

Pursuant to the authority vested in the Commissioner of Health by Section 2500-g of the Public Health Law, Subpart 69-8 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York is amended, to be effective upon publication of a Notice of Adoption in the New York State Register, to read as follows:

Subdivisions (g) and (h) of Section 69-8.1 are amended, and new subdivisions (i) through (q) are added, to read as follows:

(g) Two-tier infant hearing screening is defined as the use of otoacoustic emissions (OAE) screening or auditory brainstem response (ABR) screening followed by auditory brainstem response (ABR) screening if the patient does not pass the initial OAE or ABR screening.

(h) Parent means a parent by birth or adoption, legal guardian, or any other person legally authorized to consent to medical services for the infant.

[(h)] (i) Article 28 Facility or Facility shall mean a health care facility established under Article 28 of the Public Health Law.

(j) Early Intervention Program means the New York State Early Intervention Program for infants and toddlers with disabilities and their families, established under Title II-A of Article 25 of Public Health Law, including state-approved Program offices at the county level.

(k) Referral to the municipal Early Intervention Program means referral to the designated early intervention official in the municipality where the child resides, as is required of primary referral sources. Such referral shall occur within two working days of identifying an infant or toddler who is less than three years of age and suspected of having a disability or is at risk of having a disability.

(l) Early intervention official means the official designated by the municipality as responsible for the administration of referrals of children suspected of having or are at risk for developmental delays or disabilities.

(m) Early Intervention Program evaluator means an individual approved by the Early Intervention Program to evaluate children from birth to three years old with standardized assessments and criterion-referenced assessments to determine eligibility for early intervention services.

(n) Primary referral sources are defined as all individuals who are Early Intervention Program qualified personnel; all approved evaluators, service coordinators, and providers of early intervention services; Article 28 facility hospitals and clinics; child health care providers; day care programs; local health units; local school districts; local social service districts including public agencies and staff in the child welfare system; public health facilities; early childhood direction centers; domestic violence shelters and agencies; homeless family shelters; and, operators of any clinic approved pursuant to Article 16 of the Mental Hygiene Law, or Article 31 of the Mental Hygiene Law.

(o) An “at risk” referral to the Early Intervention Program means referral of an infant who has failed newborn hearing screening prior to discharge from neonatal care with no documented follow-up results reported by the birth facility at 60 days post-discharge. Upon such referral, the county Early Intervention Program shall facilitate newborn hearing screening follow-up.

(p) A “suspected of hearing loss” referral to the Early Intervention Program means referral of an infant who has failed a two-tier inpatient hearing screening and any follow-up out-patient re-screening. Upon such referral, the Early Intervention Program evaluator may first provide a

confirmatory audiological evaluation to determine whether a hearing loss exists, pursuant to section 69-4.8 of this Part.

(q) A prescription shall mean a written order issued by the facility for an infant to obtain a follow-up screening or diagnostic audiological evaluation, as appropriate, from an article 28 licensed facility or a provider authorized to perform audiological evaluations under title eight of the education law.

Subdivisions (b) and (c) of Section 69-8.2 are amended to read as follows:

(b) General requirements of an infant hearing screening program are:

(1) T[t]he conduct of a two-tier inpatient infant hearing screening prior to discharge from [the facility;] neonatal care for infants in the normal newborn nursery. Two-tier infant hearing screening consists of initial screening with OAE or ABR on both ears. Each ear must pass the OAE or ABR screening to be considered a “pass.” If the OAE or ABR screening is not passed in one or both ears, an ABR screening is performed on both ears. If the infant passes the ABR screening, the infant has "passed" the hearing screening. If one or both ears do not pass the ABR screening, the infant shall be referred for outpatient re-screening and/or diagnostic audiological evaluation.

(2) The conduct of newborn hearing screening using ABR for infants who have received care in a neonatal intensive care unit (“NICU”), for the initial and any secondary screening. Infants cared for in the NICU who do not pass the inpatient ABR screening shall be referred to a provider licensed under State Education Law and authorized to provide infant hearing screening

and diagnostic audiological evaluations for rescreening, and, if indicated, given a comprehensive audiological evaluation including diagnostic ABR.

[(2)] (3) C[c]ommunication of results of infant hearing screenings to parents by designated personnel, including provision of written materials supplied by the department[;].

[(3)] (4) T[t]he conduct of follow-up infant hearing screening or provision of referrals to obtain follow-up screening on an outpatient basis for those infants who fail or do not receive infant hearing screening prior to discharge from the facility. On an annual basis, facilities shall notify the department whether the facility will conduct follow-up infant hearing screening or provide referrals for infants to obtain such screening from another facility or provider licensed under State Education Law and authorized to provide infant hearing screening[;].

[(4)] (5) R[r]eferral of infants who are suspected of having a hearing loss as defined in this part to the Early Intervention Program for appropriate evaluation and early intervention services pursuant to section 69-4.3 of this title including, but not limited to:

* * *

[(5)] (6) T[t]he reporting of aggregate data on infant hearing screenings to the department upon department request, in a format and frequency prescribed by the commissioner[; and].

[(6)] (7) T[t]he establishment of facility quality assurance protocols as necessary pursuant to section 405.6 of this Title to determine and evaluate the effectiveness of the program in ensuring all infants are screened for hearing loss.

(8) Individual infant data must be reported or updated through the Early Hearing Detection and Intervention – Information System (EHDI-IS) or any successor system whenever new screening results are obtained.

(c) Facilities with 400 or fewer births annually, based on a three-year rolling average, may provide referrals for infants to receive hearing screening from an article 28 facility or a provider licensed under State Education Law and authorized under such law to perform infant hearing screening, or medical assistants trained and deemed capable by an infant hearing screening program manager, as defined in section 69-8.3 of this Subpart, to perform basic hearing tests which do not require exercise of clinical decision-making.

(1) Such referrals shall include a prescription issued by the facility for infants to receive hearing screening, including a request for results of the screening to be returned to that facility [for infants to receive hearing screening from an article 28 facility or a provider licensed under State Education Law and authorized under such law to provide infant hearing screening].

* * *

Subdivision (b) of Section 69-8.3 is amended to add a new paragraph (6) to read as follows:

(b) The program manager shall be responsible for ensuring:

* * *

(6) Establishment of policies and procedures for the audiological screening of newborns, including training of all personnel, conduct of the screening, referral, follow-up and documentation procedures.

Section 69-8.4 is amended to read as follows:

(a) All infants born in the facility shall receive an initial hearing screening prior to discharge from the facility, pursuant to section 69-8.2(b) of this Subpart, except as provided in section 69-8.2(c) of this Subp[P]art.

* * *

(e) In the event that an infant is not screened for hearing loss prior to discharge from [the facility] inpatient neonatal care, the program manager shall ensure that:

* * *

(f) If the infant fails the two-tier inpatient hearing screening, [a repeat screening shall be conducted whenever possible prior to the infant's discharge from the facility to minimize the likelihood of false positive results and need for a follow-up outpatient screening] an outpatient follow-up screening and/or diagnostic audiological evaluation shall be performed to confirm the results of the inpatient screenings.

[(g) If the infant fails the inpatient screening and any repeat screening, if performed, an outpatient follow-up screening shall be performed to confirm the results of the inpatient screens.

(h) (g) If the facility has elected to conduct follow-up hearing screening either directly or through a contractual agreement, the following procedures shall be followed:

* * *

(7) If the facility or provider under contract with the facility cannot reach the family or for any other reason cannot schedule and complete a follow-up screening within [seventy-five] sixty days from discharge, the infant shall be referred to the early intervention official in his or her county of residence as an at-risk child in accordance with section 69-4.3 of this title, unless the

parent objected to the referral at the time of the inpatient hearing screening[;]. The parent's objection to a follow-up screening must be entered into EHDI-IS or any successor system;

* * *

[(i)] (h) If the facility elects to refer infants who fail the inpatient hearing screening to other facilities or providers licensed under the State Education Law and authorized by such law to perform infant hearing screening on an outpatient basis, the following procedures shall be used:

* * *

(4) The parent shall be informed that if results of a follow-up outpatient screening are not returned to the facility within sixty days, the infant will be referred as an at-risk child to the early intervention official in their county of residence for follow-up purposes unless the parent(s) object to such a referral, in accordance with section 69-4.3 of this Part.

* * *

(7) If results of a follow-up outpatient screening are not returned to the facility within [seventy-five] sixty days, the infant shall be referred as an at-risk child to the early intervention official in his/her county of residence for follow-up purposes, in accordance with section 69-4.3 of this part, unless the parent has objected to such a referral. The parent's objection to a follow-up screening must be entered into EHDI-IS or any successor system.

Subdivision (d) of Section 69-8.5 is amended, and a new Subdivision (e) is added to read as follows:

* * *

(d) The program manager shall report all infant hearing screening results in the EHDI-IS, or any successor system, as directed by the department.

[(d)] (e) The department may seek corrective action as necessary to ensure infants are screened for hearing loss under the referral process provided for in this section.

Section 69-8.6 is amended to read as follows:

(a) In the event that an infant is transferred from one facility to another such facility, the facility discharging the infant to home shall be responsible for ensuring that infant hearing screening services are provided to the infant and reported to the department in a manner consistent with the applicable provisions set forth in this [Part] Subpart. If the infant fails [both an initial] the inpatient infant hearing screening and any follow-up outpatient infant hearing screening, the infant shall be referred for an evaluation to the early intervention official in his or her county of residence, according to the procedures set forth in Section 69-4.3 of this Part unless the parent objects. The parent's objection to a follow-up screening must be entered into EHDI-IS or any successor system.

(b) Medically unstable infants shall receive infant hearing screening prior to discharge to home and as early as development or medical stability will permit such screening. In instances where the medical condition of the infant contraindicates infant hearing screening, a decision to forgo such screening may be made and documented in the medical record and reported to the department in a manner consistent with the applicable provisions set forth in this Subpart.

A new Section 69-8.7 is added to read as follows:

Section 69-8.7 Responsibilities of Persons Performing Infant Hearing Screening.

(a) Anyone who performs an infant hearing screening and/or diagnostic audiological evaluation upon a child under six months of age shall report the results of such screening or evaluation to the department through the Early Hearing Detection and Intervention – Information System (EHDI-IS) or any successor system as directed by the department.

(b) Infant hearing screening reporting must include:

(1) the results of each newborn infant hearing screening performed and

(2) such other information or data as may be required by the department to fulfill the purposes of this section.

Regulatory Impact Statement

Statutory Authority:

Section 2500-g of the Public Health Law (PHL) provides authority for the Department of Health (Department) to oversee and regulate Statewide newborn hearing screening and follow-up.

Legislative Objectives:

The proposed regulations satisfy the objective of PHL section 2500-g to establish a Statewide program for screening newborns for hearing problems and detecting hearing problems as early as possible in an infant's life. Particularly, this statute directs the Commissioner to incorporate medical guidelines and protocols that reflect the most cost-effective methods for early detection of newborn hearing problems. Consistent with this objective, the regulations will align with National Joint Committee on Infant Hearing (JCIH) evidence-based practices for newborn hearing screening to ensure early detection and referral for infants identified as having hearing difficulties, while also reducing the number of infants requiring follow-up hearing screening following discharge from neonatal care, which can result in cost savings.

Needs and Benefits:

The proposed rule is necessary to establish procedures for a two-tier inpatient newborn hearing screening protocol for infants in the well-born nursery, which will align with National Joint Committee on Infant Hearing (JCIH) evidence-based practices and reduce the number of infants requiring follow-up hearing screening following discharge from neonatal care. Implementation of two-tier inpatient newborn hearing screening benefits families with newborns by decreasing the number of infants who do not pass their hearing screening prior to discharge (reduces the

number of infants who receive false positive results) and benefits perinatal facilities by reducing the number of infants that require tracking to report outpatient hearing screening results. This method will increase the accuracy of the newborn hearing screening program. In addition, the proposed rule changes are necessary to update the requirement to report hearing screenings to the Department, to ensure effective Statewide monitoring and clarify the responsibilities of health care professionals with respect to reporting newborn hearing screening data.

Costs for the Implementation of, and Continuing Compliance with the Regulation to the Regulated Entity:

Some Article 28 facilities that do not have both otoacoustic emissions (OAE) and auditory brainstem response (ABR) technology available will need to acquire new equipment to comply with the updated newborn hearing screening requirements. Based on 2021 data, approximately 76 Article 28 facilities statewide have both OAE and ABR equipment for newborn hearing screening. Approximately 56 facilities have ABR only and can opt to continue utilizing this technology for their newborn hearing screening programs. A significantly smaller number of birth facilities (an estimated two facilities) will need to acquire ABR equipment, an expenditure of approximately \$15,000 for either ABR alone or combination ABR/OAE screening equipment. Initial costs would be offset by revenue (global fee for inpatient stay).

Costs to the Agency, the State and Local Governments for the Implementation of and Continuing Compliance with the Rule:

The proposed rules will result in no additional costs for the Department or State and local governments.

Local Government Mandates:

The proposed rule does not impose any new duty upon any county, city, town, village, school district, fire district, or other special district, as all existing EIP requirements on localities that administer the EIP at the local level will remain unchanged by the amended regulations.

Paperwork:

The proposed rules do not impose any new paperwork requirements upon any state or local governments.

Duplication:

The proposed rules do not duplicate, overlap, or conflict with relevant rules and other legal requirements of the state and federal government.

Alternatives:

Alternatives to the proposed rules include amendments or additions to the following;

- Subdivision (g) of Section 69-8.1: Includes the addition of auditory brainstem response (ABR) screening as a Two-tier infant hearing screening option,

- Subdivision (b) of Section 69-8.2: Requires that infants cared for in the NICU who do not pass the inpatient ABR screening are referred to a licensed provider to perform a comprehensive audiological evaluation, follow up screenings/referrals are obtained prior to discharge from the facility, hearing screening data is reported to the Department upon request and in a format and frequency prescribed by the commissioner, and the establishment of facility quality assurance protocols pursuant to Section 405.6.

Not adopting these rules is not a viable option, as amendment is necessary to align Department regulations with the Joint Committee on Infant Hearing recommendations, thereby satisfying the directive in PHL section 2500-g to regulate newborn hearing screening in a manner that incorporates consensus medical guidelines and protocols that reflect the most cost-effective methods for detecting hearing problems as early as possible in an infant's life.

The Department presented the proposed regulations to the Early Hearing Detection and Intervention (EHDI) Advisory Group meeting on June 17, 2021. The EHDI Advisory Group was supportive of the proposed changes; no specific alternative proposals were recommended by the EHDI Advisory Group.

Federal Standards:

There are no applicable federal standards.

Compliance Schedule:

The proposed rules will be effective immediately upon adoption. These proposed rules conform current regulation to existing requirements in state statutes.

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Statement in Lieu of Regulatory Flexibility Analysis

No Regulatory Flexibility Analysis is required pursuant to section 202-b(3)(a) of the State Administrative Procedure Act. The proposed amendment does not impose an adverse economic impact on small businesses or local governments, and it does not impose reporting, record keeping, or other compliance requirements on small businesses or local governments.

Statement in Lieu of Rural Area Flexibility Analysis

A Rural Area Flexibility Analysis for these amendments is not being submitted because amendments will not impose any adverse impact or significant reporting, record keeping, or other compliance requirements on public or private entities in rural areas. There are no professional services, capital, or other compliance costs imposed on public or private entities in rural areas as a result of the proposed amendments.

Statement in Lieu of Job Impact Statement

A Job Impact Statement for these amendments is not being submitted because it is apparent from the nature and purposes of the amendments that they will not have a substantial adverse impact on jobs and/or employment opportunities.

ASSESSMENT OF PUBLIC COMMENT

Public comments were received from seven (7) stakeholders including but not limited to birth facilities (5), one non-facility provider of newborn hearing screening services, and one company that furnish newborn hearing screening services. These comments and the Department's responses are summarized below.

COMMENT: One commenter expressed concern about using otoacoustic emissions (OAE) as the initial screen in the two-tier screening protocol in the well-born nursery. The commenter stated that if the newborn passes the OAE screen, they would not have an automated auditory brainstem response (AABR) screen and therefore miss an entire subset of hearing loss known as Auditory Neuropathy Dys-Synchrony Syndrome.

RESPONSE: The Joint Committee on Infant Hearing (JCIH) 2019 Position Statement (page 8) indicates that “Although it is not the goal of universal newborn hearing screening to identify all infants who are deaf or hard of hearing (e.g., infants with auditory neuropathy will be missed when screened by OAE; infants with minimal-mild hearing thresholds will be missed when either technology is used), the importance of acknowledging, and estimating the occurrence of false-negative outcomes must continue to receive attention.”¹ No changes were made to the regulation as a result of this comment.

COMMENT: One commentor suggested repeating the OAE more than once prior to discharge, eliminating the need to complete the AABR. The commenter noted that this method is less time

¹ | Joint Committee on Infant Hearing (2019). Year 2019 position statement: Principles and guidelines for Early Hearing Detection and Intervention Programs. *Journal of Early Hearing Detection and Intervention*, 4(2): 1-44.

consuming and that it's cheaper to rescreen using the OAE at a different session rather than performing an AABR immediately after the failed OAE.

RESPONSE: One goal of the current amendments to the statewide newborn hearing screening regulations is to reduce loss to follow up/loss to documentation for those infants who fail inpatient newborn hearing screening. A two-tier protocol consisting of initial OAE or AABR screening followed by AABR for infants who fail the initial screening can decrease the fail rate at hospital discharge, thereby reducing the need for outpatient follow up, according to the Joint Committee on Infant Hearing (JCIH) 2019 Position Statement.² No changes to the regulation were made as a result of these comments.

COMMENT: One commentor indicated support of the Department authorizing the option of utilizing either automated AABR or OAE as the initial screening, and automated AABR for the secondary screening in the proposed two-tier system.

RESPONSE: The Department appreciates and acknowledges the commentor's support.

COMMENT: On commentor asked if sequential AABR screens are required or one AABR is acceptable for screening in the NICU. The commentor asked if an infant does not pass the first AABR screen, what is the time interval between screening sessions for the second rescreening before discharge. The commentor further stated that most babies are tested close to their discharge date.

RESPONSE: Birth facilities will be required to implement a two-tiered screening protocol for infants who have received NICU care, as they must be screened using AABR equipment for the

² | Joint Committee on Infant Hearing (2019). Year 2019 position statement: Principles and guidelines for Early Hearing Detection and Intervention Programs. *Journal of Early Hearing Detection and Intervention*, 4(2): 1-44.

initial hearing screening and for any secondary screening. The JCIH 2019 Position Statement (page 5) states that the JCIH continues to recommend AABR screening and rescreening protocols in the NICU to allow for detection of auditory neuropathy. Birth facilities retain the option to conduct repeat AABR screening for infants who have received NICU care. The JCIH 2019 Position Statement (page 8) recommends providing a single repeat screen prior to discharge, as close to discharge as practicable, if the infant does not pass the first hearing screen, and notes that the second screen, if required, should not be performed immediately following the first screen, but should occur at least several hours later.³ The proposed amendments are intended to ensure a consistent, reliable approach in the EHDI Program across the State and facilitate early identification of infants suspected of hearing loss. No changes to the regulation were made as a result of these comments.

COMMENT: A commenter asserted that if inpatient initial screening is not passed in only one ear, only that ear should be rescreened to save time and money.

RESPONSE: If a baby fails a screening in one ear, the rescreening must still be done on both ears. The JCIH 2019 Position Statement indicates that “a pass outcome implies that the infant passes both ears simultaneously (in the same screening session). Specifically, an infant who does not pass both ears in the same screening session, even if each ear has separately passed a screening, does not constitute a pass outcome” (page 7)³. The JCIH 2019 Position Statement further notes that outpatient rescreening should always include the testing of both ears, even if

³ | Joint Committee on Infant Hearing (2019). Year 2019 position statement: Principles and guidelines for Early Hearing Detection and Intervention Programs. *Journal of Early Hearing Detection and Intervention*, 4(2): 1-44.

only one ear did not pass the inpatient screening (page 10). No changes to the regulation were made as a result of this comment.

COMMENT: Two commenters inquired if their birthing facility is able to perform the repeat bilateral AABR outpatient re-screening for newborns discharged from the well-born nursery who did not pass the two-tiered screening. The commenters stated that if the newborn does not pass the AABR rescreening, the facility would refer the infant for diagnostic audiological evaluation.

RESPONSE: The recommended modification is incorporated in section 69-8.2(b)(4) of the proposed regulation. “The conduct of follow-up infant hearing screening or provisions of referrals to obtain follow-up screening on an outpatient basis for those infants who fail or do not receive infant hearing screening prior to discharge from the facility. On an annual basis, facilities shall notify the department whether the facility will conduct follow-up hearing screening or provide referrals for infants to obtain such screening from another facility or provider licensed under State Education Law and authorized to provide infant hearing screening.”

The JCIH 2019 Position Statement (page 8), JCIH has renewed the recommendation that only one high-quality outpatient rescreening be performed prior to referral to a pediatric audiologist for the child who needs follow-up testing after the outpatient rescreen. A high-quality screen implies that the infant is sleeping or resting quietly without movement throughout the screening period, and that patency of the ear canal is assured to the extent possible prior to initiating the screen. The JCIH 2019 Position statement (page 10), rescreening should comprise of a single valid rescreen of both ears in the same session.⁴ No changes to the regulation are necessary as a result of these comments.

⁴ | Joint Committee on Infant Hearing (2019). Year 2019 position statement: Principles and guidelines for Early Hearing Detection and Intervention Programs. *Journal of Early Hearing Detection and Intervention*, 4(2): 1-44.

COMMENT: Clarification was requested on the rescreening method. One commentor noted that previously, outpatient rescreening was performed using the same screening method as performed in the in-patient setting. The commentor noted that rescreening with AABR as an outpatient would only occur if the newborn was in the NICU.

RESPONSE: The two-tier hearing screening protocol for inpatient screening in the well-born nursery includes a secondary newborn hearing screening using AABR for infants who fail the initial newborn hearing screening. If the newborn from the well-born nursery does not pass the two-tiered screening, they will be referred for outpatient rescreening or diagnostic evaluation. Infants from the well-born nursery who did not pass the in-patient hearing should have had an AABR screen. No changes were made to the regulation as a result of this comment.

COMMENT: One commentor explained to out-patient providers that when they perform in-office follow-up OAE hearing screening, they also need to conduct an AABR to rule out auditory neuropathy.

RESPONSE: Infants who received care in the NICU who do not pass the inpatient AABR screening shall be referred to a provider licensed under State Education Law and authorized to provide infant hearing screening and diagnostic audiological evaluations for rescreening, and if indicated, given a comprehensive audiological evaluation including diagnostic AABR. Infants from the well-born nursery who did not pass the inpatient hearing screening shall receive a referral for follow-up infant hearing screening or diagnostic audiological evaluation. The JCIH 2019 Position Statement (page 2), endorses, for well-born infants only, who are screened by automated auditory brainstem response (AABR) and do not pass, that rescreening and passing by otoacoustic emissions (OAE) testing is acceptable, given the very low incidence of auditory

neuropathy in this population. No changes to the regulation are necessary as a result of this comment.

COMMENT: One commentor supported the requirement for follow-up screens to be conducted by professionals licensed to do so.

RESPONSE: The Department appreciates and acknowledges the commentor's support.

COMMENT: One commentor noted they do not consistently receive follow-up results from the local pediatricians who perform in-office follow-up OAEs. The commentor stated they request the pediatrician offices to enter the screen results into the Health Commerce System; however, the pediatricians respond that they do not do that.

RESPONSE: Pursuant to new section 69-8.7(a) of the regulations, anyone who performs an infant hearing screening and/or diagnostic audiological evaluation upon a child under six months of age must report the results of such screening or evaluation to the Department through the Early Hearing Detection and Intervention–Information System (EHDI-IS) or any successor system as directed by the department. No changes to the regulation are necessary as a result of this comment.

COMMENT: A commentor asked, for babies who receive outpatient audiology follow up at outside facilities (not their birth hospital), who have a refer rescreening test result or an abnormal diagnostic evaluation but do not return for a follow up appointment, does the outside facility or the birth hospital issue the referral to the Early Intervention Program? The commentor felt the outside facility would have that responsibility because they are the baby's audiologist.

RESPONSE: Section 69-8.4(g)(7) of the regulations relates to infants with failed inpatient screenings and changes the time frame from 75 days post-discharge to 60 days post-discharge for a birth facility, or provider under contract with the facility, to make a referral to the Early Intervention Program in the child's county of residence if they have not been successful in contacting the family to schedule a follow-up screening, unless the parent objected to the referral at the time of the inpatient hearing screening. The parent's objection to a follow-up hearing screening must be entered into the EHDI-IS or successor system. No changes to the regulation were made as a result of this comment.

COMMENT: One commentor suggested that the Department postpone running reports of "missing" screens by one month because most missing hearing screens are babies in the NICU or who have not been entered into the Health Commerce System. This would save staff time looking up each baby to learn they were tested after the report was run. Reports of "missing screens" also include those that were entered as refused or transferred to another facility.

RESPONSE: No changes were made to the regulation as a result of these comments; however, the Department will take the comments under advisement.