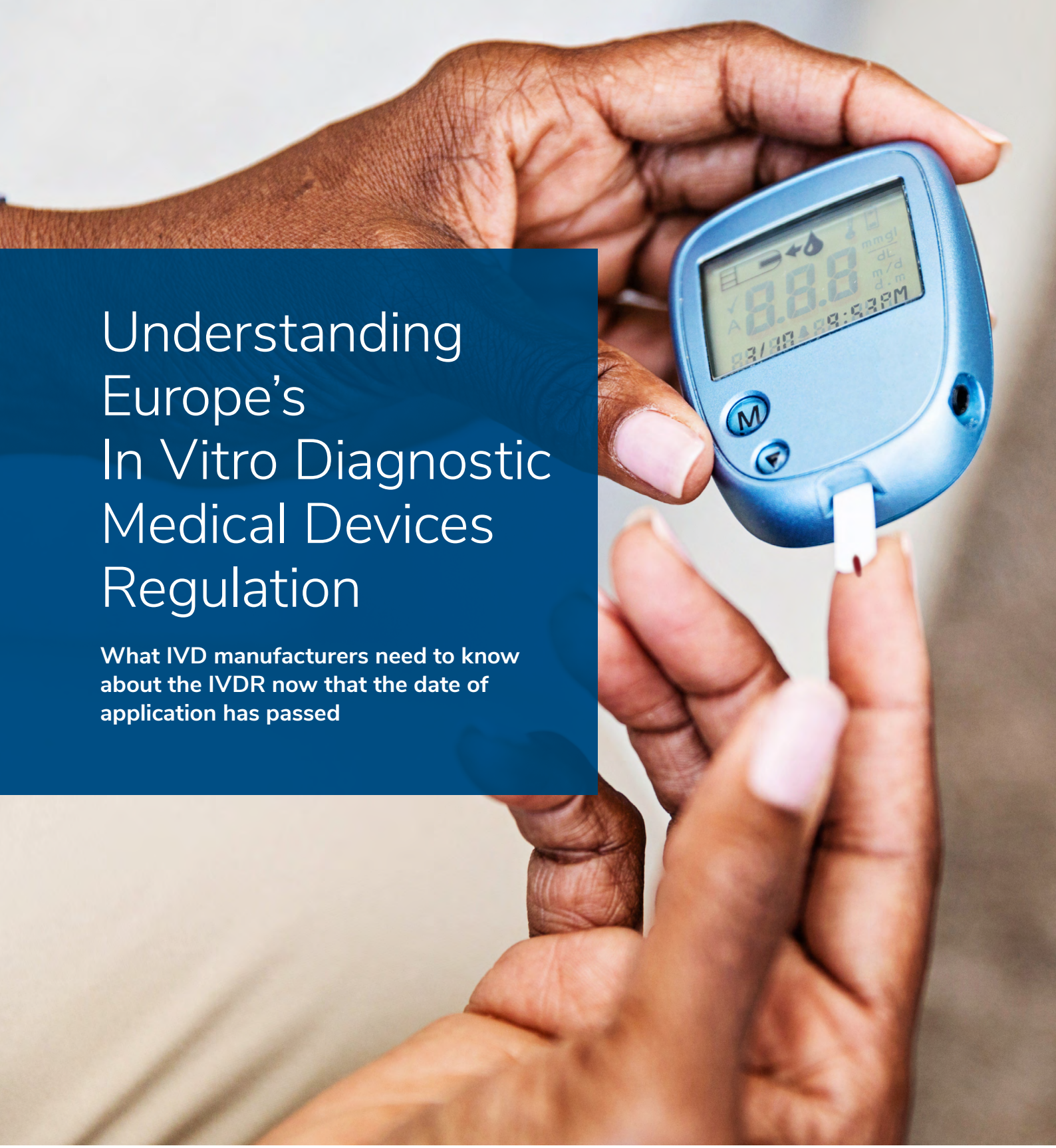

Understanding Europe's In Vitro Diagnostic Medical Devices Regulation

What IVD manufacturers need to know about the IVDR now that the date of application has passed

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How the IVDR came about

The first version of the proposed European Regulations for In Vitro Diagnostics (IVDs) was published by the European Commission (EC) in 2012. The European Parliament, European Council and EC vigorously negotiated it. The negotiations resulted in a "Consolidated Compromise text." Publication of the Regulation in the Official Journal of the European Union (OJEU) occurred in 2017 as the In Vitro Diagnostic Medical Devices Regulation (IVDR) (EU) No. 2017/746[1] with a date of application (DoA) of May 26, 2022.

From initial proposal to final document

In 1998, the IVD Directive (IVDD) 98/79/EC was introduced to regulate the free movement of IVDs within the European market. In 2008 and 2010, the EC held public consultations to assess the need for an update to this legislation.

In 2010, it became clear that a next step had to be taken. Several weaknesses of the IVDD were identified: new developments regarding genetic testing and companion diagnostic devices that are not specifically addressed in the IVDD, the need to better align with international guidelines — including a risk-based classification system — and the lack of control over high-risk in-house tests. At the same time, the Poly Implant Prothese (PIP) scandal pointed to weaknesses in the system of CE marking certification by notified bodies. The notified bodies championed a code of conduct in the hope of self-policing. Currently, most members of the notified body association Team-NB have signed this code of conduct. However, the number of notified bodies actively certifying medical and IVD devices is dropping rapidly. Although initially the impact of the change from industry partner to police is bigger for the medical devices industry, the IVD industry will feel this change as well once their own new classification rules are applied.

When work started on a major update to the Medical Devices Directive (MDD), the first intent was to combine the MDD, the Active Implantable Medical Devices Directive (AIMDD) and the IVDD into one regulation. However, the outcome of those update efforts created separate legislation for IVDs.

In September 2012, the EC published the initial proposals for the Regulations for medical devices (MDR)[2] and IVDR[3]. In April 2014, the European Parliament came up with a total of 347 amendments for the proposed MDR[4] and 254 amendments for the proposed IVDR[5]. The European Council responded in September 2015 to the proposals adopted by Parliament.

As the EC, Parliament and Council apparently couldn't agree on the final document, a so-called trilogue was started. In the trilogue, Parliament and Council discuss their positions, facilitated by the EC. The trilogues started in October 2015 and resulted in a compromise in June 2016. The "Consolidated Compromise text" was made publicly available in June 2016.

From publication in 2017 in the OJEU to current-day 2023

Since publication of the MDR and IVDR, the Medical Device Coordination Group (MDCG) has published a few implementing legislations as well as a large number of guidance documents. We will discuss this further.

In early 2022, Regulation (EU) No. 2022/112[6] was officially announced and has had the most significant impact on the implementation of the IVDR. Unlike the IVDR, this amending regulation was quickly negotiated and published. The DoA remained May 26, 2022. While the lowest-risk IVD devices (classification Class A nonsterile IVDR) would still need to comply with the IVDR on the DoA in order to continue to be placed on the EU market, additional time for IVD devices self-certified to the IVDD that are upclassifed to the IVDR (analogous to Corrigendum 2 for the MDR) are granted additional time to comply with aspects of the IVDR.

This also helps the enterprise manage the volume of devices that are IVDD self-certified, upclassified per the IVDR, and the paucity of notified bodies designated to the IVDR.

Regulation 2022/112 essentially expands the category of legacy devices from IVD devices with notified body-issued IVDD CE marking certificates (classification: self-testing, Annex II, List B, and Annex II, List A) to include IVD devices self-certified to the IVDD, which are upclassified to the IVDR and hence require a notified body-issued IVDR CE marking certificate. This expanded category of legacy devices can continue to be placed on the EU market compliant with the IVDD even now, after the IVDR DoA (to the deadline in Regulation 2022/112), provided the devices and manufacturer comply with Article 110(3).

IVDD classification	IVDR classification	Date device needs to be compliant with the IVDR in order to continue to be placed on the market after the IVDR DoA
Self-certified	• Class A, self-certified	**May 26, 2022**
Self-certified/notified body IVDD CE marking certificate	• Class D	**May 26, 2025**
Self-certified/notified body IVDD CE marking certificate	• Class C	**May 26, 2026**
Self-certified/notified body IVDD CE marking certificate	• Class B	**May 26, 2027**
Self-certified	• Class A sterile	**May 26, 2027**

Note that self-certified IVD devices (upclassified per the IVDR) must have been placed on the EU market in compliance with the IVDD before the IVDR DoA to benefit from the additional time granted for these categories of legacy devices. This means that:

- The IVD devices need to comply with the IVDD.
- Regulatory documents including a Declaration of Conformity (DOC) signed before the IVDR DoA are needed to support claims of IVDD compliance.
- The IVD devices must be notified to Competent Authorities in EU member states in which the manufacturers are based, or where their Authorized Representatives (AR) are based.

One extra year is afforded to notified body IVDD CE marking certificates; these certificates will remain valid until May 27, 2025.

Regulation 2022/112 essentially granted a reprieve for manufacturers with IVD devices that require a notified body-issued IVDR CE marking certificate. Regulation 2023/607[7] eliminated all sell-off dates.

Main themes of the IVDR

The biggest change from the IVDD to the IVDR is the introduction of a risk-based approach to classification in combination with increased notified body oversight. The Regulation identifies four risk classes: Class A (lowest risk), Class B, Class C and Class D (highest risk). Class A sterile, B, C and D IVD devices will require notified body intervention as part of their conformity assessment. This will put an extra strain on notified body resources.

Compared to the IVDD, the IVDR promotes a shift from the pre-approval stage, i.e., the path to CE marking, to a life cycle approach. This approach is similar to the life cycle view advocated by the US Food and Drug Administration (FDA) and is advanced by many international standards[8]. The life cycle approach is illustrated by incorporating some concepts from European guidance (MEDDEVs) into the regulation that previously did not apply to IVD devices: Borderline and Classification issues, Authorized Representation, Performance Evaluation, Vigilance, and Post-Market Performance Follow-Up. According to the draft document, notified bodies would be placed under a strict regimen of supervision, though it remains unclear whether intended sanctions against notified bodies, should the need for them occur, could be implemented against the will of a member state. The requirements for notified body staff to be considered qualified have steeply increased (Article 27, Annex VI).

Organization of the Regulation

The Recital section of the IVDR provides rationales for the requirements that follow. The Regulation is organized into 10 chapters comprising 113 articles. The articles reference 14 annexes.

Chapter I: Scope and Definitions

Descriptions of the scope of the Regulation

This Regulation lays down rules concerning placing IVD devices on the EU market. It also applies to performance evaluation studies on IVD devices conducted in the EU. Devices incorporated as an integral part in a medical device will be considered a medical device, and they need to comply with the MDR. However, the requirements of the IVDR shall apply to the IVD component of that device. As these requirements are not explicitly limited to the General Safety and Performance Requirements (GSPR) from Annex I, the IVD component must also be certified in accordance with the IVDR. In practice, this could lead to a Class I medical device incorporating a Class D IVD component that must obtain certification from a notified body[9]. The Regulation also specifically does not affect national laws concerning the organization of healthcare services, including limitations to the distribution of certain IVD devices to specific groups of professionals. For example, some member states prohibit layperson use of Class D IVD devices, or at least want to see the distribution of those tests limited to medical professionals.

There are 74 definitions — this section is significantly expanded (the IVDD only contained 10 definitions). The definition of an IVD device is now more specific in defining different types of diagnostic procedures. Genetic testing has been introduced by referring to "the predisposition to a medical condition or a disease" and "(predicting) treatment response reactions." In the list of product types that could be considered IVD devices, the word "software" is added to align with the interpretation in MEDDEV 2.1/6. This may have consequences for stand-alone software such as mobile medical apps, though there is MDCG guidance in the form of MDCG 2019-11 on qualification and classification of software. Added under the Regulation is the word "define" as in, "to define or monitor therapeutic measures." This is due to the introduction of companion devices (see Recital 11b). In practice, these IVD devices are already considered to be covered by the IVDD, albeit likely as a self-certified IVD device.

The definition of an accessory to an IVD device has now added that it must be used together with "one or several particular IVDs to specifically enable the IVD to be used in accordance with its intended purpose or to specifically and directly assist the medical functionality." Therefore, the manufacturer of the accessory must specify the IVD device(s) to which this product is the accessory, which may be problematic for generally used accessories. The word "assist" is new, and this may lead to new products included in the scope of this Regulation.

The definition of a "device for self-testing" has been reduced to "to be used by laypersons;" the use in the "home environment" has been dropped from the definition. It appears that a test done by a patient will be considered self-testing, regardless of where it is done, though we would expect that the IVD device would need to provide results to the layperson.

The IVDR presents some new concepts:

- Genetic testing has been introduced as “concerning the predisposition to a medical condition or a disease.” Although with some rule bending these tests are currently overseen under the IVDD, they will now be formally defined as IVD devices.
- Devices for near-patient testing — Intended for testing outside a laboratory environment, generally near or at the side of the patient by a health professional; self-testing is excluded.
- Companion diagnostic – A device that is essential for the safe and effective use of a corresponding medicinal product to identify potential users or patients likely to suffer adverse reactions
- Single-use device – Intended to be used during a single procedure; the concept of single-use devices has already been introduced in the MDD but is new for IVD devices. This particular condition only impacts user information and registration of the device, as this information must be mentioned on the label, in the indications for use (IFU) and in the registration information for the IVD device’s unique device identifier (UDI).
- Falsified device – A device with a false presentation of its identity, its source and/or its CE marking certificate; however, unintentional noncompliance or infringements of intellectual property is not in the scope of this definition. This particular product status is of importance for obligations for distributors and importers to report falsifications and enables authorities to take appropriate action.
- Kit – A set of components packaged together and intended to be used to perform a specific examination or a part thereof; this definition codifies the interpretation in MEDDEV 2.14/1 and will help determine borderline cases where devices work together in an IVD procedure.
- Common specifications (CS) – CSs are intended to provide a means to comply with the requirements and can apply to a device, process or system. The Common Technical Specifications (CTS) of the IVDD were intended to apply to Annex II, List A, or Annex II, List B, though in reality, only CTS for Annex II, List A, IVD devices were published.
- A set of definitions is introduced to facilitate understanding of the requirements for clinical evidence (Definitions 28-48).

Chapter II: Placing Products on the Market

This chapter provides substantial definitions and responsibilities of the respective economic operators[10]. It also delineates the responsibilities of the AR, the importer and the distributor.

All economic operators must control the distribution of the devices they handle — upstream as well as downstream. The MEDDEV on ARs is essentially incorporated into the Regulation, which highlights the complementary but incompatible roles of the AR, the importer and the distributor[11,12].

Chapter II also introduces the Person Responsible for Regulatory Compliance (PRRC). This highly educated and experienced person is intended to safeguard regulatory compliance within the manufacturer or AR where they work. This person is implicitly responsible for batch releases of produced devices. Guidance exists in the form of MDCG 2019-7 on PRRC[13]. It also introduces measures to ensure that an injured patient can claim damages for defective products, in parallel with the existing measures already provided in the Product Liability Directive[14].

In-house tests (also called home-brew tests) made and used within a single health institution do not have to comply with the IVDR, though compliance with the GSPR is mandated (Article 5(2)). However, in-house tests have to meet certain conditions to qualify for this exemption. First, the health institution must justify the use of such a test by demonstrating that no commercially available alternative exists. Second, a declaration must be drawn up by which the health institution declares that the test meets the GSPR. This second condition is stricter for Class D IVD devices.

There is guidance available on this health institution exemption (Article 5(5)), MDCG 2023-1[15].

For genetic testing and counseling, the Regulation requires member states to have certain measures in place to ensure provision of adequate information to patients. Manufacturers of in-house tests may face additional requirements in specific member states.

Devices offered over the internet ("information society services") that are accessible to European citizens must comply with the Regulation at the moment they are offered for use in Europe (Article 6(1)).

Article 3 of the IVDD is retained as Article 5(2) in the IVDR; IVD devices must comply with relevant Annex I GSPR, referred to in the Directive as "Essential Requirements"). Similarly, Article 5(1) of the IVDD exists as Article 8(1) of the IVDR; compliance with EN harmonized standards published in the OJEU presumes compliance with Annex I.

General Safety and Performance Requirements

Annex I, GSPR, resembles the Essential Requirements of the current IVDD. Chapter I, Section 1, remains identical except for an important insertion: "taking into account the generally acknowledged state of the art." Of course, the use of current standards, CS and published literature will facilitate addressing this requirement. Reduction of risk "as far as possible" is explained as reducing "without adversely affecting the risk–benefit ratio" according to Annex 1, Section 1aa. Also, the manufacturer is required to use a risk management system (also stated in Article 10(2) and Article 10(8)(e)).

Article I describes requirements for performance characteristics in detail. Also new are specific requirements for "electronic programmable systems," and there is a section for self-testing and near-patient testing. The other requirements can already be seen in the IVDD, but they are more detailed in Article I of the IVDR.

The number of requirements and the level of detail have increased as the GSPR has expanded.

Chapter III: UDI and Databases

The challenge posed regarding how to keep track of devices placed on Europe's borderless yet fiercely sovereign market is addressed via a combination of mandatory inputs from notified bodies, economic operators and member states in the European Database on Medical Devices (EUDAMED) and other databases. Most of these databases will be publicly accessible, though some information will only be available to certain parties. The EC is responsible for organizing these databases by providing structure and technical facilities, but the users will all be responsible for the content.

There will be an extensive amount of information collected and transmitted electronically as well as a mandate to use UDI. To facilitate the use of these databases, the EC will ensure that internationally recognized nomenclature is available free of charge for those parties that need it as part of the IVDR. The European Medical Device Nomenclature (EMDN)[16] was declared as the nomenclature for EUDAMED in January 2020 and the first version released in May 2021[17]. The EMDN Codes are available from an EC website[18].

It must be clear who the economic operators are, where they are based and their relation with each other in terms of who supplies to whom. This only involves direct business relationships, i.e., the manufacturer needs to know the importer, but not the distributor. Distributors and importers must work together with manufacturers and/or ARs regarding device traceability. This will probably limit — if not eradicate — parallel imports into the EU. All these details will be registered, yet the Regulation still allows for individual member states to set up their own registrations for high-risk devices.

Note: Mandatory UDI is introduced with the intention of facilitating device traceability. Devices will be allocated device identifiers, and batches or production series will be identified with production identifiers. The basic device identifier must also be referred to in the Declaration of Conformity. Various databases for clinical investigations, product registration and vigilance are introduced under the aegis of the EU Commission.

Note: EUDAMED will be part of a system of several databases closely interacting with each other to provide data regarding:

- Devices being placed on the market
- Economic operators, excluding the distributor
- CE certificates
- Performance studies
- The UDI database
- Summaries of safety and clinical performance of Class C and D IVD devices
- Vigilance cases and post-market surveillance (PMS), including the results of data analysis
- Notified bodies, including specific data related to the notification procedure, their functioning, subcontractors, etc.
- Device nomenclature

Part of EUDAMED will consist of a "summary of safety and performance" for Class C and D IVD devices. In such instances, the manufacturer is required to compile a document clearly readable for the intended user and, if applicable, the patient. The notified body will assess this document and upload it to EUDAMED. The database will also contain data on vigilance and PMS. The MDCG provides a template[19].

Economic operators, notified bodies, Competent Authorities and the EC will be able to access EUDAMED. The economic operators who are "actors" per the EUDAMED actor module will have to apply for a Single Registration Number (SRN) to uniquely identify the legal entity and its role. This also means that companies with several roles must have multiple SRNs. These stakeholders will also upload that information directly into EUDAMED. They will each have different levels of access to information. For the proper functioning of EUDAMED, access to the EMDN will be provided free of charge. (Further details on **EUDAMED** are covered in a separate **white paper**.)

Chapter V: Classification and Conformity Assessment: Annexes II and VII

IVD devices will be divided into four risk classes based on their risk profiles. Annex VII of the IVDR describes risk classification, referring to seven classification rules.

Assessment of the risk class of the IVD device requires all seven rules to be reviewed, and the rule leading to the highest risk class will apply. All IVD devices fall under Class B (Rule 6) unless one of the other rules applies. When the current system of "general" IVD devices; self-testing; Annex II, List B; and Annex II, List A, devices is compared to the proposed system, no direct relation clearly exists between the "old" and the new system. A "General" IVD device can end up in all four risk classes. In-house tests also have to be classified because Class D devices require extra measures.

Conformity assessment procedures (Article 48) are linked to the risk classes:

- Class A (nonsterile) IVD devices may self-certify.
- Class A sterile IVD devices require an assessment by the notified body of the sterile aspects according to Annex VIII (or Annex X).
- Class B IVD devices require quality systems (Annex VIII, except Chapter II), with their notified bodies sampling at least one technical file per generic device group as part of on-site audits unless these devices are self-testing or near-patient testing, in which case the technical documentation of all devices needs to be assessed.
- Class C devices require either a full quality management system combined with a review of the technical documentation of at least one device per generic device group (Annex VIII, except Chapter II), or an EC type-examination (Annex IX) together with production quality assurance or EC verification (Annex X).
- Class D requires the same procedure as Class C, plus batch verification and reference laboratory involvement (Annex VIII). Alternatively, Annex IX and Annex X certification is possible.
- In-house tests require laboratory compliance with EN ISO 15189, Medical Laboratories – Requirements for Quality and Competence, and a declaration that the general safety and performance requirements are met; for Class D devices, a quality management system is required.

In the interest of public health or the health of an individual patient, a Competent Authority may decide to allow an IVD to be placed on the market without a conformity assessment procedure.

Annex II lists requirements for technical documentation. A detailed list of items should be mentioned in the technical documentation. Although the basic concept of the Summary of Technical Documentation (STED)[20] format can still be recognized, Annex II goes into further detail and adds extra requirements.

Classification should be done by verifying all rules. (Again, the rule which leads to the highest risk class applies.) For devices with multiple intended purposes, all purposes must be classified, and the highest risk class is applicable. The text in this table is shortened and summarized. This table should only be used as a quick reference; the original rules must be referenced for classification.

Rule	Text of Rule	Class
1	• Transmissible agents in substances, cells, tissues, organs, etc. intended for donation • Transmissible life-threatening agent with high risk of propagation • Monitoring infectious load of life-threatening disease	D
2a	Blood grouping, or tissue typing as part transfusion, transplantation or administration	C
2b	Except for certain high risk blood groups and tissue types	D
3	• Infectious diseases, including sexually transmitted agents • Pre-natal screening, congenital disorders in embryo, fetus, or new-born • Companion diagnostics • Disease staging • Screening, diagnostics, and staging of cancer • Genetic testing	C
4a	Self-testing, unless:	C
4b	• Self-testing for detection of pregnancy, fertility testing, cholesterol level determination • Self-testing for glucose, erythrocytes, and bacteria in urine	B
5	• Product for general laboratory use, accessories with no critical characteristics, buffer solutions etc. • Instruments intended for IVD procedures • Specimen receptacles	A
6	Devices not covered by the above-mentioned classification rules	B
7	Controls without a quantitative or qualitative assigned value	B

Source: Emergo by UL

In addition, there is MDCG guidance , MDCG 2020-16, on classification per the IVDR[21].

Conformity assessment procedures

Class	Procedure
A	**Self-declare conformity:** • Technical documentation, including risk/benefit analysis, risk management, product verification and validation, etc.
A sterile	**Notified Body (NB) intervention by:** • Quality management system of sterile aspects (Annex VIII, except Chapter II) or • Production quality assurance of sterile aspects (Annex X)
B	**Notified body intervention by:** • Quality management system (Annex VIII, except Chapter II) • Review of technical documentation of at least one device per generic device group • Additional: All self-testing and near-patient testing needs technical documentation assessment
C	**Notified body intervention by:** • Quality management system audit (Annex VIII, except Chapter II), and • Review of technical documentation of at least one device per generic device group, or • EC type-examination (Annex IX), and • Production quality assurance (Annex X) • Additional: All self-testing and near-patient testing needs technical documentation assessment
D	**Notified body intervention by:** • Full quality management system audit (Annex VIII), and • Assessment of technical documentation, and • Batch verification, or • EC type-examination (Annex IX), and • Production quality assurance (Annex X), and • Batch verification • Additional: All self-testing and near-patient testing needs technical documentation assessment, and • The notified body will request that a reference laboratory verify the performance
In-house, A, B, and C	**Self-declare:** • Appropriate quality management system • EN ISO 15189-compliant • Documentation according to Article 4.5
In-house D	**Self-declare:** • Appropriate quality management system • EN ISO 15189-compliant • Documentation according to Article 4.5 • Additional documentation regarding quality system, performance data, etc.

Source: Emergo by UL

Chapter VI: Clinical Evidence, Performance Evaluation and Performance Studies Annexes XII-XIII

Clinical evidence and post-market performance follow-ups are introduced as new concepts for IVD devices.

Clinical evidence consists of analytical performance, scientific validity and clinical performance, and their mutual relationship. Clinical evidence is based on clinical data and performance evaluation of an IVD device to ensure that it meets the purported clinical benefits and safety. The clinical benefit is the positive impact of a device on its function or on patient management or public health.

The clinical evidence shall support the intended purpose and is based on a continuous process of performance evaluation. This needs to be planned in a performance evaluation plan (Article 56(2)). This requirement will ensure identification of outdated and underperforming devices for noncompliance, which may stimulate innovation. The performance evaluation plan will describe how to demonstrate:

- Scientific validity (“Scientific Validity Report”);
- Analytic performance (“Analytical Performance Report”);
- Clinical performance (“Clinical Performance Report”);
- Performance evaluation (“Performance Evaluation Report”).

Performance studies can have different risk profiles depending on their study designs. For Class C and D IVD devices, performance evaluation reports must be updated annually as part of the PMS plans. Such reports for Class A and B IVD devices are required, but without the requirements for annual updates.[22] MDCG 2022-2 addresses clinical evidence for IVD devices.

Chapters VII and IX: Post-market Surveillance, Vigilance and Market Surveillance, and Confidentiality

Annex III — Technical Documentation on Post-Market Surveillance

An IVD manufacturer must draw up a PMS plan that monitors specific elements of safety, clinical performance and risk/benefit ratios. Manufacturers are also required to develop PMS reports in accordance with Annex III of the IVDR.

Manufacturers of Class C and Class D devices additionally must create periodic safety update reports and update them at least annually (Article 81(1)). Finally, manufacturers of Class D IVD devices must submit these annual updates to EUDAMED and have them reviewed by their notified bodies.

Incidents and field safety corrective actions need to be reported through EUDAMED. Manufacturers must investigate incidents and report their findings. Serious incidents (Article 2(68)) need to be reported directly to the member state(s) involved.

EUDAMED will have specific sections for uploading incidents and PMS data to facilitate all these reporting requirements.

Confidentiality

Article 102 ensures confidentiality of certain information, but it is likely that patients seeking compensation will get access to detailed information about devices[23] in question.

Confidentiality of information provided to any database as part of this Regulation is respected in terms of personal data or commercially confidential information unless disclosure is in the public interest. This disclaimer appears to conflict slightly with the intention to safeguard confidentiality to promote effective implementation of this Regulation, as the results of inspections, investigations and/or audits may be considered to be of public interest.

Chapter VIII: Cooperation Between Member States, Medical Device Coordination Group (MDCG), EU Reference Laboratories, Device Registers — Standards and Transition Timelines

MDCG

The MDCG replaces the proliferating member state-only bodies (CMC, COEN, MSOG), which were structures established to try to coordinate actions of Competent Authorities[24]. The MDCG may be assisted by expert panels and EU reference laboratories. These experts have to be independent from notified bodies or manufacturers when providing their scientific opinions. Expert panels must take into account relevant information from stakeholders.

Standards

The role of standards is maintained. Articles 8(1) and (9) state that if there are standards and CS, and the manufacturer is compliant, the manufacturer is presumed to be compliant with the relevant aspects of the Regulation. The MDCG will play an important role in developing standards, CS and scientific guidelines. There are now standards harmonized in OJEU to the IVDR[25].

Transitional provisions

Manufacturers with legacy devices compliant with the IVDD still have requirements per the IVDR. The provision of note is Article 110(3), which describes the requirements for legacy devices as “no significant changes in the design and intended purpose” and compliant with the requirements of “post-market surveillance, market surveillance, vigilance and registration of economic operators.” The MDCG guidance titled Guidance on significant changes regarding the transitional provision under Article 110(3) of the IVDR[26]” may provide context on how to evaluate significant changes.

In addition, there is also MDCG guidance for IVD devices covering the IVDR and legacy devices[27], which is helpful in interpreting what applies to legacy IVD devices at the IVDR DoA.

Conclusion: New era of IVD device regulation in Europe

Member states have the authority to levy fees to cover costs associated with this Regulation. The fees must be transparent and based on cost recovery. Also, the EC will be funding costs associated with the joint assessment activities, while at the same time developing a structure to recover these costs.

Clearly, the IVDR is vastly more "legal" in nature than its predecessor, which took more of a "good will" approach in many ways. Such a new approach will have consequences for staffing at Competent Authorities, notified bodies, and economic operators, manufacturers included.

The increased requirements for clinical performance data (and the expectation that the data be current) may discourage development of innovative tests for rare conditions. On the other hand, institutions will have clear direction on how they should manage and safeguard their in-house tests. This may lead to a completely new infrastructure for innovation in the field of IVD devices in the European Union.

With Regulation 2022/112, manufacturers have been granted additional time to work with notified bodies designated to the IVDR. If an IVD device is Class A nonsterile, it must comply with the IVDR in order to be placed on the EU market.

IVD devices with notified body-issued IVDD CE marking certificates or IVD devices that are self-certified to the IVDD and upclassified by the IVDR placed on the EU market compliant with the IVDD became legacy devices on the IVDR DoA. These IVD devices can continue to be placed on the EU market compliant with the IVDD provided they comply with Article 110(3). This will hopefully grant sufficient time for manufacturers to engage and work with the notified bodies currently designated to the IVDR.

End Notes

1. https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:02017R0746-20170505
2. http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52012PC0542&from=EN
3. http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52012PC0541&from=EN
4. http://data.consilium.europa.eu/doc/document/ST-12040-2015-REV-1/en/pdf
5. http://data.consilium.europa.eu/doc/document/ST-12042-2015-INIT/en/pdf
6. https://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX:32022R0112
7. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:32023R0607
8. This is also a concept noted globally among many regulatory authorities
9. Art. 1.3 https://health.ec.europa.eu/system/files/2020-09/md_mdcg_2019_11_guidance_qualification_classification_software_en_0.pdf
10. Previously only the manufacturer and the authorized representative were defined.
11. The Council also added to the definition of Economic Operator the assembler of procedure packs or systems and the person sterilizing procedure packs or systems.
12. https://ec.europa.eu/health/system/files/2021-12/mdcg_2021-27_en.pdf
13. https://ec.europa.eu/health/system/files/2020-09/md_mdcg_2019_7_guidance_art15_mdr_ivdr_en_0.pdf
14. Product Liability Directive
15. https://health.ec.europa.eu/system/files/2023-01/mdcg_2023-1_en.pdf
16. https://ec.europa.eu/health/system/files/2020-09/md_emdn_eudamed_nomenclature_en_0.pdf
17. https://ec.europa.eu/health/system/files/2021-06/md_2021-12_en_0.pdf
18. https://webgate.ec.europa.eu/dyna2/emdn/
19. https://health.ec.europa.eu/system/files/2022-05/mdcg_2022-9_en.pdf
20. Former Global Harmonization Task Force, Summary Technical Documentation guidance.
21. https://health.ec.europa.eu/system/files/2023-02/md_mdcg_2020_guidance_classification_ivd-md_en.pdf
22. https://ec.europa.eu/health/system/files/2022-01/mdcg_2022-2_en.pdf
23. See article 8.9
24. This was verbally communicated at a stakeholders' meeting in April of this year, hosted at the Dutch Permanent Representation in Brussels
25. https://single-market-economy.ec.europa.eu/single-market/european-standards/harmonised-standards/iv-diagnostic-medical-devices_en
26. https://health.ec.europa.eu/system/files/2022-05/mdcg_2022-6.pdf
27. https://health.ec.europa.eu/system/files/2022-05/mdcg_2022-8_en.pdf

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About the author

Evangeline Loh, Ph.D., RAC (US, EU), holds one of the most senior positions in the Emergo by UL consulting group and has more than 20 years of global regulatory experience. Her background includes compiling European Technical Files and Design Dossiers; European Technical File reviews and gap assessments; borderline classifications; and 100+ peer reviews of Technical Files, including Clinical Evaluation Report reviews and responding to notified body findings. She specializes in borderline classification assessments, global vigilance and global regulatory strategy. As the global regulatory manager, Evangeline manages Emergo by UL's in-country representation services, including EU Authorized Representative, US Agent and Australian Sponsor, and oversees global vigilance activities for these customers. She also supervises a team of international consultants and reviews dozens of device submissions and clinical evaluation reports each year. Prior to Emergo by UL, she held positions at Cook Incorporated and The Association of American Medical Colleges. Evangeline holds a doctorate in pharmacology from the University of Texas Health Science Center at San Antonio and studied microbiology at Cornell University. She joined Emergo by UL in 2007.

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