InterQual® Procedures Criteria: Orthopedic Upper Extremity

Bibliography

Change Healthcare 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, technology assessment, or systematic review</td>
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<tr>
<td>Class II</td>
<td>Randomized controlled trial</td>
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<td>Class III</td>
<td>Observational or epidemiologic study</td>
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<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,</td>
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<td>descriptive study, case report, or case series</td>
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Class I

Class I sources synthesize the results of multiple studies. When quantitative synthesis is possible, meta-analyses can provide a more accurate estimate of the effect or association size than individual smaller studies can. A Class I study that finds insufficient evidence to support or refute an intervention (due to a lack of appropriate primary research) is inconclusive. A potential weakness of Class I studies is that they may only assess published research, potentially leaving their findings vulnerable to publication bias.
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 published.

Comparative Effectiveness Research (CER)

Citations are designated with the CER label as part of the evidence classification if the article cited is one of the following:

1. A clinical trial or other clinical study that directly compares two or more health care interventions for the same clinical scenario.
2. A systematic review that compares two or more health care interventions by synthesizing the research from previous clinical studies.


Bhattacharyya et al. Distal radial fractures: the significance of the number of instability markers in management and outcome. Iowa Orthop J 2014. 34:118-22. (III)


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Callandro et al. Treatment for ulnar neuropathy at the elbow. The Cochrane database of systematic reviews 2012. 7:CD006839. (I)


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Contreras et al. Predictors of success of corticosteroid injection for the management of rotator cuff disease. HSS J 2013. 9(1):2-5. (III)


Hegedus et al. Which physical examination tests provide clinicians with the most value when examining the shoulder? Update of a systematic review with meta-analysis of individual tests. Br J Sports Med 2012. 46(14):964-78. (I CER)


Huisstede et al. Carpal tunnel syndrome: hand surgeons, hand therapists, and physical medicine and rehabilitation physicians agree on a multidisciplinary treatment guideline-results from the European HANDGUIDE Study. Arch Phys Med Rehabil 2014. 95(12):2253-63. (V)


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Lumsden et al. Medical and endovascular management of critical limb ischemia. J Endovasc Ther 2009. 16(2 Suppl 2):I131-62. (V)

Mansat et al. Total elbow arthroplasty for acute distal humeral fractures in patients over 65 years old - results of a multicenter study in 87 patients. Orthopaedics & traumatology, surgery & research: OTSR 2013. 99(7):779-84. (III)


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Tibbetts and Wirth. Shoulder arthroplasty for the young, active patient. Instr Course Lect 2011. 60:99-104. (V)

Tse et al. Arthroscopic reconstruction of triangular fibrocartilage complex (TFCC) with tendon graft for chronic DRUJ instability. Injury 2013. 44(3):386-90. (III)


Zmistowski et al. Diagnosis of periprosthetic joint infection. The Journal of Arthroplasty 2014. 29(2 Suppl):77-83. (V)
