OPTN Liver and Intestinal Organ Transplantation Committee
Meeting Summary
August 1, 2025
Conference Call

Scott Biggins, MD, Chair
Shimul Shah, MD, MHCM, Vice Chair

Introduction

The OPTN Liver and Intestinal Organ Transplantation Committee (the Committee) met via WebEx teleconference on 08/01/2025 to discuss the following agenda items:

1. Six-month Monitoring Report: Update Liver Diagnosis Code Nomenclature and Treatment Options for Hepatocellular Carcinoma (HCC) Exceptions
2. Refine Project Idea

The following is a summary of the Committee's discussions.

1. Discussion: Hepatocellular Carcinoma (HCC) Guidance

The Committee discussed the National Liver Review Board (NLRB) review of HCC cases.

Data summary:

- 4 HCC exception forms utilized "Histotripsy" and 44 utilized "Other" as a locoregional treatment post-implementation
- 18.5% of the included TCR forms listed "Cirrhosis: Fatty Liver (NASH)" (diagnosis code 4214) as the primary diagnosis pre-implementation.
- 15.9% of forms listed "Cirrhosis: metabolic dysfunction-associated steatohepatitis (MASH)"(diagnosis code 4221) as the primary diagnosis post-implementation.
- 3.2% of the included TCR forms listed "Cirrhosis: Metabolic Dysfunction And Alcohol-Related – Associated Liver Disease (MetALD)" (diagnosis code 4222) as the primary diagnosis post-implementation.
- Proportions were similar for included TRR forms.

Summary of discussion:

The Chair stated that this data is what was expected. The Chair explained that the new MetALD diagnosis code combined with the new MASH diagnosis code equals about the same as the prior NASH diagnosis code. The Chair added there is a slight increase which is compatible with the epidemiology.

The Chair asked if there was more information on the locoregional treatment "Other" option.

Next steps:

The Committee will continue to monitor the updates.

2. Project Ideas

The Committee refined new project ideas.

Summary of discussion:

Previously, the Committee discussed pursuing a bundled project that would include several updates to liver allocation policy, including topics related to multivisceral transplant (MVT) guidance, the lab update schedule, the Status 1A definition, donor acceptance criteria, and HCC stratification. The Committee considered the impact and resource requirements of these various project components.

The Chair noted that separating some of the project ideas from the bundle may be helpful in terms of efficiency. The Chair explained that updating MVT guidance does not require system updates and could move on an expedited timeline. Meanwhile, bundling updates to the lab update schedule, modifications to the Status 1A definition, and changes to donor acceptance criteria may be the most efficient approach, as these are smaller projects that are already well-developed and could progress quickly. In contrast, updating HCC policy is a much larger initiative that will require more in-depth Committee discussion to refine the scope and development. Including HCC policy updates in the bundle could delay the entire project due to the complexity and level of involvement required.

The Committee considered whether to ask the OPTN Board of Directors for approval that updates to NLRB guidance could qualify for expedited actions. This means that NLRB updates would continue to receive public comment but would not need approval from the OPTN Board of Directors, provided that the proposal does not receive the specified number of objections. Therefore, implementation of NLRB guidance updates (those without system impact) could happen at a faster rate. The Chair stated that requesting this approval would be beneficial and it is something that the Committee and patients would want to improve efficiency.

The Committee then discussed specific changes to the Status 1A definition. The Chair noted that a growing portion of the U.S. population has chronic liver disease, and that these candidates are currently excluded from Status 1A eligibility if they experience acute liver failure, due to how the policy is written. The current language excludes candidates with pre-existing liver disease, even if they do not have end-stage liver disease or cirrhosis. The Chair asked whether there was data on how many candidates have been denied Status 1A due to the current language.

Next, the Committee discussed modifying the lab update schedule. The Chair explained that this idea arose from concerns about candidates receiving vasopressor therapies that can lower creatinine levels, thereby reducing their MELD scores and limiting their access to liver transplants from deceased donors. The previously agreed-upon solution was to extend the lab update schedule to report values every 14 days for candidates with a MELD score of 25 or higher. This change would also reduce the burden on transplant program staff. One member raised a concern about how this change might affect candidates with alcoholic hepatitis, noting that some of these candidates recover spontaneously, and the proposed update would preserve their initial (possibly elevated) scores. Another member added that this concern applies broadly to any recovering candidate, not just those with alcoholic hepatitis. The Chair emphasized that transplant programs retain the autonomy to inactivate candidates whose conditions are improving. Members agreed that monitoring would be important. The Committee discussed whether to propose collecting data on vasopressor use, but agreed that doing so would significantly increase the resource requirements and project timeline.

Finally, the Committee discussed modifying the minimum weight donor acceptance criteria. Members agreed that removing the minimum weight limit is the appropriate solution.

The Committee also discussed updates to HCC policy and refined the scope of the project idea. The Committee considered the following areas to include in the project:

- Incorporate HCC stratification
- Expand automatic approval of HCC exceptions
- Redefine the time period for when the six-month wait begins
- Update HCC guidance
- Redesign the HCC exception system

A member asked whether there are specific cases the NLRB often reviews that should be automatically reviewed. Members with experience on the Adult Transplant Oncology Review Board noted that common situations include candidates who were treated seven months ago and have no tumor and want to bypass the six-month wait. Other common situations include candidates on immunotherapy that have no detectable tumor two years later. A member suggested providing better guidance for immunotherapy may be helpful for the community.

Next steps:

The Committee will continue to refine the scope of their project ideas.

Upcoming Meetings

- August 15, 2025 at 2 pm ET (teleconference)

Attendance

- **Committee Members**
  - Aaron Ahearn
  - Allison Kwong
  - Cal Matsumoto
  - Joseph DiNorcia
  - Neil Shah
  - Scott Biggins
  - Shimul Shah
  - Tovah Dorsey-Pollard
  - Vanessa Cowan
  - Vanessa Pucciarelli
- **SRTR Staff**
  - David Schladt
  - Jack Lake
  - Katie Siegert
  - Nick Wood
- **UNOS Staff**
  - Benjamin Schumacher
  - Betsy Gans
  - Laura Schmitt
  - Meghan McDermott
  - Niyati Updahyay
  - Susan Tlusty