



KAISER PERMANENTE®

Mid-Atlantic States

Corneal Collagen Cross-Linking For Progressive Keratoconus Medical Coverage Policy

UTILIZATION * ALERT*

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage MUST be verified in the member's EOC or benefit document.
- For Medicare members, please refer to CMS guidelines through Medicare Coverage Database requirements.
- Medicare does not have a National Coverage Determination (NCD) for Corneal Collagen Crosslinking.
- Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) do not exist at this time.
- Note: After searching the Medicare Coverage Database, if no NCD/LCD/LCA is found, then use the policy referenced above for coverage guidelines

I. **Procedure:** Corneal Collagen Cross-Linking for Progressive Keratoconus

II. **Coverage Policy**

- A. Covered for progressive keratoconus and keratectasia.
Epithelium-off photochemical collagen cross-linkage using riboflavin and ultraviolet A is considered medically necessary for progressive keratoconus and keratectasia.
- B. Photochemical collagen cross-linkage is considered experimental and investigational for all other indications because it's effectiveness for other indications has not been established.
- C. **Epithelium-on** (transepithelial) collagen cross-linkage is considered experimental and investigational for keratoconus, keratectasia, and all other indications.
- D. Performance of photochemical collagen cross-linkage in combination with other procedures (CXL-plus) (e.g., intrastromal corneal ring segments, PRK or phakic intra-ocular lens implantation) is considered experimental and investigational.



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Approval History

Effective June 01, 2016, state filing is no longer required per Maryland House Bill [HB 798](#) – Health Insurance – Reporting

Date approved by RUMC	Date of Implementation
03/30/2017	03/30/2017
03/29/2018	03/29/2018
02/20/2019	02/20/2019
02/25/2020	02/25/2020
01/20/2021	01/20/2021
01/24/2022	01/24/2022
01/26/2023	01/26/2023
01/24/2024	01/24/2024
01/22/2025	01/22/2025

*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.

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