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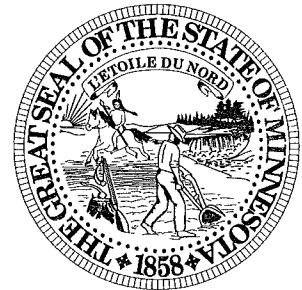
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Advisory Committee on  
Organ and Tissue Transplants

**Annual Report  
to the  
Legislature  
and the  
Department of Human Services**



State of Minnesota  
Committee on Transplants  
444 Lafayette Road  
St. Paul, Minnesota 55155-3853  
(612) 296-6429

January, 1995

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1995

Advisory Committee on  
Organ and Tissue Transplants

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**Annual Report**  
**to the**  
**Legislature**  
**and**  
**Department of Human Services**

*State of Minnesota  
Department of Human Services  
Advisory Committee on Transplants  
444 Lafayette Road  
St. Paul, Minnesota 55155-3853  
612-296-2741*

*March 7, 1995*

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## ***SUMMARY***

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This annual report of the Advisory Committee on Organ and Tissue Transplants is being presented to the Legislature and Department of Human Services pursuant to Minnesota Statutes. The purpose of the Advisory Committee on Organ Transplants is to offer advice and recommendations to the Commissioner of the Department of Human Services and the Legislature on the efficacy of transplant procedures, current practice standards, and other issues relating to the transplantation of organs.

This report includes findings and recommendations on small bowel plus liver and isolated small bowel transplantation, autologous bone marrow transplantation for the treatment of multiple myeloma, and autologous bone marrow transplants for the treatment of breast cancer. This report also includes an update to the medical necessity criteria for coverage established by the Advisory Committee and published in the 1992 annual report.

The Advisory Committee recommended no additional coverage at this time. However, recommendations for some transplant procedures were deferred until 1995. If the Advisory Committee and the Commissioner recommend additional procedures for coverage, the additions to coverage and effective dates will be published in the State Register.

## ***Committee Members***

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***\*Kathy DeShazor***

St. Paul Urban League

***Barbara Elick, BSN***

Chief Transplant Coordinator  
University of Minnesota  
Hospital and Clinic

***Mary Fahey***

Senior Research Analysis Specialist  
Minnesota Department of Health

***Marty Halvorson, LMFT***

Director of Pastoral Care &  
Clinical Pastoral Education  
Methodist Hospital, Minneapolis

***Ruud Krom, M.D., Ph.D.***

Consultant in Surgery  
Director, Liver Transplant  
Program  
Mayo Clinic

***Barbara LeTourneau, M.D.***

Vice President of Medical Affairs  
Unity Hospital  
Fridley, MN

***\*Kirsten Libby***

Executive Budget Officer  
Budget Division  
Minnesota Department of Finance

***Del K. Ohrt, M.D.***

Vice President and Medical Director  
Blue Cross Blue Shield of Minnesota

***Ralph Peterson***

Transplant Patient Support  
Group

***Reinhard Priester, J.D.***

Health Policy Consultant

***Norma K.C. Ramsey, M.D.***

Professor, Dept. of Pediatrics  
Director, Pediatric Bone Marrow  
Transplant Program  
University of Minnesota  
Hospital and Clinic

***David Sutherland, M.D., Ph.D. \****

Professor, General & Transplant  
Program  
Director, Pancreas Transplant  
Program  
University of Minnesota  
Hospital and Clinic

\*Agreed to participate, but was not available for meetings. Review of Report only.

## ***Minnesota Medical Assistance Transplant Coverage***

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The Minnesota Medical Assistance program provides coverage for cornea, heart, liver, bone marrow, and kidney transplant procedures which meet diagnosis guidelines consistent with Medicare policy. In addition the program covers lung transplants using cadaveric donors, heart-lung transplants for persons with primary pulmonary hypertension, pancreas transplants for uremic diabetic recipients of kidney transplants, and allogeneic bone marrow transplants for persons with stage III and stage IV Hodgkin's disease.

In March 1994, the State of Minnesota Department of Human Services added the following transplant procedures for reimbursement by the Minnesota Medical Assistance program; autologous bone marrow transplants for the treatment of myelogenous leukemia, and pancreas transplants alone (without kidney) for the treatment of hypoglycemic unawareness. These transplant procedures were recommendations included in the Advisory Committee on Organ and Tissue Transplants 1994 annual report.

Coverage for organ transplant procedures includes: preoperative evaluation; recipient and donor surgery; follow-up care for the recipient and live donor; drugs; and retrieval of organs and tissues. See Appendix A (Medical Assistance coverage criteria) from the Minnesota Health Care Programs Provider Manual May 1994 edition.

## **Criteria for Coverage**

The Advisory Committee on Transplants developed and used the following criteria to evaluate a transplant procedure for medical necessity and make recommendations for coverage by the Medical Assistance program.

**1. Proven effectiveness of procedure.** Transplants are performed as treatment and an alternative to other therapies for which the outcome often is unsatisfactory, and rarely are they performed purely for research or experimental purposes. The Committee does not support Medical Assistance funding of transplants performed on a purely experimental or research basis. In addition, the Committee does not recommend transplant procedures for coverage unless evidence is available that clearly indicates the procedure has been demonstrated to be medically effective. Published outcome data for each procedure must be available (see number 2. below for survival criteria.) A number of procedures sufficient to allow for an evaluation of effectiveness must have been performed. Transplant centers performing the procedure, on a trial or therapeutic basis, must meet standards of excellence established by appropriate medical authorities for performing the designated transplant procedure.

**2. Life expectancy after surgery:** Graft and host survival statistics on specific transplant procedures must be available and considered. Survival rates for the first year following surgery are most significant, although long term graft and patient survival rates should be assessed in order to continually evaluate the procedure. Consideration also must be given to the total number of transplants performed in each specific area and experience over time. Procedures must have at least a 50 percent graft survival rate for the first year following surgery.

**3. Status of patient.** Individual patient factors such as health status and alcohol and other drug consumption affect transplant outcomes. Transplants would be inappropriate in someone who will die shortly whether the transplant is or is not done, but usually the probability of survival of a particular patient can only be estimated. Medical Assistance funds should not be used to pay for transplants performed as a "last hope" if they do not otherwise meet criteria for coverage. Patient evaluation and monitoring for the appropriateness of transplant surgery is best conducted by transplant facilities with

standards of excellence. This is the primary reason for stressing that facilities are chosen carefully.

**4. Quality of life.** There should be a higher probability that a satisfactory quality of life can be achieved with a transplant than without. In some cases, it could be less expensive to provide alternative care to the transplant, but the quality of life and productivity of the individual may be so much lower that cost should not be the only factor considered.

**5. Other Considerations.** The Committee also considered the following issues in its discussion of transplant procedures that should be covered by Medical Assistance, although the issues did not directly affect the decision to recommend certain transplants for coverage. These issues are important to include in any discussion on transplant coverage.

- a. **Cost.** The Committee did not base recommendations on cost of transplants, because this was not part of its charge from the Legislature. Cost has to be considered in the context of society as a whole, although cost estimates should be calculated as part of any recommendation to cover additional transplants.
- b. **Cost of care without a transplant.** Costs arise for persons who need transplants whether or not the transplant is provided. Cost also must be looked at within the context of transplants that already are provided. Transplants may be more or less expensive than alternative treatments depending on the individual patient and transplant procedure. For some transplants, there are no viable alternative treatment and so the patient dies.
- c. **Comparability to other plans.** It is important to examine transplant coverage by other programs and third party payers to understand criteria used and determine if those criteria are appropriate for decisions on Minnesota Medical Assistance coverage. The Committee will continue to study public and private funding of transplants to gain an understanding of the rationales



used for coverage. However, care must be taken when comparing other third party payer coverage with Medical Assistance. For instance, Blue Cross and Blue Shield of Minnesota began to provide coverage for some transplants while the transplants procedures were still considered to be investigative. The criteria have to be looked at very carefully, particularly the administrative decisions which ultimately lead to the decision to provide coverage for a class of transplants.

## ***RECOMMENDATIONS ON TRANSPLANT PROCEDURES AND FACILITIES***

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Liver/small bowel transplants:

In 1993, the State of Minnesota was ordered by District Court to pay all expenses for a Medical Assistance recipient to receive a liver/bowel transplant at the University of Pittsburgh hospital. As a result of this court case, and growing application of this procedure, the Advisory Committee on Organ and Tissue Transplants recommended in their 1994 report that the Department establish a subcommittee to review the issue of liver-bowel transplants and present findings to the Committee for consideration. A liver/bowel transplant work group was formed in 1994 made up of experts in the transplant field and related health areas. Members of the liver/bowel transplant advisory work group were: Rainer Gruessner, M.D. intestinal transplantation, University of Minnesota; Coleman Smith, M.D., gastroenterologist, Digestive Healthcare; and Darlene Kelly, M.D. gastroenterologist/nutritionist, Mayo Clinic. The liver/bowel work group held two meetings during September and October 1994. Dr. Rainer Gruessner presented the findings of the liver/bowel work group to the Advisory Committee on Organ and Tissue Transplants on October 27, 1994.

Currently 5 facilities are performing liver/small bowel transplants. The University of Pittsburgh during their 4 years of experience, performed 62 intestinal transplants; fifteen adults and 7 children received isolated small bowels, twenty-two children and seven adults received liver/small bowel, and six adults and five children received multivisceral transplant. The University of Nebraska - Omaha has performed 15 transplants on 14 patients since 1991; 11 children received liver/small bowel, and 3 children and 1 adult received isolated small bowel transplants.<sup>1</sup> The University of Wisconsin -Madison performed 3 liver/small bowel transplants and Presbyterian St. Luke - Chicago performed 1 small/bowel transplant.

The University of Minnesota is ready to perform these transplants, and anticipates they will perform their first transplant in the next 2 to 3 months. Clinical data/studies and findings are limited to 18 months or less.

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<sup>1</sup>United Network for Organ Sharing Update, "Intestinal Transplantation Given Mixed Reviews" presented at the XVth World Congress of the Transplantation Society in Kyoto, Japan. (October, 1994, volume 10, issue 10, page 14.)

The two main problems with these transplants are post-graft rejection and lymphoma. The University of Pittsburgh had a median follow-up of 15 months after transplant, overall graft survival for intestinal transplantation was 48 percent (53 percent for pediatrics and 43 percent for adults.) Fourteen recipients suffered graft losses of isolated small bowel. Eight were caused by rejection, five from infection and one from "other".<sup>2</sup> Of the 14 liver/small bowel losses, three each were contributed to rejection, infection or post transplant lymphoproliferative disorder.

At the University of Nebraska, the one year patient survival rate was 66 percent for liver/bowel (3 of the 11 patients are deceased) and 100 percent for the isolated small bowel transplants. The graft survival rate for isolated small bowel was also 100 percent. No patient had acquired graft versus host disease nor lymphoproliferative disorder.<sup>3</sup>

Clinical studies indicate that intensity of care required for these patients in the first year is a challenge, and usually exceeds what is required for patients having transplants of the liver, kidney, or heart. The long term effect depends on the donor and recipient selection criteria and the availability of FK506 drugs to reduce rejection of organs.

United Network for Organ Sharing (UNOS) is currently in the process of developing a data base for intestinal transplantation. UNOS has compiled a list of transplant facilities with standards of excellence that will be performing these procedures in the near future.

The Advisory Committee considered the findings of the liver/bowel work group and recommended that the Minnesota Medical Assistance Program not cover liver/bowel or solitary bowel transplantation at this time. The total number of transplants performed in this area are not sufficient to make an assessment of whether this procedure meets the proven effectiveness criterion and other medical necessity criteria established by the Committee. Published outcome

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<sup>2</sup> United Network for Organ Sharing, "Intestinal Transplantation Given Mixed Review" presented at the XVth World Congress of the Transplantation Society in Kyoto, Japan. (October, 1994, volume 10, issue 10, page 14)

<sup>3</sup>United Network for Organ Sharing Update, "Intestinal Transplantation Given Mixed Reviews" presented at the XVth World Congress of the Transplantation Society in Kyoto, Japan. (October, 1994, volume 10, issue 10, page 14)

data do indicate that liver/small bowel and isolated small bowel transplantation survival rates have increased due to newer immunosuppressive agents. However, no publication recommends widespread application of these procedures.

While this procedure holds promise for the future, it is in too early a stage of development to make a recommendation for coverage. Nevertheless, federal regulations require state Medicaid programs to furnish all medically necessary services to treat conditions detected by periodic screening provided to children under the age of 21 as part of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The Committee recommended that children being evaluated for this procedure under the EPSDT program be evaluated at the University of Minnesota hospital which will be performing liver/bowel transplants in the near future.

**Other discussion:**

The Advisory Committee deferred a recommendation on **autologous bone marrow transplants for the treatment of multiple myeloma** due to lack of time to thoroughly discuss the issue. The Committee will resume discussion at their next meeting to be held in 1995.

The Committee also agreed to delay a recommendation on **autologous bone marrow transplants for the treatment of breast cancer** until the Health Technology Advisory Committee completes its evaluation of this procedure. This committee reports to the Minnesota Health Care Commission and intends to evaluate this procedure in 1995.

**6701.01 Covered Services**

As of July 1, 1989, the Minnesota Legislature limited MA coverage of organ and tissue transplants to those procedures covered by the Medicare program. Those include cornea, heart, liver, bone marrow, and kidney transplant procedures which meet diagnosis guidelines consistent with Medicare policy. Effective May 28, 1993, the Legislature approved the following additional procedures: lung transplants using cadaveric donors, heart-lung transplants for persons with primary pulmonary hypertension, pancreas transplants for uremic diabetic recipients of kidney transplants, and allogeneic bone marrow transplants for persons with stage III or IV Hodgkin's disease. Transplant coverage includes: preoperative evaluation; recipient and donor surgery; follow-up care for the recipient and live donor; and retrieval of organs and tissues.

**6701.02 Providers**

Cornea and kidney transplants must be performed in a facility that is participating as a provider of services in the Medicare program, and which meets DHS standards of safety and efficacy.

Heart and liver transplants must be performed in a facility approved by Medicare to perform that procedure. A pediatric hospital that has met HCFA approval criteria for performing a heart or liver transplant on a child may also perform these transplants.

Lung, heart-lung and pancreas transplants must be performed in a Minnesota facility which meets United Network of Organ Sharing criteria to perform that procedure.

Bone marrow transplants must be performed in a Minnesota facility which is participating as a provider of services in the Medicare program, and which meets American Society of Hematology and Clinical Oncology criteria for bone marrow transplants. In order to receive prior authorization approval for a bone marrow transplant, the facility must have on file with the Department a report of the facility's standards and experience indicating that these criteria are being met.

**6701.03 Coverage of Eligibility Groups**

Transplant coverage applies to any person eligible for MA as either categorically or medically needy, or any person eligible for GAMC or MinnesotaCare. For MA, undocumented and nonimmigrant recipients are not eligible for transplant coverage or care and services related to the organ transplantation procedure. GAMC recipients and MinnesotaCare enrollees should be referred to their county human services agency for application to MA; MinnesotaCare enrollees must apply for MA upon hospital admission. If an enrollee is not eligible for MA, any maximum benefit limits applicable to MinnesotaCare enrollees will apply; please refer to the MinnesotaCare chapter of this manual for further information.

**6701.04 Prior Authorization**

Prior authorization is required for the following transplant procedures: bone marrow, heart-lung, liver, lung and pancreas. Transplants performed in out-of-state facilities also require prior authorization. The transplant facility must submit the prior authorization form with a medical report attached. The medical report must include the following information:

- Diagnosis including ICD-9 diagnosis code
- Proposed treatment
- Sufficient information to show medical necessity of proposed treatment
- Any additional information that is pertinent. For out-of-state hospitals this evidence of meeting the requirements of Medicare, United Network of Organ Sharing, and American Society of Hematology and Clinical Oncology.

If a transplant is to be performed out of the state, the provider must get prior authorization according to the instructions for out-of-state services described in the Prior Authorization chapter.

#### **6701.05 Heart Transplant Coverage**

Cardiac transplants are covered when performed in a facility on the Medicare list of approved heart transplant centers. Artificial heart transplants are not covered.

#### **6701.06 Liver Transplant Coverage**

Liver transplants in children (ages 17 and under) with extrahepatic biliary atresia or any other form of end-stage liver disease are covered. Liver transplants for children with a malignancy extending beyond the margins of the liver or those with persistent viremia are not covered.

Liver transplants are covered for adults with the following conditions:

- A. Primary biliary cirrhosis.
- B. Primary sclerosing cholangitis.
- C. Postnecrotic cirrhosis, hepatitis B surface antigen negative.
- D. Alcoholic cirrhosis.
- E. Alpha-1 antitrypsin deficiency disease.
- F. Wilson's disease.
- G. Primary hemochromatosis.

Adult liver transplants are covered retroactively to March 8, 1990, with prior authorization and provided that the recipient was eligible for MA and the facility that performed the transplant is approved by Medicare to perform liver transplants. See 6701.04 for prior authorization information requirements.

Liver transplants require prior authorization including those covered by other third-party payers. Liver transplants for recipients with Medicare coverage do not require prior authorization.

#### **6701.07 Bone Marrow Transplant Coverage**

Transplant centers must be participating as a provider of Medicare services and must meet American Society of Hematology and Clinical Oncology criteria for bone marrow transplants and be located in Minnesota to receive reimbursement for bone marrow transplants. Transplant facilities requesting prior authorization must have on file with the Department a report of the facility's standards and experience indicating that these criteria are being met. All bone marrow transplants require prior authorization.

Allogeneic bone marrow transplants are covered for the following:

- A. Treatment of leukemia or aplastic anemia when it is reasonable and necessary for the individual patient to receive this therapy.
- B. Treatment of severe combined immunodeficiency disease (SCID).
- C. Treatment of Wiskott-Aldrich syndrome.
- D. Treatment of stage III or IV Hodgkin's disease.

Autologous bone marrow transplants are covered for the following:

- A. Acute leukemia in remission with a high probability of relapse and no HLA-matched donor.
- B. Resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response.
- C. Recurrent or refractory neuroblastoma.
- D. Advanced Hodgkin's disease in patients who have failed conventional therapy and have no HLA-matched donor.
- ▷ E. Chronic Myelogenous Leukemia.

**6701.08 Kidney Transplant Coverage**

Kidney transplants must be performed in a hospital that is participating as a provider of services in the Medicare program. Kidney transplants require prior authorization if they will be performed in an out-of-state facility.

**6701.09 Lung Transplant Coverage**

Lung transplants using cadaveric donors are covered when performed in a Minnesota facility which meets United Network of Organ Sharing criteria to perform lung transplants. All lung transplants require prior authorization.

**6701.10 Heart-Lung Transplant Coverage**

Heart-lung transplants for persons with primary pulmonary hypertension are covered when performed in a Minnesota facility which meets United Network of Organ Sharing criteria to perform heart-lung transplants. All heart-lung transplants require prior authorization.

**6701.11 Pancreas Transplants**

Pancreas transplants for uremic diabetic recipients of kidney transplants and persons with hypoglycemic unawareness are covered when performed in a Minnesota facility which meets United Network of Organ Sharing criteria to perform pancreas transplants. All pancreas transplants require prior authorization.

**6701.12 Donor Coverage**

The organ donor is covered for medically necessary inpatient hospital days and other services directly related to the transplant. Donor charges should be billed to the transplant recipient's Minnesota Health Care Programs (MHCP) number. Donor travel expenses will be reimbursed by the recipient county of residence according to MA travel reimbursement policy. Patients should contact their county case worker to arrange travel.

**6701.13 Billing**

The costs of organ and tissue procurement should be included on the inpatient hospital billing form. Hospital days of stay for the donor are included in the DRG payment for the donee (MA recipient). All charges for the donor should be billed using the donee MHCP identification number.

**6701.14 Other Payers**

Liable third-party payer coverage and research and grant monies must be used to the fullest extent before MA payment will be made for a transplant. If payment is denied by a third-party payer, the denial and documentation of efforts to secure payment must be submitted with the claim. If appeals are available through the insurer, the Department will ask the client to pursue these appeals.

Providers must obtain prior authorization for transplants that require it even though private insurance will pay part of the bill.

**Legal References** Minnesota Statutes, section 256B.0625, subd. 27

CHAPTER 256B

MEDICAL ASSISTANCE FOR NEEDY PERSONS

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256B.0629 Advisory committee on organ and tissue transplants.

Subdivision 1. Creation and membership. By July 1, 1990, the commissioner shall appoint and convene a 12-member advisory committee to provide advice and recommendations to the commissioner concerning the eligibility of organ and tissue transplant procedures for reimbursement by medical assistance and general assistance medical care. The committee must include representatives of the transplant provider community, hospitals, patient recipient groups or organizations, the department of human services, the department of finance, and the department of health, at least one representative of a health plan regulated under chapter 62A, 62C, or 62D, and persons with expertise in ethics, law, and economics. The terms and removal of members shall be governed by section 15.059. Members shall not receive per diems but shall be compensated for expenses. The advisory committee does not expire as provided in section 15.059, subdivision 6.

Subd. 2. Function and objectives. The advisory committee shall meet at least twice a year. The committee's activities include, but are not limited to:

(1) collection of information on the efficacy and experience of various forms of transplantation not approved by Medicare;

(2) collection of information from Minnesota transplant providers on available services, success rates, and the current status of transplant activity in the state;

(3) development of guidelines for determining when and under what conditions organ and tissue transplants not approved by Medicare should be eligible for reimbursement by medical assistance and general assistance medical care;

(4) providing recommendations, at least annually, to the commissioner on:

(i) organ and tissue transplant procedures, beyond those approved by Medicare, that should also be eligible for reimbursement under medical assistance and general assistance medical care; and

(ii) which transplant centers should be eligible for reimbursement from medical assistance and general assistance medical care.

Subd. 3. Annual report. The advisory committee shall present an annual report to the commissioner and the chairs of the human services finance division of the house health and human services committee and the health care and family services finance division of the senate family services and health care committees by January 1 of each year on the findings and recommendations of the committee.



Subd. 4. Responsibilities of the commissioner. The commissioner shall periodically:

(1) Determine criteria governing the eligibility of organ and tissue transplant procedures for reimbursement from medical assistance and general assistance medical care. Procedures approved by Medicare are automatically eligible for medical assistance and general assistance medical care reimbursement. Additional procedures are eligible for reimbursement only if they are recommended by the task force, approved by the commissioner, and published in the State Register.

(2) Determine criteria for certifying transplant centers within and outside of Minnesota where Minnesotans receiving medical assistance and general assistance medical care may obtain transplants. Only centers recommended by the task force and approved by the commissioner may be certified by the commissioner.

1990 c 568 art 3 s 52; 1993 c 4 s 29; 1993 c 339 s 24;  
1Sp1993 c 1 art 5 s 55; 1Sp1993 c 6 s 11; 1994 c 529 s 9,10,19

5. In addition to or in place of participating at the hearing, any person may also submit written recommendations for the disposition of the application. These recommendations must be mailed to the administrative law judge on or before April 6, 1994.

6. Any subpoena needed to compel the attendance of witnesses or the production of documents may be obtained pursuant to *Minnesota Rules* 1400.7000.

7. At the hearing the applicant will present its evidence showing that a license should be granted and that all persons will be given an opportunity to cross-examine witnesses, to be heard orally, to present witnesses, and to submit written data or statements. All persons are encouraged to participate in the hearing and are requested to bring to the hearing all documents, records, and witnesses needed to support their position. It is not necessary to intervene as a party in order to participate in the hearing.

8. Please be advised that if nonpublic data is admitted into evidence, it may become public data unless an objection is made and relief is requested under *Minnesota Statutes* § 14.60, subd. 2.

9. You are hereby informed that you may choose to be represented by an attorney in these proceedings, may represent yourself, or be represented by a person of your choice if not otherwise prohibited as the unauthorized practice of law.

10. A Notice of Appearance must be filed with the administrative law judge identified above within 20 days following receipt of the Notice by any person intending to appear at the hearing as a party.

11. In accordance with the provisions of *Minnesota Statutes* § 14.61, the final decision of the Commissioner in this proceeding will not be made until the Report of the Administrative Law Judge has been made available to the parties in this proceeding for at least 10 days. Any party adversely affected by the Report of the Administrative Law Judge has the right to file exceptions and present arguments to the Commissioner. Any exceptions or arguments must be submitted in writing and filed with the Commissioner of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55440, within 10 days of the receipt of the Administrative Law Judge's Report.

Dated: 23 February 1994

Mary Jo O'Brien  
Commissioner of Health

## Minnesota Historical Society

### State Review Board Regular Meeting

A meeting of the State Review Board of the Minnesota Historical Society to consider nominations to the National Register of Historic Places will be held on Thursday, March 24, 1994, in the Minnesota Historical Society History Center, Cargill Commons, MacMillan Education Wing, St. Paul, Minnesota. The State Review Board will meet for a light dinner at 5:30 p.m. and an informational presentation on program activities will be made by the Preservation Office staff. The meeting will be called to order and consideration of the meeting's agenda will begin at 7 p.m. For further information contact the State Historic Preservation Office, Minnesota Historical Society, 345 Kellogg Boulevard West, St. Paul, MN 55102, (612) 296-5434.

## Department of Human Services

### Additions to Organ Transplant Coverage and Procedure Codes Requiring Second Surgical Opinion; Corrections to Prior Authorization List

#### Coverage of organ transplants

Effective for services provided on or after March 17, 1994, the Department of Human Services (DHS) will cover the following organ transplant services for recipients of the Medical Assistance program.

1. **Autologous bone marrow transplants for chronic myelogenous leukemia.** The transplant facility must: 1) be approved by DHS as meeting American Society of Hematology and Clinical Oncology criteria to perform bone marrow transplants; 2) be located within the state of Minnesota; 3) submit a written prior authorization request to DHS for each transplant; and 4) meet all other program requirements as described in the Medical Assistance provider manual.

2. **Pancreas transplants for hypoglycemic unawareness.** The transplant facility must: 1) meet United Network for Organ Sharing criteria to perform pancreas transplants; 2) be located within the state of Minnesota; 3) submit a written prior authorization request to DHS for each transplant; and 4) meet all other program requirements as specified in the Medical Assistance provider manual.

#### Procedure codes requiring second surgical opinion

Providers must call the DHS medical review agent for a second surgical opinion for all inpatient cholecystectomy procedures for

## Official Notices

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recipients of Medical Assistance, General Assistance Medical Care, and MinnesotaCare. This includes the following new cholecystectomy procedure codes published in the 1994 *Physician's Current Procedural Terminology*.

56340 Laparoscopy, surgical; cholecystectomy (any method)

56341 cholecystectomy with cholangiography

56342 cholecystectomy with exploration of common duct

Instructions for obtaining a second surgical opinion are in the Medical Assistance provider manual.

### Prior Authorization

Corrections to the January 10, 1994, *State Register* Prior Authorization List are as follows:

Add:

32853 Lung transplant, double (bilateral sequential or en bloc):  
without cardiopulmonary bypass

32854 with cardiopulmonary bypass

Code change:

48554 Transplantation of pancreatic allograft (was code 48160)

## Department of Labor and Industry

### Labor Standards Division

#### Notice of Prevailing Wage Certifications for Commercial Construction Projects

Effective March 7, 1994 prevailing wage rates were determined and certified for commercial construction projects in:

**Aitkin County:** DNR/Savanna Portage Precast Vault Toilet, MN/DNR New Consolidated Area Headquarters-Aitkin.

**Anoka County:** Anoka Sr. High School-Anoka, Sorteberg Elementary School-Coon Rapids.

**Beltrami County:** DNR/Lake Bemidji State Park Precast Vault Toilet.

**Blue Earth County:** DNR/Minnepoa Precast Vault Toilet.

**Brown County:** DNR/Flandrau Precast Vault Toilet.

**Carver County:** Chanhassen New Elementary School & Site Preparation-Chanhassen.

**Cass County:** DNR/Pillager Precast Vault Toilet.

**Chisago County:** DNR/Wild River State Park Precast Vault Toilet. MSU Heating Plant Asbestos Removal, MSU Heating Plant Repairs-Moorhead.

**Clearwater County:** DNR/Itasca State Park Precast Vault Toilet.

**Cook County:** DNR/Judge Magney State Park Precast Vault Toilet.

**Crow Wing County:** DNR/Crow Wing State Park Precast Vault Toilet.

**Dakota County:** J.F. Kennedy & Orchard Lake Elementaries' Asbestos Removal-Lakeville.

**Douglas County:** DNR/Lake Carlos State Park Precast Vault Toilet.

**Fillmore County:** DNR/Forestville State Park Precast Vault Toilet.

**Hennepin County:** Plymouth Community Library-Plymouth, ISD #279 Boiler Burner Replacement-Maple Grove, U of M Mayo 6th Floor HVAC-Minneapolis.

**Itasca County:** DNR/Bigfork State Park Precast Vault Toilet, Greenway Sr. High School; Scofield Building; Connor-Jaspar Middle School; & Van Dyke; Marble; Phillip Murray Elementary School Emergency Lighting and Exit Sign-Coleraine.

**Kandiyohi County:** Willmar High School Technology Systems-Willmar.

**Koochiching County:** DNR/Frans Jevne State Park Precast Vault Toilet.

**Lake of the Woods County:** DNR/Near Williams & Near Fannic Precast Vault Toilet.

**Lyon County:** DNR/Camden State Park Precast Vault Toilet.

**Nicollet County:** St.Peter RTC High Security Building Reroofing-St.Peter.

**Ottertail County:** DNR/Maplewood State Park Precast Vault Toilet.

**Ramsey County:** MWWTP Corrosion Control for MCC, Administration Building Cooling Tower Replacement-St. Paul.