Research Compliance Professional's Handbook, Third Edition
11 Clinical Research Billing Compliance

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Introduction

The goal of this chapter is to discuss clinical research billing compliance. The regulations and reimbursement rules associated with billing third-party payors are not static and providers should consult federal, state and individual commercial insurance contracts to ensure the most up to date rules are applied to their claims for services. The regulations and rules are also heavily subject to interpretation due to lack of published commentary by federal and state governments.

The Medicare Program's July 2007 version of the Clinical Trial Policy (CTP)[2] provides much of the conceptual framework for research billing compliance. The CTP is a "national coverage determination" by the Centers for Medicare & Medicaid Services (CMS) and not a formal regulation published in the Code of Federal Regulations. The CTP interprets circumstances during clinical research studies in which CMS believes items and services may be "reasonable and necessary," the statutory criteria for Medicare coverage. CMS also issued a "clarification" to the CTP on September 30, 2008 in the form of a "Special Edition Article."[3] The Special Edition Article discusses how a provider's pursuit of collections against non-Medicare enrollees in research could have an impact on billing Medicare for the same services.

While the CTP only applies to clinical research services provided to Medicare beneficiaries, and is specifically written for only a sub-set of research studies (government-funded studies and drug studies), it nevertheless contains the most advanced framework for analyzing clinical research services for reimbursement. For some studies which are not covered by the CTP, including device studies, CMS defers to certain definitions and rules within the CTP. Likewise, some States have modeled their commercial insurance laws on the CTP and their Medicaid program clinical research services rules. Every third-party payor may have its own rules for coverage of services during clinical research studies, but many rely on the CTP's conceptual framework.

Since most healthcare providers participate in the Medicare Program and Medicare's CTP is the driver for much of the discussion and foundation for clinical research reimbursement rules in the United States, this chapter will focus on Medicare rules. The goal of the chapter is to provide a broad discussion of Medicare's clinical research coverage rules and does not seek to be an exhaustive review of the many ambiguities and interpretations of the CTP nor a review of the CTP's interaction with other frequently changing Medicare rules. A review such as that would be outdated as soon as it would be printed.

Basic Framework of Billing for Clinical Research Services

Clinical Research Services

Understanding terms is critical in any compliance program, but especially so in research billing compliance because numerous regulatory schemes, rules and agencies cover the same thing or activity. They do not all use the same terms. To complicate the situation, the clinical research community has spent several decades mostly isolated from reimbursement rules and terms. Establishing clear definitions of terms in a research billing

compliance program is key to its success and essential for successful training and education on research compliance policies.

The very first question research billing compliance must deal with is which items and services should be covered by a clinical research billing compliance program and the billing safeguards that the provider should design. The terms "clinical trial" and "clinical research" are often used interchangeably to mean a research study that enrolls a human person. A provider should avoid taking the CTP reference to "clinical trials" literally to mean only a drug or device trial. CMS attempted to clarify this in its 2007 reconsiderations of the CTP by noting that the rule applies to "clinical research" in general, and accordingly proposed to change the name of the CTP to the Clinical Research Policy.[4] The name change was not adopted by CMS but this appears to be more the result that virtually all the proposed 2007 changes were not adopted by CMS in order to study the CTP's potential interaction with legislation that was passed during the time of the CTP's reconsideration period.

This chapter uses the term "clinical research" instead of "clinical trial" to impress the reader that when a patient is enrolled in a research study of any kind, compliance safeguards should address whether the services being provided can be billed to third-party payors. While the CTP does not address all types of clinical research studies, a provider's compliance program should consider the reimbursement status of clinical research services once a patient has signed an informed consent and formally begin participating in a clinical research study.

This chapter also uses the term "clinical research services" to denote any item or service that is scheduled to be provided to the patient by the study's protocol. Some of these services will be used for the clinical management of the patient's disease or condition, while others will be used only for research services. However, since any scheduled service is used at base for research purposes (even if merely to provide a reliable control for therapy), the services are research-related. There can sometimes be a misconception among personnel at healthcare providers that clinical research services are only those services which are used for research purposes only, without any clinical value. However, any service scheduled by the protocol is research-related in some fashion or it would not be required by the protocol. Services required to be provided by a protocol are by their nature not designed with a specific individual in mind and are part of the controlled study. Scheduled services during certain studies have the fortune of being dual purposed, for both the benefit of the individual patient enrolled in the research study and for use in assessing the objectives of the research study.

It is because the protocol requires specific types of services be provided at certain timepoints for all enrollees that all scheduled services must be considered by a research billing compliance risk control. While protocols are designed with a hypothetical patient in mind who meets the study's inclusion criteria, the scheduled services are not designed with an individual in mind. Third-party payors typically only pay for services that meet medical necessity, a patient-specific determination. In fact, many payors, such as Medicare, cover only a subset of medically necessary services—the subset being those services that meet that payor's rules on medical necessity and other factors that comprise the payor's coverage policy.[5] In other words, a third-party payor only pays for services that are designed to address a specific patient's disease, condition or signs and symptoms. For most payors, every service must meet medical necessity rules with adequate documentation in the medical record.

Clinical research services that are scheduled by the protocol need to be assessed not only for the individual enrollees, but fundamentally against the hypothetical patient who meets the minimum inclusion criteria. One of the critical questions for planning research billing safeguards is whether a particular scheduled service would be medically necessary for every patient enrolled in the research study. Consequently, all protocol scheduled services fall under the purview of a research billing compliance program because they are first scheduled to be performed because the protocol requires them to be performed, not as a dynamic response to the patient's immediate presentation. In a sense, there is a presumption that the service is for research purposes because that is the reason it is scheduled and then sites must overcome this presumption of the service being strictly for

research by finding justification that a protocol-required service meets insurance coverage rules for every hypothetical patient eligible for the study.

As a final note, this chapter will often use the term "services" to mean any drug, device or procedure that involves interaction with a human or a biological specimen of the person. The Social Security Act sets out the terms "items and services" as a descriptor of the things and activities that the Medicare Program covers.[6] Use of the term "service" alone is merely used for convenience and includes what also may be defined as "items." When referring specifically to drugs, biologics, devices, procedures or such other discrete things and activities required by a research study, this chapter uses those discrete terms as a sub-set of "services."

The Three-part Conceptual Framework of Clinical Research Billing

Billing third-party payors for clinical research services should be analyzed within a three-part conceptual framework:

- Does the clinical research study qualify for coverage?
- Which items and services required by the research study meet the definition of "routine costs"?
- Does the third-party's reimbursement rules allow for coverage of the specific routine costs?

This three-part framework is important for a research billing initiative to adopt because it is important to counteract a common misunderstanding that services during a research study stand alone against the individual patient as to whether or not a third-party payor will cover the services. At a minimum, the services must be justified alone against the patient's disease or condition. But in addition to the individual services being medically necessary to manage or treat the patient's condition, the research study itself must be assessed as to whether it is a type of research study in which the third-party payor is willing to pay for services. In other words, does the study itself even "qualify" for coverage. Specifically with respect to Medicare, CMS has set out certain types of research studies which it is not willing to pay for services required by the study that may even be medically necessary. Research services involved with a device with a Category A investigational device exemption (IDE) are one type of research study in which Medicare is very reluctant to cover the routine costs unless the overall purpose of the study is to address a life-threatening condition among other strict conditions.[7]

As discussed below, it is not always clear whether a research study qualifies for coverage under the third-party payor's rules. Some of this is due to the difficulty in designing rules that contemplate all types of research studies. The Medicare Program has clear rules with respect to Category A or Category B IDE devices, and there are certain types of studies under the CTP that are clearly qualifying, but there are numerous types of research studies that third-party payors may disagree on about coverage. Early phase drug studies and investigations of experimental procedures that do not involve an investigational drug or device are types of research studies that pose the most vexing questions to healthcare providers for coverage. The safest approach for healthcare providers is to pose specific questions to payors, including the local Medicare contractors. However, understanding that the question of whether the study is qualifying or not is a critical step in a research billing compliance program.

When a study qualifies for coverage, this does not mean that all services required by the protocol are covered by Medicare. Qualifying for coverage only means that the services required by the protocol are potentially eligible for coverage. Additional layers of rules must be worked through before the clinical research service can be considered covered. Various payors set out different names for the next step in the framework, but Medicare uses the term "routine costs."[8] If an item or service required by the protocol meets the definition of a routine cost,

then another step toward coverage is crossed.

The term "routine cost" is an unfortunate term because "cost" is not always recognized as equating to "item or service." CMS attempted to reform this term in the 2007 reconsiderations of the CTP, but did not adopt a change. The concept of a "routine cost" comes down to whether the item or service is being used for the clinical management of the patient. At base, a "routine cost" must be something that is being performed for the benefit of a specific individual. But this question of routine cost is not a wholesale deference to the physician; rather, the conclusion that something is a routine cost should be anchored in something objective (*e.g.*, peer review literature) to support the strongest defense and overcome the presumption that the service is for research purposes.

The clinical research community often uses the term "standard of care" to mean therapy that is akin to the CTP's "routine costs." However, the Medicare program does not use the term "standard of care." A later section of this chapter, "Routine Costs During Clinical Research," examines the specific wording of the CTP's term "routine cost," but "routine costs" arguably includes items and services that may be more than the standard of care and are justified for coverage based on the medical necessity of the item or service once the patient is enrolled in the research study. An example of this is a laboratory test to monitor the patient's kidney function during a drug study because the study drug is known to be toxic to the kidneys. This service would be a "routine cost" even though the standard therapy for the patient would not require kidney function tests.

Not all routine costs, however, are covered by third-party payors. Routine costs during qualifying research studies are only billable to third-party payors if the specific service is usually paid for outside the research study under the third-party payor's normal billing rules and meets applicable coverage criteria under a participant's benefit plan with a payer . If a commercial insurer does not cover dietician services for a particular condition, but dietary consultations meet the definition of a "routine cost," the service will not be covered because the payor normally does not cover dietary services for that condition. Likewise, the Medicare program does not cover most self-administered drugs provided in an outpatient setting,[9] and just because the self-administered drugs meet the definition of a "routine cost" during a qualifying research study does not mean that they are automatically billable to Medicare. Indeed, many self-administered drugs are medically necessary in an outpatient setting but are generally not covered by the Medicare program.

The CTP contains a powerful line after discussing the basics of qualifying clinical trials and routine costs: "All other Medicare rules apply." This statement succinctly identifies the CTP as merely an initial step for determining whether research services are covered. It also identifies the CTP as a peer coverage rule to all other Medicare coverage rules.

While specific third-party payors may differ in their specific rules as to what is or is not covered during a clinical research study, most payor rules implicitly follow the framework set out by Medicare, given that the Medicare program's CTP in the end requires medical necessity justification.

Qualifying Research Studies

The term "qualifying research study" is not a technical term found in the CTP or other Medicare rules. It is the term this chapter uses to mean a clinical research study that meets the initial consideration for whether any protocol scheduled services are eligible for coverage. Unfortunately, there is no single term used by Medicare to identify these qualifying research studies. The CTP uses the term "qualifying clinical trial" and in 2007 attempted to change to the "approved clinical research study." The 2007 reform attempts did not adopt this term. The device study coverage regulations likewise use a different term, referring to "covered device trials" or "approved device trial."

Although there is no common regulatory term, what all of these terms have in common is the concept that the study must initially qualify for coverage for scheduled services to be eligible for coverage. We have chosen to use the term "qualifying research study" to reinforce this concept of initial qualification of the study based on what is being studied and the design of the research study. Many research sites use the CTP term "qualifying clinical trial" to cover all qualifying studies and that is an operational choice. We have chosen in this chapter to use "qualifying research study" to emphasize that the qualifying concept applies to research studies that are far beyond studies with an investigational article, the classic design for a "trial."

Whether a research study is a qualifying research study turns on what is being studied. Medicare uses different rules for qualifying the study depending upon what is being studied. The Medicare rules provide qualifying rules for device studies that involve a device that is being investigated under an IDE. These rules also arguably include studies that are post-marketing approval studies as well. For all non-device studies, the CTP sets out the qualifying criteria. The CTP, however, comes up short because it is not technically possible for a research study that is studying an investigational procedure or technique to be a qualifying research study. Nor does the CTP specifically allow coverage for an observational study of an FDA-approved device being used for its labeled purposes when the study is not mandated by the FDA. CMS is silent as to whether research studies that do not fit within the CTP or device study coverage regulations can qualify for Medicare coverage. The proposed 2007 changes to the CTP would have addressed these questions by allowing a "certification" process, but those changes were not adopted. In lieu of addressing these questions on a national level, CMS deferred to local Medicare contractors as to whether coverage exists for these types of studies.[10] Medicare contractors hold diverse opinions on coverage for these studies. Providers should consult local Medicare contractor rules for research studies that do not squarely fall within a qualifying research study rule. A trend appears to be lenient for coverage of pure observational studies as not falling within the jurisdiction of the CTP and relying on basic Medicare coverage rules; but, this stance can vary by jurisdiction.

Device Studies

The qualifying status of a device study turns on the type of device being studied. If the research study includes an investigational device that is considered a "covered device," then there is the potential for reimbursement from Medicare during the study. If the research study includes an investigational device that is considered a "noncovered device," the study is not a qualifying research study and the scheduled services would not be reimbursable.

The device study regulations state:

> Medicare payment is not made for medical and hospital services that are related to the use of a device that is not covered…These services include all services furnished in preparation for the use of a noncovered device, services furnished as necessary after-care that are incident to recovery from the use of the device or from receiving related noncovered services.[11]

The Medicare Benefit Policy Manual (Chapter 14, Section 10) sets out a list of "covered devices:"

> Devices that may be covered under Medicare include the following categories:
>
> - Devices approved by the FDA through the Pre-Market Approval (PMA) process;
> - Devices cleared by the FDA through the 510(k) process;

- FDA-approved Investigational Device Exemption (IDE) Category B devices; and
- Hospital Institutional Review Board (IRB) approved non-significant risk devices[12]

The Medicare Modernization Act added by statute Category A IDE device studies to the list of qualifying research studies but CMS has disallowed coverage for the device itself (codified at42 U.S.C. § 1395y(m)).[13]

Category A IDE Device Studies. In a November 6, 2014 revision to the Medicare Benefit Policy Manual, a Category A device is defined as "...a device for which 'absolute risk' of the device type has not been established (that is, initial questions of safety and effectiveness have not been resolved) and the FDA is unsure whether the device type can be safe and effective."[14]

Category B IDE Devices. A Category B IDE device is defined as: "...a device for which the incremental risk is the primary risk in question (that is, initial questions of safety and effectiveness of that device type have been resolved), or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained FDA premarket approval or clearance for that device type." [15] "

Criteria for Coverage. In the November 6, 2014 revision to Chapter 14 of the Medicare Benefit Policy Manual, CMS spells out the criteria for coverage of Category A and Category B IDE studies.

- For Category A: "Medicare covers routine care items and services furnished in an FDA-approved Category A IDE study if CMS (or its designated entity) determines that the Medicare coverage IDE study criteria are met."[16]
- For Category B: "Medicare may make payment for a Category B IDE device and routine care items and services furnished in an FDA-approved Category B IDE study if CMS (or its designated entity) determines prior to the submission of the first related claim that the Medicare coverage IDE study criteria are met."[17]

Category A and B IDE studies must meet the following criteria to warrant Medicare coverage:

1. The principal purpose of the study is to test whether the device improves health outcomes of appropriately selected patients.
2. The rationale for the study is well supported by available scientific and medical information, or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.
3. The study results are not anticipated to unjustifiably duplicate existing knowledge.
4. The study design is methodologically appropriate and the anticipated number of enrolled subjects is adequate to confidently answer the research question(s) being asked in the study.
5. The study is sponsored by an organization or individual capable of successfully completing the study.

6. The study is in compliance with all applicable Federal regulations concerning the protection of human subjects found at 21 C.F.R. parts 50, 56, and 812 , and 45 C.F.R. part 46.

7. Where appropriate, the study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Studies of all medical technologies measuring therapeutic outcomes as one of the objectives may be exempt from this criterion only if the disease or condition being studied is life threatening and the patient has no other viable treatment options.

8. The study is registered with the National Institutes of Health's National Library of Medicine's ClinicalTrials.gov.

9. The study protocol describes the method and timing of release of results on all pre-specified outcomes, including release of negative outcomes, and that the release should be hastened if the study is terminated early.

10. The study protocol must describe how Medicare beneficiaries may be affected by the device under investigation, and how the study results are or are not expected to be generalizable to the Medicare beneficiary population. Generalizability to populations eligible for Medicare due to age, disability, or other eligibility status must be explicitly described.[18]

Further guidance on on categorizing IDE device studies can be found in an FDA guidance document, FDA Categorization of Investigational Device Exemption (IDE) Devices to Assist the Centers for Medicare and Medicaid Services (CMS) with Coverage Decisions: Guidance for Sponsors, Clinical Investigators, Industry, Institutional Review Boards, and Food and Drug Administration Staff.[19]

The result of whether a device study is approved (or qualifies) is at the time of this printing published on the CMS website for any study with an FDA IDE letter dated January 1, 2015 or afterwards. A submission is made to CMS, which will review the ten (10) criteria and make a determination on whether to approve the study. If the study is approved, then it is listed on the CMS website and the study qualifies for coverage across the country.[20]

Non-Device Research Studies

A non-device research must use the CTP to determine whether the study is a qualifying research study. Under the CTP, a qualifying research study is known as a "qualifying clinical trial" and must meet ten criteria. But how it meets these ten criteria is complex and not straight-forward. The ten criteria were originally designed as a certification approach—in which the investigators would certify that the study qualified under the CTP. That self-certification approach was never operationalized and the only way to meet the qualifying clinical trial status is for a provider to be sure that the research study is the type of research study that CMS considers to meet the criteria. Self-certifying with the ten criteria listed in the CTP is not a CMS-approved approach to meeting qualifying clinical trial status.

The research studies that meet the qualifying clinical trial criteria must be a study that is "deemed" by CMS to have seven of the ten criteria and meet the other three criteria. There are only four groups of studies which CMS "deems" to meet the first seven criteria. These types of studies are often referred to as "deemed" studies. The following are the studies that the CTP lists as meeting these criteria:

1. Trials funded by NIH, CDC, AHRQ, CMS, DOD, and VA;
2. Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD and VA;
3. Trials conducted under an investigational new drug application (IND) reviewed by the FDA; and
4. Drug trials that are exempt from having an IND under 21 CFR 312.2(b)(1) [21]

If a research study is one of these four types of "deemed" studies then it automatically meets the seven so-called "desirable characteristics." At this time there is no other way to meet the seven desirable characteristics (i.e., seven of the ten criteria) unless a study is one of these four types of studies. If a study meets one of these four types of studies, then it must also meet the following three criteria to be a qualifying clinical trial:

1. The subject or purpose of the trial must be the evaluation of an item or service that falls within a Medicare benefit category and not statutorily excluded from coverage (*e.g.*, cosmetic surgery, hearing aids).
2. The trial must have therapeutic intent.
3. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers.[22]

Routine Costs During Clinical Research

For a qualifying research study, the CTP allows coverage for "routine costs" that Medicare rules would cover outside of a research study. The CTP also allows approved device trials to utilize the "routine cost" definition for coverage. So, although there are different paths to coverage for device trials and non-device research studies, once a study qualifies under either approach, then there is potential coverage for any item or service required by the protocol that meets the definition of a "routine cost."

The CTP lists the following as "routine costs":

- "Items or services that are typically provided absent a clinical trial (*e.g.*, conventional care);
- "Items or services required solely for the provision of the investigational item or service (*e.g.*, administration of a noncovered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- "Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service—in particular, for the diagnosis or treatment of complications."

This definition is highly complex, confusing, and arguably self-contradictory. It also appears to erroneously use an "and" to connect the third bullet point. Read literally, particularly when including the "and," the definition is not achievable. The definition only makes sense if the "and" is treated as a scrivener's error and should be an "or" and the remaining definitions are distilled. A common approach to applying these definitions of "routine cost" is to consider them to cover: (a) conventional care items and service; (b) items and services to detect or prevent complications; or (c) the administration of the investigational article.

Just meeting of these three permutations of "routine cost" is not sufficient in itself. The item or service must not be excluded from coverage generally from Medicare. The CTP states that "all other Medicare rules apply." As discussed above, a self-administered drug in an outpatient setting may meet the definition of "routine cost" but

that does not allow coverage because a peer Medicare rule prohibits coverage of a self-administered drug in the outpatient (inside or outside a research study) unless it meets one of a handful of narrow exceptions.

Application of Study Documents to Research Billing

As important as the Medicare rules are, so also are the study documents. The study documents can influence whether an item or service is billable or will be considered to be for research purposes only. Also, if the research billing is ever audited by government authorities, the study documents will be used, so it is critical that how the study services are described in the study documents be taken into account. The most relevant study documents are the clinical trial agreement, the protocol, the coverage analysis and the IRB-approved research informed consent form.

Clinical Trial Agreement

1. Parties. The clinical trial agreement is a contract usually between an institution, such as a university, and the sponsor. Sometimes the clinical trial agreement also has the hospital (provider) as the main party to the contract or as a third-party to the contract. The parties will vary based on the study and the legal relationships between the parties involved in research. In community provider settings, the physician may be the main party to the clinical trial agreement.

The principal investigator is usually also a signatory to the clinical trial agreement. How the investigator signs this document and in what capacity he or she signs the document is important to understand. If the investigator signs the clinical trial agreement to note that the investigator has read and understands the protocol and accepts responsibility for conducting the research, then the investigator may not necessarily be a contractual party. However, the wording of the signature may make the investigator a person party to the contract. Most institutions try to avoid the investigator being seen as a party to the contract.

In what capacity the investigator signs the clinical trial agreement can determine what party is liable for any actions of the investigator. If the investigator signs in his or her name alone, then the investigator may be personally liable. If the investigator signs as an employee of the investigator's practice group, then the practice group may be liable. If the investigator signs in the investigator's capacity as an employee of the university (under his or her faculty position), then the university may be liable.

2. Relevant Parts of the Clinical Trial Agreement for Billing. From a billing compliance perspective, the three most important parts of the clinical trial agreement are a) any parts of the main body of the contract that discusses compensation or financial terms; b) the exhibit incorporating the protocol; c) the compensation arrangement of "sponsor budget" that is usually an exhibit to the contract.

3. Terms in the Main Body of the Contract. What financial terms the main body of the contract commits the parties to are as varied as there are contracts. An important goal in clinical trial agreement contracting is to be as simple and straightforward as possible. This usually suggests that the main part of the contract should discuss as little as possible about compensation and financial terms and rather should refer all financial terms to the exhibit that sets out the budget compensation terms.

Problematic language in the main body of the contract includes such statements as "the compensation provided under this agreement constitutes payment to the institution for all costs associated with conducting the research study," or "the compensation covers the costs for all Services required by this agreement" (note that "Services" is often defined to be the protocol services that are set out in a separate exhibit.

The financial terms set out in the main body of the contract must be reconciled with any terms set out in the

budget exhibit.

4. Protocol as Part of Clinical Trial Agreement. The protocol is usually always incorporated into the contract through an exhibit. Protocol activities often are defined as the "Services" in a clinical trial agreement; in other words, the protocol activities are what the institution is committing itself to do. Since the "Services" under a clinical trial agreement are rarely distinguished as "for research purposes only" services and "clinical care" services, any activity required by the protocol can become a "Service" under the contract.

It is important to keep in mind that the protocol is not merely a scientific document. Because the protocol in toto is usually incorporated by reference into the clinical trial agreement, the protocol is a contractual document as well. How the investigator performs under the protocol and what services are required by the protocol (whether they be "for research purposes only" or are "standard of care"), they are still contractual services and carry all obligations of a valid contract.

5. Sponsorship Budget/Compensation Exhibit. The sponsorship budget is usually set out as an exhibit in the clinical trial agreement. It is critical to understand that the budget/compensation exhibit is part of the contract. The sponsorship budget is every bit a part of most contracts as is the main body of the contract. Keeping the sponsorship budget and the main body of the contract harmonized—recognizing that the protocol are the services—is vital to successfully negotiating a clinical trial agreement with as few ambiguities as possible.

The sponsorship budget can have many methods for providing compensation. The budget may set out a "lump sum" that is paid at certain milestones, or the budget may set out payment for specific services. There may be a combination of both. There also may be inadvertent ambiguities in the budget as to what the payments pay for.

6. Interpreting the Clinical Trial Agreement. The following are basic points that apply to interpreting a clinical trial agreement:

- The clinical trial agreement is interpreted as a whole—the main body of the contract, the incorporated protocol, the budget exhibit are one, singular contract.
- The plain language of the contract will be considered to mean what it says. This is particularly so when two highly sophisticated parties (universities and drug/device companies) negotiate contracts.
- If the parties disagree on the meaning of the terms, then ancillary evidence can be used to show that the words did not mean what was written—based on actions of the parties or based on evidence/material from the time of executing the contract that shows what the real intent of the parties are. It is rarely sufficient for one party to take plain language interpretations and assert they mean something different without evidence that the other party also understood the terms to be different.
- If terms are ambiguous, then the general rules of contract interpretation instruct courts to interpret the language against the drafter of the agreement and in favor of the party that took the words to mean something different than what the drafter wrote. This is usually used when the parties disagree on the meaning of the term and the terms are ambiguous. Clear, plain words rarely can utilize this canon of interpretation.
- If the terms in the main body of the contract are not in sync with the budget exhibit (or if the terms within the exhibit contradict themselves), then the words must be interpreted together to determine the meaning of the words. The plainest words in the contradictory statements would be used to harmonize the contradictions. In other words, the language that most easily and readily conveys an understanding of what the terms mean would be used.

- If two statements exist that cannot be reconciled: X=3 and X=4, then there may be no way to reconcile these statements except to either amend the contract so that the parties agree on what was meant, or if disputes occur, then to look to the actions of the parties to determine if those will help inform the meaning of the terms.

7. CMS "Clarification" of September 30, 2008. On September 30, 2008, CMS issued a Special Edition Article which discussed clauses in clinical trial agreements that have long been debated. So-called "conditional payment clauses" or "contingency payment clauses" were addressed in which the sponsor agreed to pay for a service only after the enrollee's insurer denied coverage for the service. These clauses had been debated for several years under the Medicare Secondary Payer statute, particularly with respect to treatment of research-related injuries, but the Special Edition Article tackled the question of whether the contingency payment clauses operated to provide services "free of charge" to enrollees and therefore disallowed billing Medicare.

The Special Edition Article utilized Chapter 16, Section 40 of the Medicare Benefit Policy Manual to argue that when the sponsor (or anyone else) has a legal obligation to pay for a service and the provider does not pursue collection against an enrollee after the patient's insurance denies coverage, then that clause triggers the CTP's provision that services paid for by the sponsor cannot be billed to the Medicare Program.

The Special Edition Article has caused certain controversy because it went beyond commenting on the contingency payment clauses and focused on when a provider decides not to pursue collection against a research subject. If the provider decided not to pursue payment from a non-Medicare research subject, then a Medicare enrollee in the study must also received the service free of charge.

The Special Edition Article stated:

> If the routine costs of the clinical trial are furnished gratuitously (*i.e.*, without regard to the beneficiary's ability to pay and without expectation of payment from any other source), then Medicare payment cannot be made and the beneficiary cannot be charged. If private insurers deny the routine costs and the provider of services does not pursue the non-Medicare patients for payment after the denials (even though the non-Medicare patient has the ability to pay), Medicare payment cannot be made and the beneficiary cannot be charged for the routine costs.[23]

CMS offered an exception to this application of the Special Edition Article if the patient is indigent. If the patient is indigent pursuant to the provider's indigency policy, then the sponsor may pay the provider for the service and it will not disturb Medicare billing for the same service.

With respect to indigency, the Special Edition Article stated:

> If the routine costs of the clinical trial are not billed to indigent non-Medicare patients because of their inability to pay (but are being billed to all the other patients in the clinical trial who have the financial means to pay even when his/her private insurer denies payment for the routine costs), then a legal obligation to pay exists. Therefore, Medicare payment may be made and the beneficiary (who is not indigent) will be responsible for the applicable Medicare deductible and coinsurance amounts.[24]

The Special Edition Article also clarified that sponsors may not pay enrollees' co-payments and deductible

without risking violations of fraud and abuse laws:

> If a research sponsor offers to pay cost-sharing amounts owed by the beneficiary, this could be a fraud and abuse problem. In addition to CMS' policy, the Office of Inspector General (OIG) advises that nothing in OIG rules or regulations under the Federal anti-kickback statute prohibits hospitals from waiving collection of charges to uninsured patients of limited means, so long as the waiver is not linked in any manner to the generation of business payable by a Federal healthcare program.[25]

Coverage Analysis

A coverage analysis is best practice to ensure that the protocol-related services are outlined and, if the services will be billed to insurance, that a rationale is given which overcomes the implicit presumption that a service required by the protocol is medically necessary for all possible eligible subjects. The coverage analysis allows commentary to anchor the rationale for coverage in national guidelines, national and local CMS rules and not just what a physician performs as local practice or the physician's intuitive sense of what needs to be done for the patient. Just as a medical record must document medical necessity for insurance coverage and not simply record a physician's order, so too, a coverage analysis provides rationale that articulates why a service is not for research purposes only but meets one of the definitions of "routine cost." A coverage analysis is a formalized review of what is within the protocol and study event calendar to ensure that a site has validated where it intends to send charges once a participant is registered onto a study that has services that generate charges within a facility's charge capture system. If the research study will generate a charge in the research site's charge capture system, then it is industry standard to develop a coverage analysis.

It has become industry standard to have the coverage analysis developed by offices other than the study team's, though in dialogue and concert with the Principal Investigator and study team. Industry experience has shown that development of a coverage analysis by individuals other than the study team minimizes bias and allows incorporation of specialized insurance rule knowledge that the study team may not possess.

Informed Consent Form

1. Basic Interpretation of Informed Consent Form. The OHRP and FDA regulations for protection of human subjects require that the informed consent be written in language that it is understandable to the subject. Many organizations set this level at an 8th grade reading level; some require a lower reading level. Consequently, interpreting the informed consent document is different from the clinical trial agreement because there is an assumption that the two parties are not on equal footing.

The critical component of interpreting an informed consent form is to remember that the words must be taken at face value. The perspective the government uses to interpret an informed consent is the perspective of the patient. A question to always ask when interpreting a research informed consent form is, "what would the patient understand this language to mean?"

The informed consent form becomes relevant for billing compliance in at least three ways: a) the expression of therapeutic benefit; b) the disclosure of added costs to the patient (which often becomes a recitation of what services are provided free or at no cost to the subject); and c) what services are the responsibility of the patient after a research related injury.

2. Expression of Therapeutic Benefit. The informed consent must describe what benefits the patient could receive

as a result of participating in the research study. If the informed consent states that the patient will not receive benefit from participating in the study (but rather benefit may be derived for future patients), then the government would likely interpret that statement to mean that the study is not designed with therapeutic intent in mind. No undocumented oral statements will likely be able to override clear language in the informed consent in which the patient has been told that participating in the study will not benefit the patient.

If the benefit section of the informed consent contains language that identifies that the investigator hopes the study benefits the patient but cannot guarantee benefit, then that language supports the idea that the study has been designed with therapeutic intent in mind.

3. Added Costs Section. The research informed consent must disclose what added costs the patient will incur by enrolling in the research study. The OHRP and FDA regulations do not require that free services be listed in this section, but informed consents often list the free services for any number of reasons (some IRBs require this).

Any service that is promised free or at no cost to the participant in the research study cannot be billed. The words will be interpreted from the perspective of the patient. What would a patient (without the aide of oral interpretation) understand these words to mean? In other words, what is the plain language of the words?

If the language states that there will be "no costs to you for participating in the research study," keep in mind what services are required by the research study—all activities required by the protocol. When the patient is told he or she has "no costs" for participating, this means that the patient cannot be billed for any protocol-required services, whether those services are "for research purposes only" or also carry a clinical dimension to them.

If the language indicates that certain services are free, then those services cannot be billed. For instance, the informed consent document may indicate that the "CT scans conducted during screening will be at no cost." This only requires the CT scans that are done at the start of the enrollment process during screening to be provided without charge to the patient. However, if the language states that "all imaging services that are part of this research study" will be provided free, then no imaging services (whether X-Rays, CTs or MRIs) can be billed to the patient if the imaging service is required by the protocol.

If the language of the informed consent states that "there will be no costs for services that are performed only because you are enrolled in this study," then that can be interpreted to mean the services that are done only for research purposes and not the services that the patient would receive as part of standard of care or part of the normal care the patient would receive if he or she was not enrolled in the research study.

If the language of the informed consent contradicts itself, then the force of the contradiction must be weighed. This is the hardest aspect of informed consent language to interpret and it occurs not infrequently. An informed consent may state that "There are no costs to you for participating in this research study. Standard of care services will be billed to you or your insurer in the normal way." Keep in mind: what would the patient understand this language to mean? Would the patient understand this to mean that all study-required services are free but any services that are outside the study will be billed? Would the patient understand this to mean that the "for research only" services during a study are not billable but that any services required by the study but for clinical care will be billed? There is no clear answer to this. Patterns of behavior and actions could be used to interpret this one way or another; conversations with the patient at the time of consenting could also be used to interpret this.

When the language of the informed consent contradicts itself as written above, then surrounding language should be used to interpret the contradictory language. In the example above, there are merely two sentences written out. If the language occurs in the context of a longer paragraph in which the language has multiple permutations of "there are no costs to you," followed by a brief line discussing standard of care as billable, then

the language would likely be construed in favor of the patient. If the opposite is true, then the weight may be on the side of billing for the standard of care services.

Protocol

The protocol is often overlooked as making up a contractual document. The activities required by the protocol are often the "Services" in the clinical trial agreement. Obligations of the institution or provider or investigator that are set out in the protocol can be construed as contractual obligations.

The protocol is subject to all interpretations that apply to the clinical trial agreement. Language that is plainly stated in the protocol must be taken at face value unless shown to be otherwise.

The interpretation of the protocol often comes into play for billing purposes in attempting to determine whether a protocol-required service is for research purposes only or may be done for both research purposes and the clinical care of the patient. Budgeting must be done based on the patient who minimally meets the inclusion criteria. A question that must be asked is whether every patient who will receive a service will receive the service for their clinical care. If the protocol states that a service is being done for research purposes only, then the protocol must be assumed to mean that it is done for research purposes only unless the physician can demonstrate that every patient who possibly meets the inclusion criteria would receive that service for their clinical care.

Statements in the protocol that usually affect billing are those statements that indicate something is being required by the protocol only for research purposes or for data collection purposes. In conducting a coverage analysis, these statements must be taken at face value until the investigator indicates otherwise.