency—is needed. Second, debate exists over diagnostic criteria in the payer community and among physicians, and, clear-cut diagnostic criteria and protocols—or at least approaches to protocols—that are acceptable to clinicians and payers alike must be created. Fourth, improved communication is needed between pediatric and adult endocrinologists who, in the long run, are responsible for the clinical manage-

ment of these children. The panel discussed the following questions:

- What are the emerging disorders in children transitioning patients, and issues for which growth hormone is often given but not yet indicated?
- What information should physicians be providing to managed care organizations and payers?
- What information should managed care organizations and payers be providing to clinicians?
- How can clinicians and payers work together to ensure that the patient receives the best possible care in a financially responsible manner?
- What are the emerging issues in growth hormone therapy, and how can physicians and payers be "ahead of the curve" regarding these issues?

The conference program included formal presentations by clinicians and

### ACRONYM LIST

The following acronyms appear within this Special Report supplement:

|                |  |
|----------------|--|
| <b>AIDS</b>    | Acquired immune deficiency syndrome          |
| <b>ACTH</b>    | Adrenocorticotrophic hormone                 |
| <b>CRI</b>     | Chronic renal insufficiency                  |
| <b>DEXA</b>    | Dual-energy X-ray absorptiometry             |
| <b>ESRD</b>    | End-stage renal disease                      |
| <b>FDA</b>     | Food and Drug Administration                 |
| <b>GH</b>      | Growth hormone                               |
| <b>HDL</b>     | High-density lipoprotein                     |
| <b>IGF-1</b>   | Insulin-like growth factor 1                 |
| <b>IGFBP-3</b> | Insulin-like growth factor binding protein 3 |
| <b>IGHD</b>    | Isolated growth hormone deficiency           |
| <b>ISS</b>     | Idiopathic short stature                     |
| <b>ITT</b>     | Insulin tolerance test                       |
| <b>KIGS</b>    | Kabi International Growth Study              |
| <b>L-dopa</b>  | Oral levodopa                                |
| <b>LDL</b>     | Low-density lipoprotein                      |
| <b>LWPES</b>   | Lawson Wilkins Pediatric Endocrine Society   |
| <b>MRI</b>     | Magnetic resonance imaging                   |
| <b>NCGS</b>    | National Cooperative Growth Study            |
| <b>PWS</b>     | Prader-Willi syndrome                        |
| <b>SD</b>      | Standard deviations                          |
| <b>TS</b>      | Turner syndrome                              |

payers, scheduled discussion periods, case histories reflecting many of the issues that need to be resolved, and workshops in which clinicians and payers sat down together to identify areas of agreement, the steps needed to be taken, and when those steps should be taken. Highlights of some of these sessions as well as a continuing education-accredited overview article are included in this Special Report supplement.

Although much work remains to be done, the conference participants accomplished a great deal over the course of 2 1/2 days. A meaningful dialogue that fostered more open communication was initiated. Clinicians became better able to understand the payer's world, as well as the complex nature of what occurs on the payer's end after the clinician faxes in a statement of medical necessity. Payers became better able to understand the clinician's world. Continuation of that dialogue will enable clinicians and payers to achieve their common goal: providing the patient with the best possible clinical care in a financially responsible manner.