Does this Pediatric Patient Meet Criteria for a Polysomnogram?

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P.T. is a 10-year-old girl who presented to sleep clinic with the chief complaint of unrefreshing sleep. Mom states that she has never slept well, but that it has been getting worse. Mom states that, “if she falls asleep, it is extremely restless.” Mom has not heard her snore or stop breathing during the night, but she gets up 3–4 times per night to go to the bathroom. She wakes up feeling, “downright exhausted.” She wakes up with a headache weekly. She is currently being treated with methylphenidate 20 mg daily for diagnosed ADHD. On physical exam, she has dark circles under her eyes and enlarged tonsils.

The medical director of her insurance denied the request for a sleep study because it did not meet InterQual criteria for a pediatric polysomnogram. The rejection letter paraphrased InterQual’s criteria: “If your child has one of the following symptoms: snoring, gasping/choking, irregular breathing pattern; or a witnessed sleep pattern consistent with sleep apnea (pauses in breathing during sleep), and one of the following: tonsillar hypertrophy (tonsil enlargement), hypersomnolence (excessive sleepiness), irritability/moodiness, morning headaches, craniofacial abnormalities, documented behavior abnormalities, or failure to thrive.” When questioned by the American Academy of Sleep Medicine, McKesson, the writer of the criteria, referenced Marcus et al., “Diagnosis and Management of Childhood Obstructive Sleep Apnea” in Pediatrics 2012 for the guidelines that they used.

The InterQual criteria are flawed, as parents frequently do not realize that their child is having any respiratory abnormalities during sleep as they are not in the same room as their child. Even if they are, they may not recognize irregular breathing or pauses in breathing because it is quiet. If the parent is unable to recognize that his or her child has a breathing problem during sleep, then there is no way per InterQual Criteria for a child to be diagnosed with obstructive sleep apnea.

Unfortunately, the insurance also denied the appeal for P.T., despite having a History of Present Illness that contained all of the symptoms above. In the appeal, an independent board certified neurologist stated, “there was no findings supporting the diagnosis of narcolepsy, idiopathic hypersomnia, periodic limb movement disorder, or suspected parasomnia.” Oddly missing was whether the neurologist believed this child might have obstructive sleep apnea. My last appeal is to you, the experts in the field. Does this child merit a polysomnogram? If so, we must work together to ensure that these flawed criteria are changed so that girls like P.T. will not be medically treated with stimulants when treating obstructive sleep apnea may be curative.

Update: December 30th, 2014. As the result of a letter of appeal written by the American Academy of Sleep Medicine, the medical director of P.T.’s insurance agreed to allow her to have a sleep study on November 29th. This confirmed the presence of obstructive sleep apnea, with an apnea-hypopnea index of 2.8, and a minimum oxygen saturation of 90%. P.T. is now being evaluated for a tonsillectomy.

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