On July 6, the FDA proposed that every IRB that reviews clinical research conducted with government funding register with the agency so it can more easily identify and inspect the IRBs. The action, part of the FDA’s effort to increase accountability in the clinical research process, may be resisted by many researchers who consider it too intrusive and onerous.

Many hospitals are likely to be affected by the rule, “particularly those that are teaching hospitals or conduct NIH or other government-funded studies,” said attorney Robert Nicholas of McDermott Will & Emery, LLP, in Washington, DC.

A parallel regulation drafted by HHS’ Office of Public Health and Science (OPHS) on July 6 would require registration of IRBs that review human subjects conducted or supported by HHS and comply with the OHRP rule.

HHS stated in its proposal that the action will “make the IRB registration system uniform with the proposed IRB registration requirements of FDA.”

**FDA requirements**

Under the proposed regulations, IRBs must provide the following information to FDA and OHRP:

- The name, mailing address, phone number, fax number, and e-mail address of the institution operating the IRB
- The names of the IRB, each IRB chair, and the contact person
- The number of active protocols involving FDA-regulated products reviewed (both initial and continuing reviews)
- A description of the

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**Administrators need to know what, why to be effective**

**IRB leaders must mentor throughout institutions**

Many classified job advertisements call for candidates who are effective communicators with the ability to manage multiple tasks. IRB administrators are no exception, especially because of their responsibility for keeping various groups informed, educated, and on track—all within the framework of numerous regulations.

“You’ve got the IRB wanting one thing, the investigator wanting another, maybe the institution wanting something else, [and] grants and contracts needing something—and we’re often the ones who are communicating between all these competing demands,” said Ada Sue Selwitz, MA, director of the office of research integrity at the University of Kentucky in Lexington. “And that’s why advising is an important role, and how you do it is really going to impact your effectiveness in your career.”

Selwitz lectured on the importance of administrators earning their stripes through mentoring during IRB Administrator 101, a series of seminars presented in Boston by Public Responsibility in Medicine and Research in July.
types of FDA-regulated products (i.e., biological products, color additives, food additives, human drugs, or medical devices) involved in the protocols that the IRB reviews.

- An indication of whether the IRB is accredited and, if so, the date of the last accreditation and name of the accrediting body or organization

Analysis of June 10 proposal

To bring U.S. government–funded clinical research conducted in foreign countries into the fold, the FDA on June 10 proposed to revise its rules on acceptance of foreign clinical studies not conducted under an investigational new drug application. The agency proposed replacing requirements calling for studies to be conducted in accordance with ethical principles set forth under the Declaration of Helsinki. It instead wants studies to be conducted in accordance with good clinical practices.

Foreign studies would also have to be reviewed and approved by an independent ethics committee, FDA stated in its proposal.

Controls on IRBs redundant, researchers say

In fall 2003, HHS asked researchers who accept NIH grants to comment on an appropriate compliance plan to prevent conflicts of interest among researchers who accept partial or full government funding. HHS suggested that for research involving clinical trials with human subjects, all subjects ought to be fully informed as to the study’s risks and benefits. Based on the proposal, you should

- ask a sufficient number of members to review all researchers’ informed consent agreements
- call on these members to provide ongoing oversight of adverse event reporting

Most of the researchers commenting on the draft compliance plan stated that any more controls on IRBs than those already in existence would be redundant, confusing, and unnecessary. According to the Children’s Oncology Group, Emory University’s Director of Research Compliance Kristin West, and other researchers, extensive guidance on the ethical conduct of IRBs already exists and should not be duplicated.

Commenters also noted that accreditation organizations such as the Association for the Accreditation of Human Research Protection Programs, Inc., already advise researchers to disclose any conflicts of interest and conduct only ethical research.

Questions? Comments? Ideas?

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Comment instructions

FDA and HHS Office of Public Health and Science are accepting comments on the July 6 proposed IRB registration rule until October 4. For further information, contact Irene Stith-Colman at OHRP at 301/402-7005 or David Lepay at the FDA Office for Science and Health Coordination, at 301/827-3340. Lepay may also be contacted for information about the proposed rules for conducting foreign clinical trials.
Noncompliance news
A monthly look at enforcement actions in human research

In a letter to the Fred Hutchinson Cancer Research Center (FHCRC) in Seattle, the OHRP acknowledged the following corrective actions the center took in response to previous violations:

• Made sure the FHCRC protocol office verifies information submitted by investigators, informs the IRB, and annually reviews all ongoing trials
• Put written procedures in place that require investigators to submit all research changes to the IRB prior to their implementation
• Changed its IRB manual to include a detailed checklist that will assist IRB chairs in evaluating proposed protocol amendments
• Utilized an electronic system to ensure that informed consent documents are the most recent versions available
• Provided guidance to its investigators for making the language in informed consent documents easier to read

The FDA inspected the clinical site of Harland Amstutz, MD, at the Joint Replacement Institute in Los Angeles from March 18 to April 13. The inspector found that the site violated sections of the investigational device exemptions (IDE) and Protection of Human Subjects codes. Specifically, the investigation found failures to

• conduct the investigation according to the signed agreement with the sponsor, the investigational plan, and any conditions imposed by the IRB, including failure to document follow up
• prepare and submit complete, accurate, and timely reports of unanticipated adverse device effects occurring during the investigation
• establish all elements of and document informed consent
• maintain accurate, complete, and current records relating to the investigator's participation in investigation

The FDA also found violations at the clinical site of Archibald S. Miller III, MD, FACS, at Cosmetic and Reconstructive Surgery of Tulsa, OK. Miller's site violated sections of the Food, Drug, and Cosmetic Act, as well as IDE. In the warning letter, the FDA cited that Miller did the following:

• Treated patients with unapproved medical devices that posed significant risks without the knowledge or approval of the FDA, without IRB oversight, and without an approved IDE
• Did not retain records related to the clinical investigation

Because Miller did not submit information that shows his device is substantially equivalent to others that are legally marketed, his device is misbranded. The FDA felt that this showed a “fundamental misunderstanding of the custom device provisions” and warned that his actions are in serious violation of the law.

Expert tips
Don’t let pitfalls such as those listed above happen during your clinical study. Follow these tips from Adil Shamoo, PhD, a bioethicist at the University of Maryland School of Medicine in Baltimore:

1. Err on the side of doing more for regulatory compliance.
2. Hold records a little longer than required.
3. Do not make changes in protocol without IRB approval; do so only if there is an immediate health hazard to the patient.
4. Report unanticipated adverse affects as soon as possible if the regulations within the informed consent do not specify them. If the regulations do specify, then report them within the acceptable time window.
5. Check and double check your informed consent; have someone else—preferably outside the study—review it; then stick to it.
6. If you receive a warning letter, talk to the FDA or OHRP to make sure you understand the violations and what is expected/needed to correct them.

Note: Compiled by Alex Wilson, HCPro, Inc.
“If you want to increase the probability that you’re going to be a success, you need to know how to be effective at managing competing views,” Selwitz said. “And I think it’s important that you be able to explain not just the what, but the why.”

The people in your neighborhood

IRB administrators typically advise principal investigators (PI), IRB members, research staff, students, and upper-level administrators on the inner workings of key decisions. The diverse group has a common thread that ties them together: They want to know the “why” behind the “what.”

Unfortunately, providing explanations isn’t always the strong suit of an IRB administrator, she said. Selwitz cautioned about working only from policy without giving reasons for IRB decisions other than “they just didn’t do it the way our IRB says it should be done.” She said it’s easy to get so caught up in explaining away questions by referring PIs to policy that it leads to a communication breakdown between the IRB and investigators.

You need to go beyond saying, “this is what needs to be done,” she said. “[You need to] analytically look at what your options are within this framework of regulations and within your local policies—see how you can creatively use [them].”

I want to know why

Selwitz indicated there are four major federal regulations to which human subjects research is most often tied:

- Common Rule
- HHS 45 CFR 46
- FDA 21 CFR 50 and 56
- HIPAA

Being able to outline these rules is not enough for an IRB administrator, Selwitz said, and rereading regulations is a necessary evil of the job.

“For these basic regulations, you’re going to have to be an expert—that’s just the reality,” she said. “You’ve got to be an expert, and you’ve got to use your knowledge to advise on the whats and use your knowledge to explain the whys.

“Unfortunately, you’ve got to read [the regulations],” she added. “And if you say, ‘Oh my gosh, I don’t have time at work, I can’t do it,’ then I hate to say this: Do it at home on the weekend. It’ll be boring as the dickens, but read them.”

What else?

Knowing the key federal regulations—however important—is still not enough. There are also “auxiliary regulations” that IRB administrators have explain; morewhats to address further whys.

“These are regulations that indirectly impact the IRB and may directly mention the IRB . . . sometimes it doesn’t even mention the IRB, but it [applies],” Selwitz said. “In the long term, your goal to be an effective advisor is learning to identify when these requirements apply.”

IRB administrators have to know where to look and must not be afraid to ask questions when they are unsure of a regulation’s applicability. “Know them enough that you know it when you see it,” Selwitz said.

So where do these auxiliary regulations come from? Accrediting bodies are once source, including the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Association for the Accreditation of Human Research Protection Programs, Inc., and the Partnership for Human Research Protection, Inc. They create auxiliary regulations that institutions must follow if they want to achieve/maintain accreditation.

[Accreditation] is hard to do, expensive to do, but it takes your program to a whole different level,” said Selwitz. “If you’re at a smaller institution with limited resources, you probably won’t do it. If you’re at an

—Ada Sue Selwitz, MA
academic health science center, you’re going to have to do it. It will change your program—hopefully for the better.”

The ethics dilemma

Selwitz stressed the necessity of not only being familiar with ethical principles, but knowing them like the back of your hand.

“I think in the long term it is critically important to being an effective IRB administrator that you don’t just know the regs—you’ve got to learn and understand these ethical principles,” she said. “When I talk about the why, this is the big why.”

Because most IRB administrators don’t come from a bioethics background, Selwitz said, they need to be resourceful and forceful in learning the information.

“So how did I learn about this?” she asked. “I took some time. I gave as many speeches as I could because it forced me to learn it before I taught it.” She also trolled the OHRP Web site (www.bbs.gov/ohrp/) and its included IRB Guidebook.

She gave an example of having to learn what to do in addressing a vaccine trial at her institution. “I’d go to the IRB and the IRB chair and say, ‘Hey guys, these are the ethical issues you should be raising,” she said. “Then I’d go to the meetings and I’d listen. That’s how you learn.”

Selwitz offered some keys to guide you through ethical dilemmas:

- Understand ethical principles and be able to apply them
- Assist investigators in applying the principles
- Use the principles to explain why federal and IRB regulations are in place
- Advise IRB members and investigators on ethical issues
- Use the principles to explain why the IRB wants changes in the research

“Don’t just get caught up in the regs; do not lose sight of the ethical principles,” she said. “They can conflict. It’s not black and white, but it is [your] responsibility.”

AAHRPP accredits four more institutions

The Association for the Accreditation of Human Research Protection Programs, Inc., (AAHRPP) announced in early August that it has accredited four more institutions. AAHRPP awarded full accreditation to Copernicus Group IRB, Cary, NC; Fox Chase Cancer Center, Philadelphia; and Washington University in St. Louis; and qualified accreditation to Newton (MA)-Wellesley Hospital. “We congratulate these organizations for this significant achievement,” AAHRPP Executive Director Marjorie A. Speers, PhD, said in a press release.

“The diversity of this group—Independent IRB, cancer center, university, and hospital—indicates that, across the spectrum of organizations conducting or reviewing human research, accreditation is being embraced.” For more information about AAHRPP accreditation, go to www.aahrpp.org.
Defining research still key to administrator’s job

Susan Kornetsky, MPH, CIP, never asked for all this responsibility, but she simply couldn’t avoid it, thanks in large part to her husband.

“I certainly never thought in college that I’d grow up to be an IRB administrator,” said Kornetsky, director of clinical research compliance at Children’s Hospital Boston, where she has now served for more than 20 years. “I was out of school not knowing what to do, and my husband saw a job advertisement and decided to send in my résumé.”

During her first interview at Children’s, the director of research told her she’d be in and out in five years because there wouldn’t be enough work to keep her satisfied. Twenty years later, he couldn’t have been more wrong.

Kornetsky spoke about managing protocol review during the July IRB Administrator 101 conference in Boston presented by Public Responsibility in Medicine and Research. And though it may sound like the most basic tenet of the job, Kornetsky and her colleagues still face questions every day about what constitutes research. So much for being done in five years.

Defining, then redefining

“How many of you, before you came into an IRB job, thought you knew what research was?” asked Kornetsky. “How many of you are [now] confused about what research is?” she continued, drawing laughter from her audience of IRB members and administrators.

It may seem that defining human-subject research to determine whether it requires review would be a basic task, especially because research is defined for IRB administrators in 45 CFR 46 as “a systematic investigation designed to develop or contribute to generalizable knowledge” and a human subject is defined as “a living individual about whom an investigator . . . conducting research obtains (1) data through intervention or interaction with the individual, or (2) identifiable private information.”

So if you lump those two definitions together, you have a hard-and-fast definition of what research is reviewable, right? Not so fast, Kornetsky said. When she asked the audience about various areas of research that they may find unclear, a flood of answers came back. Among them were

- senior theses that promote graduate or undergraduate research
- quality assurance/quality improvement activities
- oral histories
- evaluating new educational tools
- surveys

Surveys in particular provide the most difficulty. “Surveys are used for many different [activities],” she said. “They’re used for research, and they’re used for marketing. So it’s sometimes very difficult to think about whether something is research justified on the method.”

Gauging surveys is just one of the many difficulties in defining research, she said. Another common unknown is rooted in the publication of study results, which some institutions use as an ironclad method for defining whether research is reviewable by the IRB.

“For many years we used this as a definition, too,” said Kornetsky. “But sometimes publication may not always define research. We can debate that back and forth, but this is another thing that you might want to think about as an administrator.”

Digging deeper

In spite of the lack of clarity often presented, Kornetsky has some stock questions that she asks investigators to arrive at whether or not their projects need to be reviewed. She offered the following:

- Is this hypothesis driven?
- Do you have a question you want to answer for reasons other than clinical care or routine evaluation?
- Does your project include research development, testing, and evaluation?
- Does it begin with a specific intent?
- Is there more than one sample/subject? On this point, she offered one caveat: “If you’re looking at the definitions [of research] for the FDA, all you need is one individual to be regulated by the FDA.”
With all of the “gray areas” out there, investigators and other research personnel have found a simple way to handle their problems defining reviewable research: Pass it off to the IRB.

“The jurisdiction is creeping all over the place into other areas that it may or may not be involved in,” said Susan Kornetsky, MPH, CIP, director of clinical research compliance at Children’s Hospital in Boston, during her lecture on managing protocol review at the IRB Administrator 101 conference in Boston, which was conducted by Public Responsibility in Medicine and Research. “I think sometimes institutions . . . don’t necessarily think about some of these other areas. IRBs have enough work to do so that if you don’t need to review something, don’t let someone dump it on the IRB.”

Despite their best efforts to mentor research personnel to make some of these determinations on their own (see related story on p. 1), IRB administrators will always be faced with questions of defining research.

Kornetsky offered some of the most common quandaries she faces in defining research, noting that there is no definitive answer. Weigh each instance carefully, she said. These are her most common scenarios:

• I’m only looking at records that are linked to a code, but no actual name
• I’m only using pathology tissue from a deceased individual
• I’m just a psychology student doing a project for my course
• This is a quality improvement initiative, but I may want to publish it
• I want to interview Holocaust survivors for a book I’m writing
• I just want to review billing information
• I’m just performing an innovative procedure in the catheterization lab
• I am trying to compare two methods to better educate students

Still not clear?

If you’ve gone through all of the questions and still don’t have a definitive answer about whether you’re dealing with reviewable research, there are several things you can do:

• “One of the things we did in many areas is we remained completely inconsistent,” Kornetsky quipped. “[Investigators] will tell you all the time when you are inconsistent, and you need to sort of keep track of it.” This is how they arrive at the gray areas. “Eventually, if you have enough of those and you take the time or develop a group within your institution to think about it, you can come up with some very good policies.”
• Seek regulatory guidance. “I don’t call [regulatory agencies] unless I’m prepared for the response that I’m going to be given,” she said.
• Consult others at similar institutions. This is Kornetsky’s first trick when trying to decide whether something is research. She said networking with colleagues and searching the Web can be invaluable tools on this front. “Chances are, if you’re dealing with this consistently, someone else is dealing with it consistently, too.”
• Develop guidelines and policies with input from those involved. Kornetsky said Children’s first took this approach with innovative surgeons. “It made very little sense for IRB members to sit among themselves and decide. We involved the people in the institution that this is going to impact the most. You can see their side, they can see your side, and then when the policy or procedure needs to go into effect, you have some input from the faculty.”
• Disseminate any guidance. “Policies and procedures and guidance are wonderful, but they are not wonderful if they sit on the IRB administrator’s desk and no one else in the institution knows about it,” she said.
FDA regulations at 21 CFR 312.62(c)—Investigator record retention requirements—call on investigators to retain study-related records “for two years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or if no application is to be filed or if the application is not approved for such indication, until two years after the investigation is discontinued and FDA is notified.” Assuming that no new drug application is to be filed or the application is not approved for the indication, how does the FDA interpret “until two years after the investigation is discontinued and FDA is notified?”

According to staffers in the FDA Center for Drug Evaluation and Research’s Division of Scientific Investigations (DSI), the FDA interprets this to mean the date on which the sponsor discontinues all studies under the relevant investigational new drug application (IND). Assume, for example, that a particular site’s participation is discontinued while the larger clinical program for the indication continues at other sites. Would the two-year clock begin ticking when that site’s participation is discontinued? No, according to the DSI. The two-year clock applicable to record retention would not begin ticking until all studies/sites were discontinued. In effect, that particular site’s retention requirements could last for many years depending on how long the other investigations under the IND continue.

Although in practice the agency may not split hairs on the precise date that a study “is discontinued and FDA is notified,” some at the agency whom we contacted on this issue believe that the date would be the date FDA received a sponsor’s letter stating that studies are being discontinued for a particular indication or that an entire IND is being withdrawn or inactivated. However, the FDA is not known to have provided definitive advice on this particular issue, however.

In practice, investigators often must retain these records well beyond the two-year period the FDA requires. In many cases, sponsors require investigators to maintain records for longer periods under clinical protocols. Further, International Conference on Harmonisation (ICH) good clinical practice standards may call on investigators to maintain such records for longer periods. Under the ICH’s E6 Guideline for Good Clinical Practice, for instance, investigators are called on to retain essential study-related documents “until at least two years after the last approval of a marketing application in an ICH region and until there are no pending or contemplated marketing applications in an ICH region, or at least two years have elapsed since the formal discontinuation of clinical development of the investigational products.” Depending on the particulars of a drug’s development and the sponsor’s submission of marketing dossiers, this period could easily extend well beyond the two-year retention period required under FDA regulations. The E6 guidance goes on to establish that it is the sponsor’s responsibility to inform an investigator/institution “as to when these documents no longer need to be retained.”

Q. Under 21 CFR 312.62, a clinical investigator is required to retain study records “for a period of two years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or if no application is to be filed or if the application is not approved for such indication, until two years after the investigation is discontinued and FDA is notified.” Is the FDA’s interpretation of this requirement that the site retain these records on site, or can a site retain these records off site? And can these records be retained through a trusted third party, as suggested by the Pharmaceutical Research and Manufacturers Association in a June 2003 proposal to the agency?

Q&A
Neither FDA regulations nor guidelines address this issue specifically. In practice, the FDA is aware that many clinical sites do not store their records on site (e.g., due to lack of available space), but possibly in a central location in the larger healthcare facility (e.g., a hospital's central file), or even at an off-site warehouse that may be owned by a data warehousing company.

According to DSI staffers, the agency’s policy is that it expects sites to maintain access to such records, that such records be stored under conditions that will preserve their integrity, and that sites be able to retrieve and provide “prompt access” to such records if the FDA requests them as part of an inspection. In the records retention section of the FDA’s Compliance Program Guidance 7348.811 for clinical investigator inspections, the agency acknowledges that a site may not retain “custody” of study-related records and instructs inspectors to

“Determine who maintains custody of the required records and the means by which prompt access can be assured. Determine whether the investigator has notified the sponsor in writing regarding the custody of required records, if the investigator does not retain them.”

Given that a site might maintain records off-site and may not have immediate access to them, how does the FDA interpret the requirement that an FDA inspector be provided with prompt access to required study-related records that will be inspected?

Although the FDA’s Compliance Program Guidance 7348.811 uses the phrase “prompt access,” the agency’s regulations do not specify a time period within which FDA inspectors must be provided access to study-related records. FDA regulations at 21 CFR 312.68 (Inspection of investigator’s records and reports) state that “an investigator shall upon request from any properly authorized officer or employee of FDA, at reasonable times, permit such officer or employee to have access to and copy and verify records or reports made by the investigator . . . . ”

Given that the FDA generally provides clinical investigators and sites with advance notification of a few days or more for routine inspections and that the agency even identifies the records that it wants to inspect, clinical sites will have time to locate and assemble the records in advance of the inspection.

Agency inspectors contacted on this question noted their expectation that these preidentified records be available at the start of an inspection. If such records are not available upon an inspector’s arrival or within a brief period of time following his or her arrival (e.g., a reasonable period to permit site staff to immediately retrieve records from a nearby office and bring them to the inspector), it could raise suspicions that the site has not maintained adequate access to its own records.

The relevant circumstances (e.g., the nature of the records sought, degree of delay) will determine whether the delay in access will justify further investigation or even a citation in Form 483—Inspectional Observations.

Even with advance notification, FDA inspectors sometimes request raw data or other information that the site may not have anticipated and that the site staff has not collected for the inspection.

Although there is no regulation or guideline that establishes a time frame within which access to such records must be provided, several present and former FDA inspectors contacted regarding this question suggested that 24 hours is a reasonable time frame, provided there are justifiable reasons for such a delay.

For example, the specific records may be stored at a distant facility, and the volume of records being requested makes faxing/scanning/e-mailing impractical. Alternatively, the records may exist only in microfilm/microfiche format, and printouts of these records may be blurry when faxed. In such cases, a site should be able to use an overnight courier service to provide access to the records the following business day.

Editor’s note: These questions were excerpted from nearly 400 Q&As in the second edition of Good Clinical Practices: A Question and Answer Reference Guide (May 2004). Reprinted with permission.

Go to www.barnettinternational.com for more information about the publication.
Billing Medicare for research-related injuries

Communicate with sponsors to identify upfront responsibility

In most trial documents, such as an informed consent or clinical trial agreement, there’s a clause regarding who pays for research-related injuries—be it Medicare, a private payer, or the sponsor. The hold-harmless provision ensures that the stated liable party is responsible if adverse events arise.

In many cases, the sponsor agrees to pay if the claim is denied by other payers as long as the injury relates to participation in the trial and there’s no other insurance coverage.

But it’s important to understand the fine print, says Holley Thames Lutz, a partner in the health-law practice and chair of the Clinical Research Task Force of Gardner Carton & Douglas in Washington, DC. There’s a glitch if the sponsor is considered the primary payer and Medicare is secondary.

This is where Medicare’s secondary-payer rule comes into play. “The question for me always was, when a sponsor says, ‘I’ll pay if nobody else pays,’ is the mere promise to pay enough to now make the sponsor primary?”

The sponsor often says that it never wanted to be considered primary and that it wants the research site to bill every other resource first. It doesn’t want to have to pay for something Medicare might otherwise cover.

The confusion prompted Lutz to get in touch with the Centers for Medicare & Medicaid Services (CMS) on behalf of some pharmaceutical company clients that needed answers. CMS responded by saying if there’s a promise to pay, it will disregard any caveat and the sponsor is considered primary. “Once the sponsor agrees to pay, Medicare doesn’t care about the caveats.”

What this means for sites billing Medicare is that billing pursuant to research agreements—billing Medicare first, waiting for a denial, then billing the sponsor—could be considered a false claim if the sponsor is listed as the one ultimately responsible. “And sponsors and sites don’t know that’s the position Medicare’s taking,” Lutz says. “But I think Medicare is arguably wrong in its interpretation and its logic is a little too simplified.”

Lutz gives two reasons for this assertion. First, Medicare states in the National Coverage Decision of 2000 (NCD) that it will pay for routine costs for clinical trials, including complications. Second, Medicare has historically paid for complications resulting from procedures it did not primarily cover. So Medicare contemplates covering research-related injuries.

Lutz acknowledges that the NCD also says Medicare won’t pay if the sponsor pays, but when the sponsor promises to pay only after it’s determined no one else will pay, is that a true promise to pay such that Medicare is off the hook? “It’s all a matter of how you read the language in the contract,” she says.

Action steps

Lutz says there are two ways to resolve the problem. They are as follows:

1. Take out the clause in the informed consent and clinical trial agreement so the sponsor has not promised to pay, and then Medicare may pay as a primary payer. Note the following:
   - However, the onus is on the site, not the sponsor. “For the site, if you take the language out, you tell the sponsor you’ll be billing Medicare for complications. The sponsor is off the hook.”
   - Communicate that there’s a false-claims risk if the site tells the sponsor to pay and you bill Medicare.
   - There’s a chance you may have trouble recruiting subjects. “You can’t have potential subjects not knowing who’s going to pay,” she says.
   - This shows what a strange policy result Medicare’s position is—just make the sponsor not responsible, then Medicare pays.

   Tip: Focus on front-end processes. Who are the Medicare beneficiaries? How do you flag them? How do you bill the right way so you’re not submitting a false claim?

2. As a site, you can submit a demand bill to Medicare to get a written denial. “You’re saying you don’t expect to get paid and need a denial so you can go to a private payer and get paid.” But the sponsors are displeased because
Legal corner

Blowing the whistle on research
Inside common false claims allegations and misuse of federal grants

By Jill Alvarez, Esq., and Kendra Dimond, Esq.

Researchers and institutions that misuse federal research grant funds should be aware of a powerful statute the government can employ against them: The Department of Justice (DOJ) has invoked the federal False Claims Act (FCA) against healthcare institutions and individuals alleged to have misused federal grant money.

Action was brought against Johns Hopkins University in Baltimore, charging that it had allegedly overstated and overcharged time and effort spent by researchers on grants from the NIH and other federal agencies. The result was an alleged fraudulent claim by Hopkins for payment under these grants.

Know the rules

Many research institutions are unaccustomed to dealing with claims brought by the federal government under the FCA. However, given the expanded roles of the DOJ and the Office of Inspector General (OIG) in the regulation of research institutions, institutions must understand how to work and communicate with these government agencies.

For example, the federal government may threaten to seek suspension of your research center from federal funding as part of a settlement of allegations against the center. In lieu of such action, it may opt to force you to agree to a corrective action plan/enter into an institutional integrity agreement (IIA).

An IIA is an agreement by the research institution that is stronger than the compliance plan with which many research institutions are familiar. It usually forces the institution to adapt and undertake extensive corrective action plans; the OIG monitors these plans over a time period of up to five years.

Compliance with an IIA can be monitored by the research institution itself through annual reports filed with the OIG. Or, if required by the OIG, compliance can be monitored by an external independent review organization (IRO) for which the research institution pays. Violations of the IIA result in additional fines and sanctions levied against the institution.

Be proactive

Although the terms of the settlement between Johns Hopkins and the government—which was settled in February—did not require an IIA, other institutions have had them imposed. Research institutions should take preventive and proactive measures now to ensure that they have in place appropriate policies and procedures (e.g., internal audit documents, employee education and training programs, and financial and accounting safeguards) to ensure that all federally funded research is carried out in full compliance with the terms of federal grant policies and requirements.

The best way to do this is to follow these tips:

• Scrutinize the responsibilities and obligations of each party involved in a grant and the research conducted under the grant
• Regularly monitor and audit the grants to ensure compliance by everyone, including researchers, investigators, and IRBs

Multicenter project warning

However, monitoring compliance with scientific research and grants administration in one’s own house may not be sufficient.

For example, new risks and obligations may apply if the research institution takes the lead in a multicenter or multiinstitute research project. In developing the agreements that set forth the terms of such projects, consider the following:

1. Audit access
2. Warrants
they meant for you to get paid from somewhere else.

“You need to work it out in your trial agreement, and make sure you have a preface in place to bill the right way—to not bill Medicare for complications,” she says.

“I sent a request because we had a lot of pharma clients saying that sites were telling them they couldn’t bill Medicare. And I said, ‘That’s nuts.’ But it’s not as nuts as I thought.”

Many sites don’t realize they have a problem billing Medicare, Lutz says. “It’s easy enough to address if either or both of the parties know it’s an issue. Sites are billing and [having] a problem.”

The most conservative course, she says, is to acknowledge that there’s a risk in billing Medicare when the sponsor agrees to pay if no other payer pays.

Many sites are now going to the sponsor to get them to agree to pay for complications to avoid the potential liability. Sites are telling them, “I’m not billing any government payers before I bill you.”

3. Representations
4. Indemnifications

The lead institute should ensure that participating institutes are aware of the policies and procedures of its compliance program. For example, these policies and procedures may concern auditing guidelines, reporting obligations, treatment of nonreimbursable costs, cost sharing, cost transfers, and matching grants.

This task may seem vast and costly, but it is not nearly as cumbersome as dealing with the OIG and FCA.

Both agencies will play an expanding role in monitoring research and the use of federal grant funds, so now’s your chance to prepare.

Editor’s note: Alvarez and Dimond are partners in the health law practice of Epstein Becker & Green, PC, in Washington, DC.