



**POLICY ON IRB DETERMINATION OF RESEARCH  
NOT INVOLVING HUMAN SUBJECTS  
FOR RESEARCH USING CODED SPECIMENS OR  
CODED IDENTIFIABLE PRIVATE INFORMATION**

5/15/2008

Research that uses coded specimens or coded identifiable private information, including protected health information, can be determined to be research not involving a human subject, and therefore not subject to IRB review, and to comply with the regulations of the Office of Human Research Protections (OHRP) and the Health Insurance Portability and Accountability Act (HIPAA) if all of the requirements detailed in this policy are met. This policy applies only to specimens or data not collected specifically for the current proposed research project through an interaction or intervention with living individuals, such as specimens or data collected primarily for clinical and/or quality improvement (QI) purposes, whether the specimens or information were collected in the past or will be collected in the future.

Investigators conducting human subject research in the DUHS must apply for a determination of exemption by completing a new protocol submission using the electronic e-IRB system. In his/her submission, the investigator will describe the proposed research in detail and the methods that will be used to protect the privacy of the subjects and the confidentiality of the specimens or identifiable private information, such as protected health information. These methods must include those outlined in this policy statement.

Only the IRB can declare a research activity exempt. Even if a project is declared exempt by the IRB, all key personnel must still meet the requirements for education on the protection of human research participants.

The PI must notify the IRB if during the course of this research any changes are proposed in the research study. At that time, the IRB will decide whether or not the status of the research as not involving a human subject can continue. Similarly, continued HIPAA compliance will be evaluated.

**A. Definitions**

**1. Identifiable Private Information.** OHRP regulations define identifiable private information as follows:

“Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects.”

45 CFR 46.102(f)(2)

**2. Protected Health Information (PHI).** HIPAA privacy regulations define PHI, i.e., individually identifiable health information, as follows:

“Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.” (45CFR160.103)

**3. Code.** This is a linking field as defined by HIPAA for re-identification [45 CFR 164.514(c)]. According to the federal regulation, "the code cannot be derived from or related to information about the individual and is not otherwise capable of being translated so as to identify the individual" (This language makes it impossible to use an encrypted identifier, or such combinations as Initials and Date of Birth as the code.). To comply with both OHRP and HIPAA regulations, the code cannot be part of the source specimen data or information database.

**4. Unique Identifier(s).** These are the identifiers, unique to an individual subject, that are used by the Identity Keeper (IK), who is defined below in Section B, to link the code to the subject and, in turn, extract the subject’s specimen or data record. For example, it could be the medical record number (MRN), a combination of the MRN and account number, or an identifier internal to the source specimen data or information database.

**5. Source Specimen Data or Information Database.** These are the PHI data that are collected for clinical or research purposes, from which limited data sets are extracted for specific research projects.

**6. Limited Data Set.** This is the coded data set created by the IK by removing sufficient identification from the source specimen data or information database to meet the HIPAA definition of limited data set [45 CFR 164.514(e)]. The principal investigator (PI) must document for the IRB how creation of the limited data set is to be done.

**7. Data Use Agreement (DUA).** This is the written assurance required by HIPAA that “the limited data set recipient will only use or disclose the protected health information for limited purposes” (45 CFR 164.514(e)(4)).

**B. Key Persons.** Three key persons bear the responsibility for the process of specimen/data protection, as follows:

**1. Identity Keeper (IK).** This person has access to the source specimens and/or data that retain an identifier. When requests are made to use specimens from the repository or data from the database for research purposes, the IK is responsible for extracting, coding, and creating the limited data set from the source specimens and/or data and following the other procedures required by the IRB, as explained below under the heading Process. The IK must not be involved in the research being proposed (beyond creating the limited data set for use by the PI). If the IK is using PHI only for creating the limited data set and is not participating in the research, under HIPAA his/her activities are considered part of health care operations (45 CFR

164.501(6)(v), thereby permitting his/her use or disclosure of the PHI without waiver of authorization (45 CFR 164.502(a)(1)(ii)). The IK is the only key person who has long-term access to the full subject identifiers and health information from the source specimens or information database.

**2. Privacy Officer (PO).** This is the HIPAA Privacy Officer for DUHS, or his/her designee. The specified PO must not be involved in the research being proposed. The PO is the only person who has long-term access to both the codes and unique identifiers for subjects in the research study.

**3. Principal Investigator (PI).** This person is responsible for conducting the research study in compliance with the terms of the IRB determination that the study is not human subject research. The PI is the only person who has long-term access to the limited data set for research purposes.

### **C. Responsibilities of the Key Persons.**

#### **1. The Identity Keeper (IK):**

- (a) Extracts from the source specimens or information database that portion of the data that has been requested by the Principal Investigator (PI) for a given study, plus unique identifiers for each subject,
- (b) Adds a code for each subject to the extracted data,
- (c) Creates the limited data set from the extracted data according to HIPAA [45 CFR 164.514(e)], retaining the code,
- (d) Sends the both the code and unique identifier(s) for subjects in the extracted data to the Privacy Officer (PO),
- (e) Sends the coded limited data set to the PI, and
- (f) Destroys his/her copy of the coded data that contains unique identifiers for each subject.
- (g) If additional specimens or data are requested by the PI for subjects in the limited data set after the initial request has been fulfilled, the IK will request the code and unique identifier(s) from the PO, and use them to extract the additional specimens or data, create a new coded limited data set, and send the new coded limited data set to the PI. Again, the IK will destroy his/her copy of the coded extracted data that contains unique identifiers for each subject.
- (h) If additional subjects are to be included in the study in the future, the PI may request the new specimens or data from the IK, who will perform the extraction, coding, and creation of a coded limited data set according to the same procedure used for the initial data set. Again, the IK will send the new list of codes and unique identifiers to the PO and destroy his/her copy.
- (i) Signs a document (See Attachment 1.) verifying that he/she:
  - (1) Has possessed, or will possess, the code together with the unique identifier(s) for subjects in the extracted data only as needed to prepare the original list of codes and identifiers for the PO and the coded limited data set for the PI, initially or subsequently,
  - (2) Has destroyed, or will destroy, the code and unique identifier(s) after each time they are used, and
  - (3) Will not attempt to re-link the source database to the code together with the unique identifier(s) unless requested specifically by the PI, using the code and unique identifier(s) provided by the PO.

#### **2. The Privacy Officer (PO):**

- (a) Retains a permanent copy of the code together with the unique identifier(s) sent to him/her by the IK for subjects in the PI's research study.
- (b) If additional coded specimens or data are requested from the IK by the PI after the initial request has been fulfilled, the PO will send to the IK the unique identifier(s) for the codes of subjects included in the limited data set.
- (c) If additional subjects are to be included in the study in the future, the PO will add the new codes and unique identifiers that have been sent by the IK.
- (d) Signs a document (See Attachment 1.) verifying that he/she will not reveal the code together with the unique identifier(s):
  - (1) To the IK except in response to requests from the PI for additional coded data,
  - (2) To the PI or other DUHS parties unless approved by the IRB under special circumstances that ensure the interests of human subjects involved in the research, or
  - (3) To anyone outside of the DUHS.

### **3. The Principal Investigator (PI):**

- (a) Applies for an IRB determination of research not involving a human subject under 45 CFR 46.102(f), which declares that research involves human subjects only if the private information is "...individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information.)" The letter requesting this determination must detail how these IRB policy requirements will be met.
- (b) After receiving the IRB determination of research not involving a human subject, the PI conducts the study using only the coded limited data set obtained through the process described above.
- (c) If the PI needs additional coded specimens or data after the initial request has been fulfilled, the PI will send a list of codes of the subjects for whom additional data are needed to the IK.
- (d) If the PI needs new information in the future from additional subjects to be included in the study, the PI will request the coded specimens or data from the IK.
- (e) Signs a document (See Attachment 1.) that he/she:
  - (1) Will not attempt to, or direct others to identify subjects in the research specimen/data set, or ask the IK or PO to do so, and
  - (2) Will notify the IRB if any changes are proposed in the research study that might alter the IRB's determination related to the study or the study's HIPAA compliance status.
- (f) Signs the DUA assuring that he/she will only use or disclose the protected health information for limited purposes. (See Attachment 2.)

**D. Process for Data Use Agreements (DUA).** HIPAA requires a DUA for use or disclosure of protected health information (PHI). At Duke separate documents are required for internal use and external disclosure as described below.

- 1. Internal use of PHI.** The internal DUA is a written agreement between DUHS and the PI in which DUHS provides the limited data set to the PI for research purposes, and the PI assures that he/she will only use the PHI for limited purposes. (See Attachment 2.) An IRB chair or vice-chair will sign this internal DUA on behalf of the DUHS, but only after all of the documentation required by this policy has been completed and approved.
- 2. External disclosure of PHI.** The external DUA is a written agreement and formal contract between the DUHS and an external person or organization that provides the limited data set for research purposes with the assurance that the PHI will only be used for limited purposes. (See Attachment 3.) An IRB chair or vice-chair will sign this external DUA on behalf of the

DUHS, but only after all of the documentation required by this policy has been completed and approved.

**E. Process for PI not at DUHS.** This policy can be used for external PIs. In that case, both a DUHS PI and a collaborating PI must be identified and the determination that the research will not involve a human subject must be made by both the DUHS IRB and the collaborating PI's IRB.

ATTACHMENT 1

Assurances for Research Determined to Not Involve a Human Subject that Uses Coded Specimens or Coded Identifiable Private Information, such as Protected Health Information

Duke University Health System (DUHS) Institutional Review Board (IRB)

IRB NHSR Number: \_\_\_\_\_ [For IRB office use only.]

Name of

Study: \_\_\_\_\_

Principal Investigator (PI): \_\_\_\_\_ Mail Box: \_\_\_\_\_ E-mail:

Beeper: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Dept. & Division: \_\_\_\_\_

Repository Keeper (RK): \_\_\_\_\_ Mail Box: \_\_\_\_\_ E-mail:

Beeper: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Dept. & Division: \_\_\_\_\_

DUHS Privacy Officer or designee (PO): \_\_\_\_\_ Mail Box: \_\_\_\_\_ E-mail: \_\_\_\_\_

Beeper: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Dept. & Division: \_\_\_\_\_

ASSURANCE BY THE PRINCIPAL INVESTIGATOR (PI)

I will not attempt to, or direct others to identify subjects in the research data, or ask the RK or PO to do so, and I will notify the IRB if any changes are proposed in the research study that might alter the IRB determination of the study not involving human subjects, or the HIPAA compliance status.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

ASSURANCE BY THE IDENTITY KEEPER (IK)

I have possessed, or will possess, the code together with the unique identifier(s) for subjects in the extracted specimens/data only as needed to prepare the original list of codes and identifiers for the PO and the coded limited data set for the PI, initially or subsequently; I have destroyed, or will destroy, the code and unique identifier(s) after each time they are used; and I will not attempt to re-link the source database to the code together with the unique identifier(s) unless requested specifically by the PI, using the code and unique identifier(s) provided by the PO. I am not, and will not be, involved in the research that uses the data that I extract and code.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

ASSURANCE BY THE DUHS PRIVACY OFFICER (PO)

I will not reveal the code together with the unique identifier(s) to the IK except in response to requests from the PI for additional coded data, to the PI or other DUHS parties unless approved by the IRB under special circumstances that ensure the interests of human subjects involved in the research, or to anyone outside of the DUHS.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

ACCEPTANCE BY THE DUHS IRB

On behalf of the DUHS IRB, I accept the assurances of the PI, IK, and PO for this research study.

\_\_\_\_\_  
Signature  
DUHS Chair or Vice-Chair

\_\_\_\_\_  
Printed Name

Date: \_\_\_\_\_

Data Use Agreement for DUHS Internal Use

- 1) This Data Use Agreement (DUA) is between Duke University Health System (DUHS), an Organized Health Care Arrangement acting as a covered entity under HIPAA, which is providing a Limited Data Set of Protected Health Information (PHI) to \_\_\_\_\_(RECIPIENT) for the purposes set forth below.
- 2) The Purpose for use of disclosure of the PHI is to conduct the research study, \_\_\_\_\_.
- 3) RECIPIENT agrees to not use or further disclose the PHI other than is permitted by this DUA, or as otherwise required by law.
- 4) RECIPIENT will use appropriate safeguards to prevent use of disclosure of the PHI other than as provided in this DUA.
- 5) RECIPIENT will report to DUHS any use or disclosure of the information not provided for in this agreement of which RECIPIENT becomes aware.
- 6) RECIPIENT will ensure that its agents, including subcontractors, to whom it provides the limited dataset agree to the same restrictions and conditions that apply to RECIPIENT with respect to such information.
- 7) RECIPIENT will not attempt to identify the individuals to whom the information pertains, nor to contact the individuals.

For DUHS

Signature
Printed Name:
Title: DUHS IRB Chair or Vice-Chair
Date:

For the Limited Data Set Recipient

Signature
Printed Name:
Title: Principal Investigator
Date:

**ATTACHMENT 3**  
**Data Use Agreement for DUHS External Use**

This Data Use Agreement for a Limited Data Set (“DUA”) is effective on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, (“Effective Date”) by and between the Duke University Health System (DUHS) (“Covered Entity”), a non-profit corporation located at Durham, North Carolina, and \_\_\_\_\_ Inc. (“Recipient”), a corporation located at \_\_\_\_\_; collectively, the “Parties”.

The Covered Entity is a COVERED ENTITY as defined in the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”); and the Covered Entity is providing Recipient with a Limited Data Set of Protected Health Information (“PHI”) as defined in 45 Code of Federal Regulations (CFR) § 164.514(e)(2); so that the Recipient is a “LIMITED DATA SET RECIPIENT” as defined in HIPAA;

The Parties agree to the provisions of this DUA in order to address the requirements of HIPAA and to protect the interest of both Parties.

1. **DEFINITIONS.** Except as otherwise defined herein, any and all capitalized terms in this DUA shall have the definitions set forth in HIPAA. In the event of any inconsistency between the provisions of this DUA and mandatory provisions of HIPAA, as amended, the HIPAA provisions shall control. Where provisions of this DUA are different from those provided in HIPAA, but are permitted by HIPAA, the provisions of this DUA shall control.
2. **USE OR DISCLOSURE.** Recipient shall have the right to use or disclose all PHI provided to it by the Covered Entity for the Research listed below:  
  
\_\_\_\_\_
3. **RESTRICTIONS ON USE.** Recipient agrees that it, and any employees, agents and subcontractors to whom it discloses the PHI, will not use or further disclose the PHI other than as permitted by this DUA, or as otherwise required by law or regulation. Recipient shall use appropriate safeguards to protect the PHI from misuse or inappropriate disclosure and to prevent any use or disclosure of the PHI other than as provided in this DUA or as otherwise required by law or regulation. Recipient shall not attempt to identify the individuals to whom the PHI pertains, or attempt to contact such individuals.
4. **REPORTING.** Recipient shall report to Covered Entity any use or disclosure of the PHI not provided for in this DUA of which Recipient becomes aware. Recipient will take reasonable steps to limit any further such use or disclosure.
5. **TERMINATION.** This DUA shall be effective on the Effective Date set forth above and shall continue as long as Recipient retains the data, unless otherwise terminated by applicable law or regulation. Recipient may terminate this Agreement by returning or destroying the PHI and providing written notice to the Covered Entity. Should Recipient commit a material breach of this Agreement, which is not cured within thirty (30) days after Recipient receives notice of such breach from the Covered Entity, then the Covered Entity will discontinue disclosure of PHI and will report the breach to the Secretary, Department of Health and Human Services.

For DUHS

Signature
Printed Name: Title: DUHS IRB Chair or Vice-Chair Date:

For the Limited Data Set Recipient

Signature
Printed Name: Title: Date: