INTERQUAL® SPECIALTY REFERRAL CRITERIA
BIBLIOGRAPHY: NEUROLOGIC DISORDERS
McKesson Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. The class ratings, I through V, are intended to provide a classification of the evidence but are not necessarily hierarchical. Classifications appear in parentheses at the end of each reference. References followed by an (NC) are not classified; examples include pre-published research or information from government, manufacturer, laboratory, or patient education websites.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
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<tbody>
<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
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<tr>
<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
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<tr>
<td>Class III</td>
<td>Well-designed observational or epidemiologic study</td>
</tr>
<tr>
<td>Class IV</td>
<td>Evidence-based guideline</td>
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<td>Class V</td>
<td>Expert opinion, panel consensus, literature review, text or reference book, descriptive study, case report, or case series</td>
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Class I
A meta-analysis is an analysis of the results from multiple trials. A systematic review is a qualitative means of summarizing multiple trials on the same intervention. Class I studies can show a statistically significant difference in support of an intervention when smaller studies could not. A meta-analysis or systematic review that finds insufficient evidence to support or refute an intervention (due to a lack of properly designed trials) is inconclusive. A potential weakness of Class I studies is that they may only assess published studies. Since studies demonstrating significant differences are more likely to be published than those that do not, publication bias is of concern.

Class II
A randomized controlled trial (RCT) is an experimental study design in which subjects are randomly assigned to an intervention or a control group. An RCT is the gold standard for testing cause and effect relationships. Intention-to-treat analysis should be performed to account for missing data points.

Class III
Observational or epidemiologic studies can suggest an association between events or findings. These associations cannot be used to establish causality. Cross-sectional, cohort, and case-control studies are all used to identify possible risk factors. Cross-sectional studies are also used to determine the prevalence of a condition. Cohort studies are used to study incidence, the natural history of a condition, prognosis after a specific exposure, and associated harms. Nonrandomized controlled trials are sometimes used when randomization is impossible or unethical.

Class IV
Evidence-based guidelines are systematically developed recommendations for clinical practice. Evidence-based guidelines identify the methodology used to gather the evidence on which the recommendations are based. Usually, a grading system for both the quality of the evidence and the strength of the recommendations is provided. Guidelines that are evidence-based may also contain consensus recommendations in areas where evidence is lacking, but these recommendations are clearly identified and appropriately graded.

Class V
Class V references may be the best information in the absence of other evidence. Expert opinion, panel consensus, literature reviews, and descriptive studies (case reports or case series) are subject to significant bias. A case series with comparison to historical controls can be plagued with missing data, and data extraction inconsistencies are common. The use of historical controls does not address how the diagnosis of disease or its treatment has evolved over time with newer technologies or medication. Text book information may be out of date by the time the book is...
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Comparative Effectiveness Research (CER)
"Comparative effectiveness research is the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in "real world" settings." (U.S. Department of Health and Human Services, Report to the President and the Congress on Comparative Effectiveness Research; 2009. Available from: http://www.hhs.gov/recovery/programs/cer/execsummary.html [cited Apr 20 2010])

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Connelly and James. SIGN guideline for the management of patients with dementia. Int J Geriatr Psychiatry 2006. 21(1):14-16. (IV)


Friedman and Grosberg. Diagnosis and management of the primary headache disorders in the emergency department setting. Emerg Med Clin North Am 2009. 27(1):71-87, viii. (V)


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Geere et al. Power grip, pinch grip, manual muscle testing or thenar atrophy - which should be assessed as a motor outcome after carpal tunnel decompression? A systematic review. BMC Musculoskelet Disord 2007. 8:114. (I)


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Hillbom et al. Seizures in alcohol-dependent patients: epidemiology, pathophysiology and management. CNS Drugs 2003. 17(14):1013-1030. (I)


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Lindsay et al. Toward a more effective approach to stroke: Canadian Best Practice Recommendations for Stroke Care. CMAJ 2008. 178(11):1418-1425. (IV)

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Lipton et al. Toward a more effective approach to stroke: Canadian Best Practice Recommendations for Stroke Care. CMAJ 2008. 178(11):1418-1425. (IV)


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Perry et al. Is the combination of negative computed tomography result and negative lumbar puncture result sufficient to rule out subarachnoid hemorrhage? Ann Emerg Med 2008. 51(6):707-713. (III)
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Scherer et al. Does this patient have myasthenia gravis? JAMA 2005. 293(15):1906-1914. (V)


Shneker and Fountain. Epilepsy. Dis Mon 2003. 49(7):426-478. (V)


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Steiner et al. Recommendations for the management of intracranial haemorrhage - part I: spontaneous intracerebral haemorrhage. The European Stroke Initiative Writing Committee and the Writing Committee for the EUSI Executive Committee. Cerebrovasc Dis 2006. 22(4):294-316. (IV)
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Wijesekera and Leigh. Amyotrophic lateral sclerosis. Orphanet J Rare Dis 2009. 4:3. (V)