INTERQUAL® PROCEDURES CRITERIA
BIBLIOGRAPHY: SPECIALIZED PROCEDURES
McKesson Clinical Evidence Classification

References cited in the clinical content are classified according to the type of evidence presented. Classification ratings of I through V are used. Ratings are applied as clinical content is updated; therefore, a rating may not appear after each reference. Classification ratings appear in parentheses at the end of a reference.

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Evidence</th>
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<tr>
<td>Class I</td>
<td>Meta-analysis or systematic review</td>
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<td>Class II</td>
<td>Well-designed controlled clinical trial or experimental study</td>
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<td>Class III</td>
<td>Well-designed 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, descriptive study, case report, or case series</td>
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Class I
A meta-analysis is an analysis of data pooled 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. A 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.

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.
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Alsaadi et al. Video-EEG telemetry can be a crucial tool for neurologists experienced in epilepsy when diagnosing seizure disorders. Seizure 2004. 13(1):32-34. (V)
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Carragee et al. A gold standard evaluation of the "discogenic pain" diagnosis as determined by provocative discography. Spine 2006. 31(18):2115-2123. (III)
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Hancock et al. Systematic review of tests to identify the disc, SIJ or facet joint as the source of low back pain. Eur Spine J 2007. 16(10):1539-1550. (I)
Hillbom et al. Seizures in alcohol-dependent patients: epidemiology, pathophysiology and management. CNS Drugs 2003. 17(14):1013-1030. (I)
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Levy and Wiersma. EUS-guided celiac plexus neurolysis and celiac plexus block. Gastrointest Endosc 2003. 57(7):923-930. (V)


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Moff et al. Diagnosis of primary sclerosing cholangitis: a blinded comparative study using magnetic resonance cholangiography and endoscopic retrograde cholangiography. Gastrointest Endosc 2006. 64(2):219-223. (III)
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Qureshi et al. ASGE guideline: guideline on the use of endoscopy in the management of constipation. Gastrointest Endosc 2005. 62(2):199-201. (IV)
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Scherer et al. Does this patient have myasthenia gravis? JAMA 2005. 293(15):1906-1914. (V)
Sherman. What is the role of ERCP in the setting of abdominal pain of pancreatic or biliary origin (suspected sphincter of Oddi dysfunction)? Gastrointest Endosc 2002. 56(6 Suppl):S258-266. (V)
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Smith et al. An implantable drug delivery system (IDDS) for refractory cancer pain provides sustained pain control, less drug-related toxicity, and possibly better survival compared with comprehensive medical management (CMM). Ann Oncol 2005. 16(5):825-833. (II)


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Tse et al. Stem cell transplantation in follicular lymphoma: progress at last? Bone Marrow Transplant 2004. 34(11):929-938. (V)
Wijesekera and Leigh. Amyotrophic lateral sclerosis. Orphanet J Rare Dis 2009. 4:3. (V)
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