Chlamydia Screening (CHL)

Members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active, and had at least one test for chlamydia during the measurement period.

Exclusions

- Persons with a sex assigned at birth of male.

Documentation Requirements

- Chlamydia screening must be completed during the measurement year.
- If a member is sexually active, make sure to document it in their record.
- Documentation must include:
  - Lab result
  - Date of service

Relevant Codes

The following codes may support gap closure through claims. Compliance depends on meeting HEDIS-defined criteria, including timing, documentation, and qualifying services—not code submission alone.

Code	Description
87110	Culture, chlamydia, any source
87270	Infectious agent antigen detection by immunofluorescent technique
87320	Infectious agent antigen detection by EIA, qualitative or semi-quantitative
87490	Infectious agent detection by nucleic acid direct probe
87810	Infectious agent detection by immunoassay with direct optical observation

Common Documentation Insufficiencies

- Chlamydia screening may not be captured via claims if the service is performed and billed under prenatal and postpartum global billing.
- Include a copy of lab results in the EMR.

Best Practices

- Enter results into your EMR and label clearly for easy identification.
- Ensure workflows are in place to notify and remind providers when a patient's next screening is due. Utilize Innovaccer Dashboards and/or InNote when chart prepping.
- Make follow-up phone calls if patients have not completed their screening. Utilize care gap lists to identify non-compliant patients.
- Educate patients on the risks of undetected chlamydia and available screening options (may be tested via urine, does not require pelvic exam).