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**Statement
of the
American Society of Clinical Pathologists
before the
Food and Drug Administration Workshop on CLIA Waiver Criteria**

August 15, 2000

Thank you for the opportunity to speak with you today about the criteria used to determine whether specific laboratory tests are waived from certain requirements of the Clinical Laboratory Improvement Amendments of 1988 (CLIA). My name is Michele Best, MT(ASCP). I am Director of Laboratory Compliance/Resources at the Washington Hospital Center in Washington, DC, and serve on the Board of Directors of the American Society of Clinical Pathologists (ASCP). I was part of the original subcommittee of the Clinical Laboratory Improvement Advisory Committee that developed the waived test criteria. I am here today representing ASCP.

ASCP is a nonprofit medical specialty society organized for educational and scientific purposes. Its 75,000 members include board certified pathologists, other physicians, clinical scientists, and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel.

We appreciate the list of questions posed by the FDA to assess the waiver criteria. We will address many of those questions in our general comments to follow.

Defining Simple and Accurate

Overall, ASCP agrees with the rule that a waived test must “employ methodologies that are so simple and accurate to render the likelihood of erroneous results by the user negligible.” Unfortunately, current practice is not following this example. Specifically, we are concerned with the provision of the Food and Drug Administration Modernization Act of 1997 (P.L. 105-115) that allows laboratory tests approved for home use to automatically be categorized as waived. This contradicts, at times, the rule that only methodologies that are simple and accurate must be used for a test to be considered waived. In particular, without reference to specific manufacturers, we are concerned that prothrombin time point-of-care devices are approved for home use and, therefore, are categorized as waived tests. An inaccurate prothrombin time test result could result in stroke, myocardial infarction, or death to the patient, if the subsequent coumadin level is adjusted based on that inaccurate test result. Also, just because a patient is trained in the home-use of a specific device for a particular condition, a complete waiver for home-use misapplies this level of skill to a broad range of unskilled users.

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The current threshold for waiver that permits no significant inaccuracy and no significant imprecision should be raised. Waived tests, when performed by poorly trained users, should provide an accurate result with no significant clinical or statistical error when compared to a measure of truth. Noting the increasing number of less-trained, without laboratory oversight, users permitted by state law and regulation to perform waived tests, it is imperative, from a public safety perspective, that waived tests are so accurate that inaccurate results will not occur.

Similarly, if a waived test requires a confirmatory second test for accurate medical evaluation, it should not be waived in the first place. If the test result is questionable enough to require the performance of a second test, it does not “render the likelihood of erroneous results by the user negligible” as required by law. There are no assurances that the patient will obtain or receive a second confirmatory test. The inability or unwillingness to follow-up with a confirmatory test may create hardship for the patient, and may create public health hazards (e.g., undiagnosed and untreated strep infections are contagious and potentially life-threatening).

It is not acceptable to waive tests that have inaccurate results, even though they may not have a negative clinical impact. This would require less-trained users to make a medical evaluation at the time a waived test is performed (is the test result likely to have a negative clinical impact? or is the test inaccurate?). This type of intervention is often inappropriate and may be illegal in light of various state scope of practice laws.

When determining if a test will “pose no unreasonable risk of harm to the patient if performed incorrectly,” it is important to consider the human factors involved in an erroneous test result. For example, an incorrect pregnancy test may place unnecessary stress on the patient. An inaccurate, positive at-home drug test may generate distrust and grief within a family. However, it is not appropriate to open the waived categorization process to consider the public good of a test. To allow a test in the waived category for “access” purposes, is blatantly ignoring the science of the test and ultimately ignoring risk of harm to the patient, and yet serving the public health, which is access to safe and effective laboratory testing.

Parameters for Waived Tests

The accuracy of a waived test should be determined using designated comparative methods/materials or other acceptable reference endpoints. In other words, there should be a gold standard of laboratory methods from which to compare laboratory tests.

To evaluate the accuracy of a waived test, untrained users should perform the test since they are the potential users of the device. Studies, such as a published report in the *Journal of the American Medical Association* in February 1998, concluded that “testing personnel in many POLs (physician office laboratories) might lack the necessary education, training, and oversight common to larger facilities.... patients should be aware that preliminary findings suggest that differences in quality of laboratory tests based on testing site may exist...(and) legislators may wish to reconsider the wisdom of further easing restrictions on those to whom we entrust our laboratory specimens.” This 1997 California Department of Health Services study on physician office laboratories found that physician office laboratories had a significantly higher proficiency testing failure rate compared to non-physician office laboratories, and physician office laboratories that employ medical technologists. Therefore, waived tests should be evaluated based on the strength of the least trained individuals (e.g., a national 7th grade academic standard), not the best trained.

In addition to performing studies at non-laboratory sites, the study design should include laboratory sites with expertise in testing. These laboratory sites may discover problems that were not detected by the manufacturer and non-laboratory sites. This additional information source would validate the waived test in comparison with standard laboratory methods. A minimum of three sites should be used in the evaluation of a waived test, and real samples should be used in a waived test evaluation (e.g., urine for urine).

In light of the use of the waived tests by untrained individuals, it is important to refer to interference studies. If a sample is inappropriately heated or refrigerated before testing, how will the test result be affected? Overall, there should be no sample preparation for waived tests and no use of operator calibration. A test system must contain fail-safe mechanisms that stop producing results when the test system malfunctions and when the test result is outside the reportable range. The test system should not be able to give a result if it is out-of-control. It would be helpful for waived test regulations to explain how the "fail-safe" system attribute is to be documented in manufacturers' submissions. Waived tests should have single reagent criteria.

Qualitative studies should examine the issue of color-blindness. Color-dependent problems may arise with the use of reagent dipsticks.

It is acceptable to use ANOVA analysis (Analysis of Variance is a series of statistical procedures for determining whether the differences, among two or more groups of scores, are attributable to chance alone) as a performance threshold for determining whether precision studies are appropriate for waiver status, and the recommendation to use 20 samples at three levels to define precision should be considered a minimum number. In general, ASCP is supportive of the criteria listed for quantitative and qualitative tests in the September 13, 1995, proposed rule for waived tests, including: test system characteristics, test system instruction, field study criteria, field study data criteria, and method accuracy studies. We advocate the strict adherence to that criteria.

Apart from the specific waiver criteria, ASCP also encourages the enforcement of CLIA so that laboratory tests are not performed outside of the scope of a registered CLIA certificate.

Thank you for the opportunity to present these views. I would be pleased to answer questions.



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