Amerigroup Washington, Inc.
Apple Health | Foundational Community Supports
Amerigroup Amerivantage (Medicare Advantage)

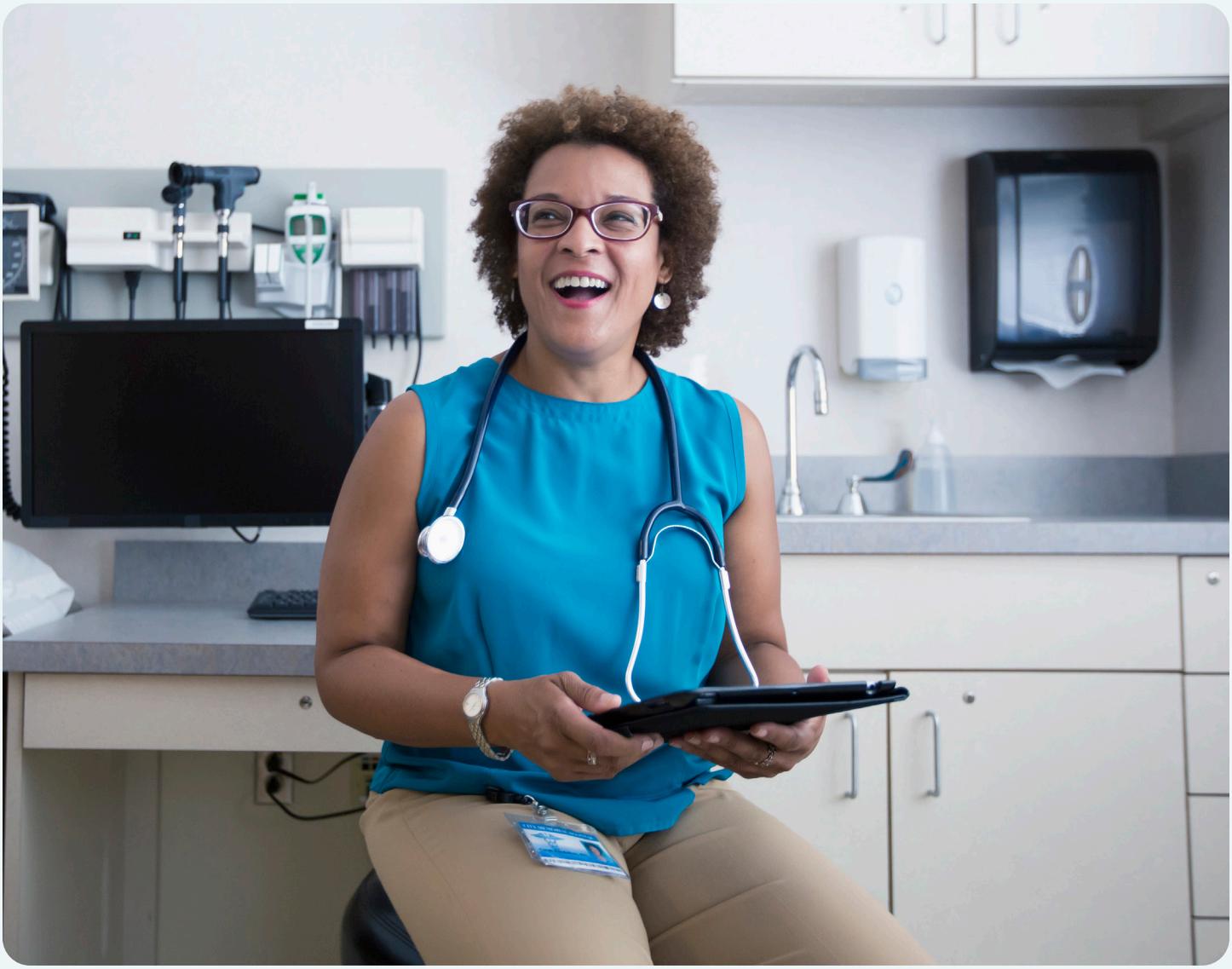
Amerigroup

Provider News | August 2022

Table of Contents

Want to receive our *Provider News* and other communications via email?
Submit your information to us using the QR code to the left or click **here**.

Coverage provided by Amerigroup Inc.
WAAGP-CDCR-003184-22



Contact Us

If you have questions or need assistance, visit the *Contact Us* section at the bottom of our provider website for up-to-date contact information and self-service tools or call Provider Services.

Provider website:

- **https://provider.amerigroup.com/WA**

Provider Services:

- Medicaid: **800-454-3730**
- Medicare Advantage: **866-805-4589**

Administrative

Medicaid

Network providers must be in active status in ProviderOne

The Health Care Authority (HCA) has announced that they will begin rejecting encounters for medical providers who are not in active status in ProviderOne. Effective January 1, 2022, Amerigroup Washington, Inc. will begin rejecting claims for providers who are not in active status with the HCA. If you are not in active status, contact the HCA at providerenrollment@hca.wa.gov or **800-562-3022, extension 16137**.

As a reminder, providers cannot bill the client unless the client was informed prior to receiving services that the provider is not an active Apple Health provider. The client must agree to receive and pay for the services, and this agreement must be documented in the client's record.

Read the **FAQ** for Medicaid requirements for ordering, prescribing, and referring providers to assist your network. If you have further questions, email hcamcprograms@hca.wa.gov with *Provider not in Active Status* in the subject line.

WA-NL-0606-21

Medicaid

Revitalizing the provider manual survey

Amerigroup Washington, Inc. is excited to share that we are revitalizing the provider manual. We are seeking feedback from our partners in helping us to improve the layout and content. Areas for discussion include:

- Are there topics that you wish were included within our current provider manual that you do not currently see?
- What are common topics that you use the provider manual for most?
- How does the Amerigroup provider manual compare to other managed care organizations?
- Is the Amerigroup provider manual easy to follow and utilize?

Take the quick survey and provide your valuable feedback.

Provider Experience will also be seeking this feedback during one-on-one meetings, joint operation committee meetings, and town hall meetings. Thank you in advance for making this provider manual revitalization project a success.

WA-NL-0708-22

Medicaid | Medicare Advantage

Standardized roster template for delegated providers

Amerigroup Washington, Inc. has recently completed work on a standardized delegated roster for Washington state providers. This roster will be available for use by delegated credentialed providers only — These are the provider groups that own and attest to their credentialing for their providers. Meaning, Amerigroup does not credential these providers, and all practitioner loads should be submitted on the *2022 Standardized Delegated Roster Template*, which is then sent to waopsrequest@amerigroup.com in a collaborative measure between the health plans in the Washington market.

Moving to a standardized roster will offer ease of use, less confusion, and noted process to ensure that all roster changes are worked appropriately.

WAAGP-CD-001496-22

Webinar trainings are now available

You can access all provider-coding education events for Amerigroup Washington, Inc. with one easy convenient link. Amerigroup will add new topics to the training page, so please check it often. Enjoy informative webinars designed specifically for network providers, coders, billers, and office staff. A variety of helpful and educational topics relating to coding and documentation, claims and billing issues, member care, quality measures, and more are available.

Sign up for a live webinar today.

Topic	Date	Time
HEDIS® Pediatric Prevention and Screening	Thursday, August 25, 2022	Noon PST
HEDIS Behavioral Health	Tuesday, August 30, 2022	Noon PST
HEDIS Chronic Conditions	Tuesday, September 13, 2022	Noon PST
HEDIS Pediatric Prevention and Screening	Thursday, September 22, 2022	6 a.m. PST
HEDIS Chronic Conditions	Tuesday, October 11, 2022	Noon PST
HEDIS Adult Prevention and Screening	Thursday, October 20, 2022	Noon PST
HEDIS Pediatric Prevention and Screening	Thursday, October 27, 2022	Noon PST
HEDIS Behavioral Health	Thursday, November 3, 2022	Noon PST
HEDIS Chronic Conditions	Friday, November 11, 2022	Noon PST
HEDIS Adult Prevention and Screening	Thursday, November 17, 2022	Noon PST

Live events:

Each live training webinar event offers awards one unit of continuing education.

Register today!

- Access the **Amerigroup care training site**.
- You may also access the page using the QR code:
  - Use the camera on your device to capture the QR code. A link will appear. Tap the link to open the training page.

On-demand events password: Washington22

If you have questions, comments, or suggestions, email **continuing-education@anthem.com**.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

WAAGP-CD-002772-22

Ultrasound reminder

Amerigroup Washington, Inc. covers outpatient prenatal ultrasounds for our pregnant Medicaid members. This policy communication is limited and does not apply to ultrasounds performed by maternal fetal medicine specialists, in hospital settings, or by radiology providers. Please refer to clinical guideline entitled *Maternal Ultrasound in the Outpatient Setting (CG-Med-42)*, on our provider website, for detailed medical necessity criteria for maternal ultrasound.

In alignment with the Washington State Health Care Authority, *Provider Guide* dated January 1, 2016, effective April 30, 2016, Amerigroup will cover two routine prenatal ultrasound for dating and fetal anatomic survey per pregnancy. Additional ultrasounds for suspected maternal/fetal abnormality or follow-up require an appropriate diagnosis indicating medical necessity. Without appropriate diagnosis codes supportive of medical necessity, ultrasounds will not be reimbursed. Prior authorization is not required for prenatal ultrasounds.

Our policies are based on medical necessity, consideration of nationally accepted medical practice standards, review of medical literature, and government approvals. We referred to the American College of Obstetricians and Gynecologists (ACOG) practice bulletin, *Ultrasonography in Pregnancy* (number 101, February 2009) to create this policy. According to this bulletin, ultrasonography in pregnancy should be performed only when there is a valid medical indication. Specifically, the ACOG practice bulletin states, “The use of either two-dimensional or three-dimensional ultrasonography only to view the fetus, obtain a picture of the fetus, or determine the fetal sex without a medical indication is inappropriate and contrary to responsible medical practice.”

Read more online.

WAAGP-CAID-000319-22

A message from the Washington State Department of Health.

Vaccines

Did you know that Washington state is **down 13% overall in number of vaccines administered** compared to pre-pandemic levels? Based on studies, the National HPV Roundtable estimates that it may take **10 years to catch up on cancer preventing HPV immunizations**. As we approach the busy back-to-school months of sports physicals and well-child visits the WA HPV Taskforce would like to give you some tools to help increase your HPV vaccination rates. Over 50% of HPV and adolescent vaccines are given in July to October. Being prepared for those months is key to protecting your patients from HPV related cancers and other vaccine preventable diseases.

1. **Start recommending HPV vaccine at ages 9, and 10.**
   HPV vaccine can be started at age 9 and doing so leads to higher rates of finishing the series on time at age 11 to 12, providing the best cancer prevention for your patients. Providers find that recommending HPV at age 9 is easier and faster to do.
2. **Standardize your vaccine schedule AND post it in the lobby and every exam room.**
   This is important so that all providers are using the same schedule, keeping the message consistent and reducing errors and missed opportunities. A schedule on the wall gives parents something to read while they are waiting and adds legitimacy to your recommendations. Don't have time to make a branded schedule right now? You can order free adolescent schedules (8x11.5 and poster size) from the WA HPV Taskforce and we can add your branding to it. This intervention is one of the easiest things you can do to raise your immunization rates. Order link is **here**.
3. **Make a strong recommendation every time AND don't miss any opportunities to vaccinate.**
   Research shows that a strong announcement approach is one of the best tools to increase immunization rates. Use statements like, "Today you are due for one vaccine that will protect against HPV related cancer — any questions?" or "Yes! I recommend the HPV vaccine for cancer prevention — This vaccine prevents over 30,000 cases of cancer every year." Make sure to check immunization status of patients at EVERY visit — Don't miss the opportunity to vaccinate.
4. **Prepare the office and staff for the rush of back-to-school vaccine requests.**
   Consider having some "vaccine only" nurse visit days to accommodate the back-to-school rush in August. Schedule more staff for back-to-school days or have some weekend or evening vaccine appointments. Stock up on needed vaccines as volume will increase.

We appreciate all your hard work to care for patients during the COVID-19 pandemic. We know you are short-staffed and working long hours. Thanks for all you do! Remember HPV vaccination is Cancer Prevention.

Resources:

- **Don't wait to Vaccinate** poster from the American Cancer Society
- Get free copies of the Portect Your Preteen/Teen with Vaccines poster from the **WA HPV FREE Taskforce**
- National HPV Roundtable: **Toolbox**
- National HPV Roundtable: **Evidence summary for HPV at 9**

WAAGP-CD-003104-22

Medicaid

Using SBIRT to address opioid and substance use disorders

COVID-19 impact on opioid and substance use disorders

As a result of the COVID-19 pandemic, there has been a 20% increase in substance use nationwide, and nearly 100,000 opioid overdose related deaths between 2020 and 2021.[1] Black Americans have been disproportionately affected by this increase in overdoses.[2] Increasing screening, brief intervention, and referral to treatment (SBIRT) may help provide an opportunity to engage those with emerging and existing substance use disorders through proactive identification and connection to professional services when indicated.

SBIRT Resources for providers

A provider toolkit for SBIRT is available on the Amerigroup Washington, Inc. provider portal. This toolkit includes SBIRT collateral materials for your use, which outline recommended screening tools, a guided SBIRT process, and resources to help identify appropriate referrals.

More about the SBIRT approach

SBIRT is a "comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders (SUD), as well as those who are at risk of developing these disorders," according to the Substance Abuse and Mental Health Service Administration (SAMHSA). The goal of SBIRT is to reduce the potential consequences of SUDs.[3]

SBIRT encounters include a brief screening and intervention that identifies:

- One or more behaviors related to risky alcohol or drug use.
- Right type and amount of treatment.

The screening is a brief set of questions that identify the patient's risk of SUD-related problems. The brief intervention is a short (15 to 30 minutes) counseling session to raise awareness of the risks. By leveraging motivation enhancement techniques, this seeks to work with the patient where they are at and with what they are ready and willing to do to address identified substance misuse. Referral to treatment helps the patient access specialized treatment when indicated.

The purpose of the encounter is to facilitate change with the patient's immediate behavior or thoughts about a risky behavior. In addition, SBIRT results help those with higher levels of need to obtain long-term care, including referrals to specialty providers. This evidence-based program (EBP) has been shown to result in a $2 to 4 healthcare savings for every $1 spent.[4]

Healthcare providers who encounter an at-risk member have an opportunity for early intervention and referral to appropriate treatment. The core goal is to reduce and prevent problematic use, abuse, and dependence on alcohol, opioids, and other substances. SBIRT has been proven effective regardless of age, gender, race, and culture in children, adolescents, and adults.

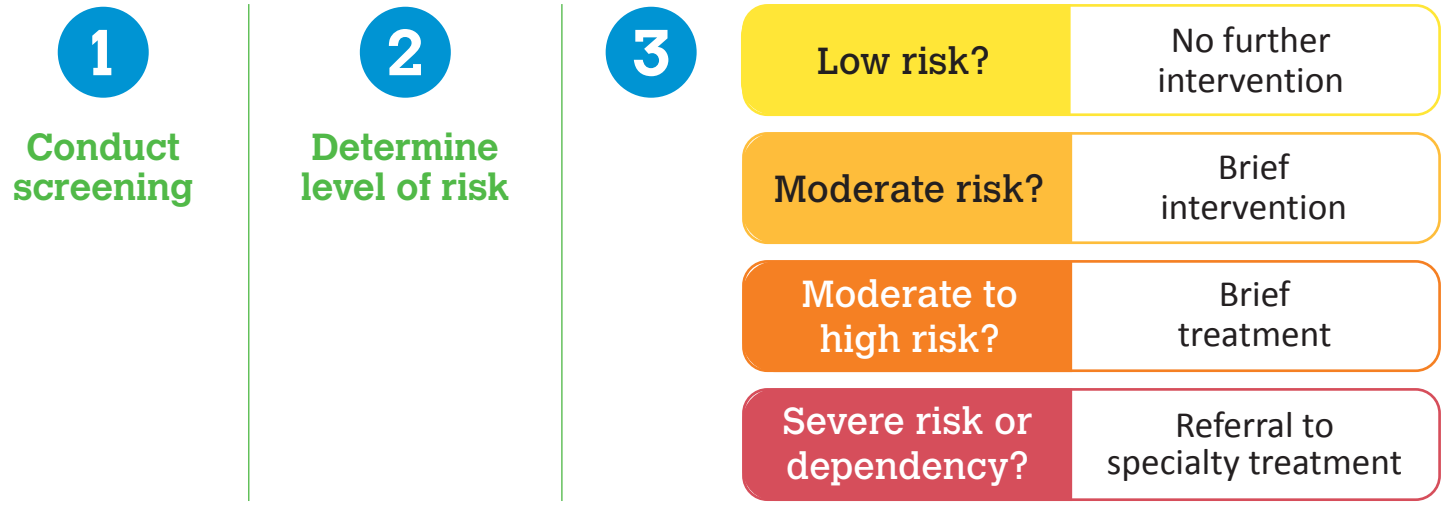
Using SBIRT to address opioid and substance use disorders (cont.)

Encounters with patients in need of SBIRT may occur in public health, non-substance use treatment settings including primary care centers, hospital emergency rooms, trauma centers, and community health settings. Primary care providers (MD/DOs, PAs, ARNPs), behavioral health providers (therapists, counselors, psychiatrists, clinical social workers), and nurses may provide SBIRT.

Recommended screening tools include:

- Alcohol use disorder identification test (AUDIT)[5] for adults with alcohol risk.
- Drug abuse screening test (DAST-10)[6] for adults with drug risk.
- Car, relax, alone, forget, family or friends, trouble (CRAFFT)[7] for children and adolescents.
- Tolerance, worried, eye opener, amnesia, k/cut down (TWEAK)[8] for pregnant people.

Below is the SBIRT process flow.



If you need assistance connecting patients to SUD treatment, or have questions about implementing SBIRT in your practice, call Provider Services at **800-454-3730** or visit the Contact Us section at the bottom of our **provider website** for up-to-date contact information.

1 Centers for Disease Control and Prevention (2022) **https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm**
2 Larochelle et al. (2021) **https://doi.org/10.2105/AJPH.2021.306431**
3 Substance Abuse and Mental Health Services Administration (2021) **https://www.samhsa.gov/sbirt**
4 Gentilello et al. (2005) **https://doi.org/10.1097/01.sla.0000157133.80396.1c**
5 World Health Organization (1987) **https://apps.who.int/iris/handle/10665/62031**
6 Addiction Research Foundation (1983) **https://www.drugabuse.gov/sites/default/files/audit.pdf**
7 Knight et al. (1999) **https://doi.org/10.1001/archpedi.153.6.591**
8 Russell (1994) **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6876474/**

WA-NL-0663-22

The cost of alcohol use disorder

The total economic cost of alcohol use disorder (AUD) was estimated to be $249 billion per year as of 2019, according to the CDC[1] with $27 billion coming from healthcare costs.[2] The CDC projected the total AUD economic impact on society to be $807 per person, per year.[3]

AUD and healthcare spending

Alcohol contributes to the highest amount of health plan spending related to substance use. 36% of Medicaid substance use claims were related to alcohol in 2020, accounting for over $129 million — an increase of 16% from 2019. Additionally, people with AUD are more likely to be high-cost claimants. In government and commercially insured patients across the country, the top 5% of high-cost claimants have either an existing AUD or health conditions resulting from alcohol use.[4]

AUD and the workforce

AUD also has a significant economic effect on the workforce by way of tardiness, absenteeism, employee turnover, and conflict. It causes a reduction in potential employees, customer base, and the taxpayer base.[5]

AUD and mortality

Alcohol use was directly tied to 95,000 deaths annually between 2011 and 2015, according to the CDC. This was more than all other substances combined including opioids, heroin, fentanyl, and methamphetamines. The CDC estimates that alcohol-attributed disease resulted in almost 685,000 years of potential life lost (YPLL) for the same period. YPLL is the estimation of the average time a person would have lived had they not died prematurely.[6]

Below is the YPLL related directly or indirectly to AUD.

Cause	YPLL
Total YPLL	> 2.7 million
100% alcohol attributed disease	684,750
Suicide	334,058
Motor vehicle crashes	323,610
Liver disease	202,391
Heart disease	118,021
Cancer	88,729

1 Center for Disease Control and Prevention, 2019 **https://www.cdc.gov/alcohol/features/excessive-drinking.html**
2 National Institute on Drug Use, 2018 **https://archives.drugabuse.gov/trends-statistics/costs-substance-abuse**
3 Center for Disease Control and Prevention, 2019
4 Internal Claims Data, 2022
5 National Institute on Drug Use, 2018
6 Center for Disease Control, 2020 **https://www.cdc.gov/mmwr/volumes/69/wr/mm6939a6.htm**

WA-NL-0666-22

Medicaid

A message from the Washington State Health Care Authority

Mental Health Assessments for Young Children (MHAYC) A-19 Travel Reimbursement Form Submission Process

The MHAYC A-19 Travel Reimbursement form is used to pay for travel when providers conduct a mental health assessment for children from birth to age five in the home or community setting. Provider travel is reimbursed by mileage. Please refer to the HCA Mental Health Services billing guides for billing guidance. This reimbursement is not valid for members enrolled in Wraparound Intensive (WISe) Services.

The MHAYC A-19 Travel Reimbursement form can be downloaded from the Amerigroup Washington, Inc. **provider website**. At this time, please submit your completed form to WashingtonDataSupport@anthem.com until a more automated process is identified. Your data will be reviewed and validated from encounters submitted for this service before payments are dispersed.

WAAGP-CD-002928-22

Medicaid

Prior authorization requirement changes — updated effective date

Effective November 1, 2022, prior authorization (PA) requirements will change for multiple codes. The medical codes listed below will require PA by Amerigroup Washington, Inc.

PA requirements will be added to the following:

- 0214U: Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood O
- 0215U: Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood O
- 81415: Exome (such as unexplained constitutional or heritable disorder or syndrome); sequence analysis
- 81416: Exome (such as unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (such as parents, siblings) (List separately in addition to code for primary procedure)
- 81417: Exome (such as unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (such as updated knowledge or unrelated condition/syndrome)

WA-NL-0685-22 | UM AROW 2892

Federal and state law, as well as state contract language, and CMS guidelines, including definitions and specific contract provisions/exclusions take precedence over these PA rules and must be considered first when determining coverage. **Noncompliance with new requirements may result in denied claims.**

To request a PA, you may use one of the following methods:

- Availity:* Once logged in to **Availity**, select Patient Registration > Authorizations & Referrals, then select **Authorizations** or **Auth/Referral Inquiry**, as appropriate.
- Fax: **800-964-3627**
- Phone: **800-454-3730**

Not all PA requirements are listed here. Detailed PA requirements are available to contracted providers on the **provider website**. Contracted and noncontracted providers who are unable to access Availity may call Provider Services at **800-454-3730** for assistance with PA requirements.

** Availity, LLC is an independent company providing administrative support services on behalf of Amerigroup Washington, Inc.*

Medicare Advantage

MCG Care Guidelines 26th edition

Effective September 1, 2022, we will upgrade to the 26th edition of MCG care guidelines for the following modules: Inpatient/surgical care (ISC). The below tables highlight new guidelines and changes.

Updates marked with an asterisk (*) notate that the criteria may be perceived as more restrictive.

Goal length of stay (GLOS) for ISC

Guideline	MCG code	25th edition GLOS	26th edition GLOS
*Aortic Valve Replacement, Transcatheter	S-1320 [W0133]	2 days postoperative	1 day postoperative
*Apnea, Neonatal (Non-Preterm Infants)	P-15	3 days	2 days
*Renal Failure, Chronic	M-325	3 days	2 days
*Subarachnoid Hemorrhage, Nonsurgical Treatment	M-79	4 days	3 days
*Craniotomy, Supratentorial	S-410	3 days postoperative	2 days postoperative
*Ankle Fracture, Closed, Open Reduction, Internal Fixation (ORIF)	S-100	Ambulatory or 1 day postoperative	Ambulatory
*Hip Arthroplasty	S-560 [W0105]	Ambulatory or 2 days postoperative	Ambulatory or 1 day postoperative
*Humerus Fracture, Closed or Open Reduction	S-632	Ambulatory or 1 day postoperative	Ambulatory
*Knee Arthroplasty, Total	S-700 [W0081]	Ambulatory or 2 days postoperative	Ambulatory or 1 day postoperative
*Lumbar Laminectomy	S-830 [W0100]	Ambulatory or 1 day postoperative	Ambulatory
*Nephrectomy	S-870	3 days postoperative	2 days postoperative
*Prostatectomy, Radical	S-960	1 day postoperative	Ambulatory or 1 day postoperative
Dehydration	M-123	1 day	2 days
Esophageal Disease	M-550	1 day	2 days
Gastritis and Duodenitis	M-560	1 day	2 days
Pneumothorax, Neonatal	P-355	2 days	3 days
Seizure	M-327	1 day	2 days
Back Pain	M-63	1 day	2 days

MCG Care Guidelines 26th edition (cont.)

New guidelines for ISC

Body system	Guideline title	MCG code
Hospital-at-Home	Cellulitis: Hospital-at-Home	M-70-HaH
Hospital-at-Home	Chronic Obstructive Pulmonary Disease: Hospital-at-Home	M-100-HaH
Hospital-at-Home	Heart Failure: Hospital-at-Home	M-190-HaH
Hospital-at-Home	Pneumonia: Hospital-at-Home	M-282-HaH
Hospital-at-Home	Urinary Tract Infection (UTI): Hospital-at-Home	M-300-HaH
Observation Care	Pancreatitis: Observation Care	OC-065
Observation Care	Renal Failure, Acute: Observation Care	OC-066
Observation Care	Stroke: Ischemic: Observation Care	OC-067

Amerigroup customizations to MCG care guidelines 26th edition

To view a detailed summary of customizations, go to **https://provider.amerigroup.com/washington-provider/home**, select the appropriate state, select **Resources**, select ***Medical Policies & Clinical UM Guidelines***, select **Other Criteria**, and select **Customizations to MCG Care Guidelines 26th Edition**.

AGPCRNL-0412-22

Medicare Advantage

New specialty pharmacy medical step therapy requirements

Effective July 1, 2022, the following Part B medications from the current *Clinical Utilization Management (UM) Guidelines* will be included in our medical step therapy precertification review process. Step therapy review will apply upon precertification initiation, in addition to the current medical necessity review (as is current procedure). Step therapy will not apply for members who are actively receiving medications listed below.

Clinical UM Guidelines	Preferred drug(s)	Nonpreferred drug(s)
ING-CC-0166	Herceptin, Kanjinti	Herzuma, Ogivri, Ontruzant, Trazimera

Clinical UM Guidelines are publicly available on the provider website. Visit the ***Clinical Criteria* page** to search for specific criteria.

AGPCARE-1348-22

Medicaid

HEDIS 2022: Summary of changes from NCQA

The National Committee for Quality Assurance (NCQA) has changed, revised, and retired some HEDIS® measures for measurement year 2022. Below is a summary of some of the key changes.

Diabetes measures

NCQA has separated the Comprehensive Diabetes Care indicators into stand-alone measures:

- Hemoglobin A1c Control for Patients with Diabetes (Two rates reported: HbA1c Control (< 8%) and Poor Control HbA1c) (> 9%) (HBD)
- Eye Exam for Patients with Diabetes (EED)
- Blood Pressure Control for Patients with Diabetes (BPD)

The process measure Comprehensive Diabetes HbA1c testing was retired as the goal is to move toward more outcome-based measures.

Race/ethnicity stratification

An important step to address healthcare disparities is reporting and measuring performance. Given this, NCQA has added race and ethnicity stratifications to the following HEDIS measures:

- Colorectal Cancer Screening (COL)
- Controlling High Blood Pressure (CBP)
- Hemoglobin A1c Control for Patients with Diabetes (HBD)
- Prenatal and Postpartum Care (PPC)
- Child and Adolescent Well Care Visits (WCV)

NCQA plans to expand the race and ethnicity stratifications to additional HEDIS measures over several years to help identify and reduce disparities in care among patient populations. This effort builds on NCQA's existing work dedicated to advancing health equity in data and quality measurements.

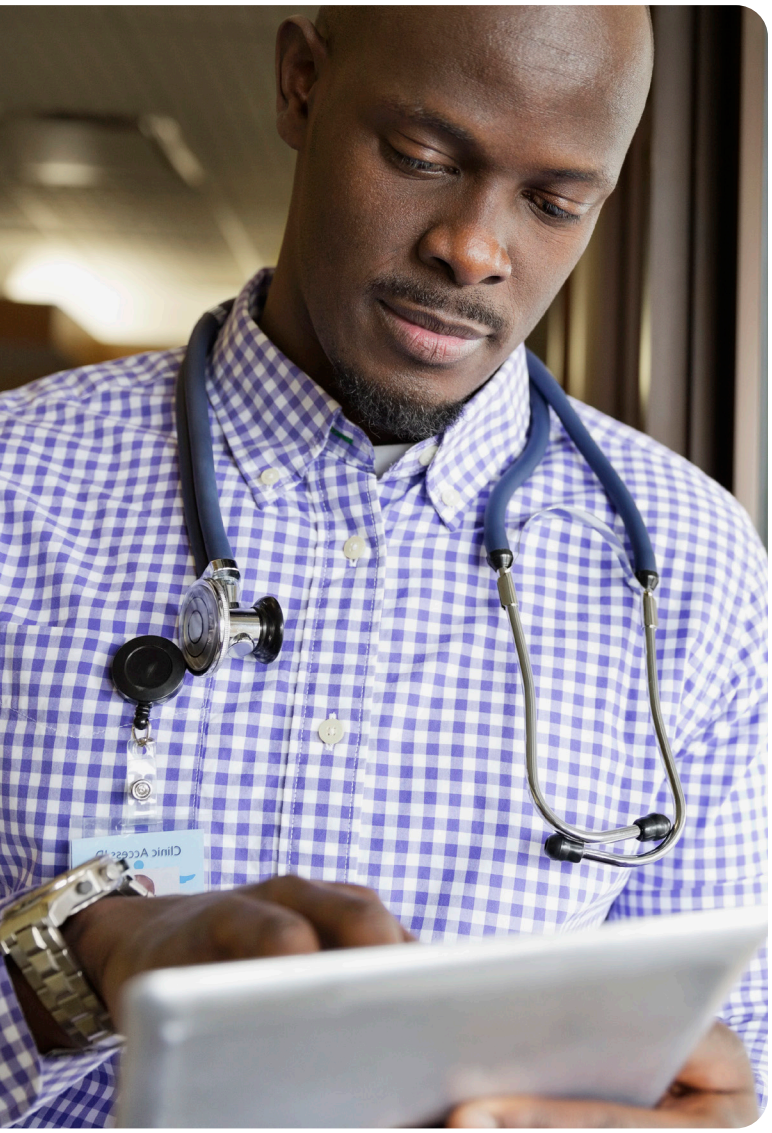
Measure changes

Colorectal Cancer Screening (COL):

Measures the percentage of members 45 to 75 years of age who had appropriate screening for colorectal cancer. The Medicaid product was added to the administrative data collection method for this measure and the age range was changed to 45 to 75 years of age. Any of the following meet criteria:

- Fecal occult blood test during the measurement year
- Flexible sigmoidoscopy during the measurement year or the four years prior to the measurement year
- Colonoscopy during the measurement year or the nine years prior to the measurement year
- CT colonography during the measurement year or the four years prior to the measurement year
- Stool DNA (sDNA) with FIT test during the measurement year or the two years prior to the measurement year

This measure can also be reported as an Electronic Clinical Data Reporting System measure: Colorectal Cancer Screening (COL-E).



Antibiotic Utilization for Respiratory Conditions (AXR):

A newly added metric which measures the percentage of episodes for members 3 months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event. This measure was added because antibiotics prescribed for acute respiratory conditions are a large driver of antibiotic overuse.

Tracking antibiotic prescribing for all acute respiratory conditions will provide context about overall antibiotic use. Given this new measure, the broader Antibiotic Utilization measure has been retired.

Use of Imaging Studies for Low Back Pain (LBP):

This measure was expanded to the Medicare line of business, and the upper age limit for this measure was expanded to age 75. Additional exclusions to the measure were also added.

For a complete summary of 2022 HEDIS changes, visit: **https://www.ncqa.org/hedis/measures**.

WA-NL-0653-22

Chlamydia screening

Chances are, one of these teenagers has chlamydia. According to the Centers for Disease Control (CDC), one of the largest growing populations for chlamydia are teens and young adults. Chlamydia infection is often asymptomatic, and screening for asymptomatic infection is a cost-effective strategy to reduce transmission and prevent pelvic inflammatory disease among females.

Talking to a teenager about sexual health issues like chlamydia can be difficult. But, left untreated, an affected individual may develop conditions such as pelvic inflammatory disease (PID), infertility, ectopic pregnancy, and chronic pelvic pain. Provider resources can help get the conversation started. To help get the conversation started, visit the **National Chlamydia Coalition website** for a free *Chlamydia How-To Implementation Guide for Healthcare Providers*.

Facts about chlamydia:

- The United States Preventive Services Task Force (USPSTF) recommends screening for chlamydia in all sexually active women 24 years or younger and in women 25 years or older who are at risk for infection.
- Chlamydia is the most commonly reported sexually transmitted disease (STD) with over 1.8 million cases reported in 2019.
- Young women account for 43% of reported cases and face the most severe consequences of an undiagnosed infection.
- It is estimated that undiagnosed STDs cause infertility in more the 20,000 women each year.

Chlamydia Screening in Women (CHL) HEDIS Measure

This HEDIS® measure looks at the percentage of women 16 to 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year, including teens and women who:

- Made comments or talked to you about sexual relations.
- Had a pregnancy test.
- Were prescribed birth control (even if used for acne treatment).
- Received gynecological services.
- Have a history of sexually transmitted diseases.
- Have a history of sexual assault or abuse.

Description	CPT® codes
Chlamydia tests	87110, 87270, 87320, 87490, 87492, 87810
Pregnancy test exclusion	81025, 84702, 84703

WA-NL-0696-22