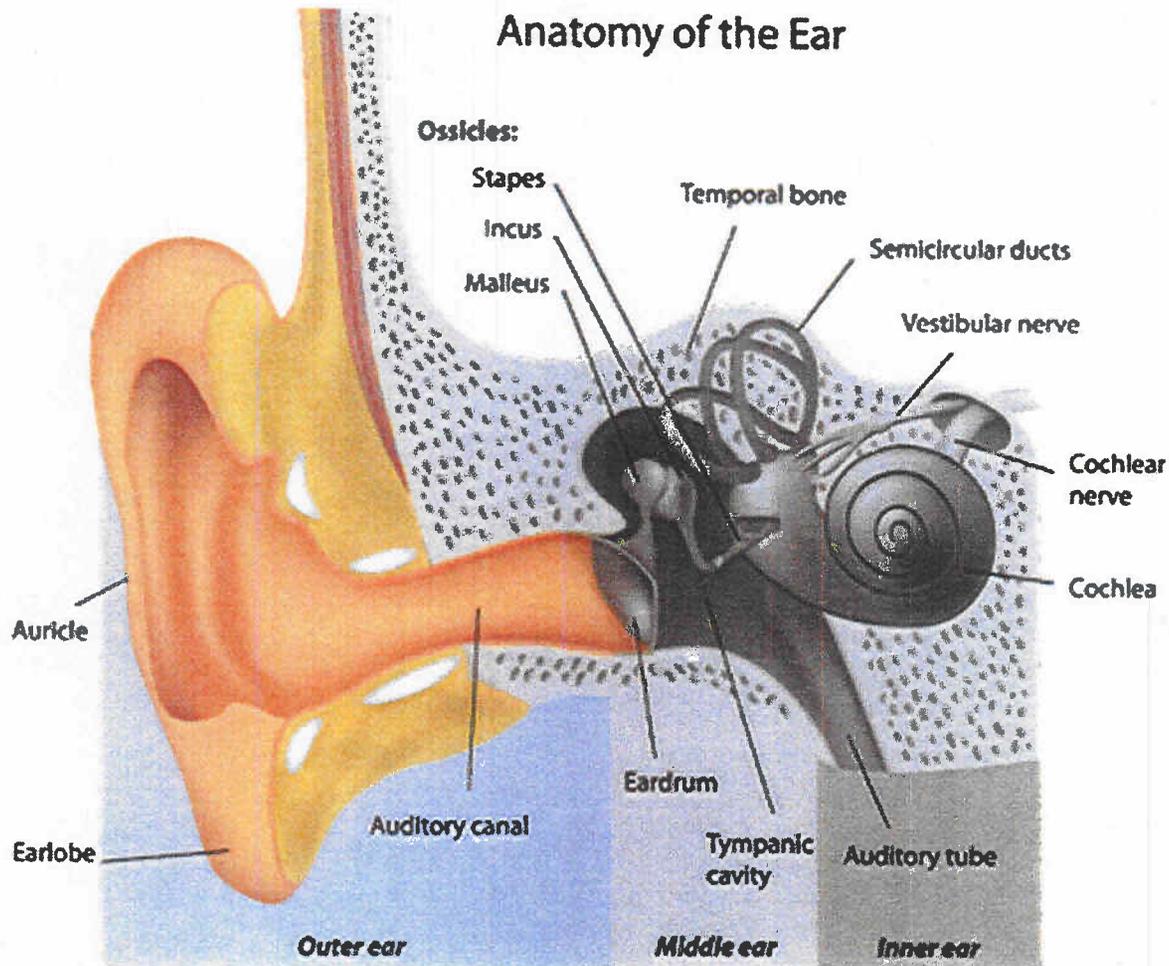


Anatomy of the Ear



(continued)

19. Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>) establish the criteria for and coverage of newborn screening procedures and programs.
20. Verify results as soon as possible, and follow up, as appropriate.
21. Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See "Hyperbilirubinemia in the Newborn Infant \geq 35 Weeks' Gestation: An Update With Clarifications" (<http://pediatrics.aappublications.org/content/124/4/1193>).
22. Screening for critical congenital heart disease using pulse oximetry should be performed in newborns, after 24 hours of age, before discharge from the hospital, per "Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart Disease" (<http://pediatrics.aappublications.org/content/129/1/190.full>).
23. Schedules, per the AAP Committee on Infectious Diseases, are available at http://redbook.solutions.aap.org/SS/Immunization_Schedules.aspx. Every visit should be an opportunity to update and complete a child's immunizations.
24. See "Diagnosis and Prevention of Iron Deficiency and Iron-Deficiency Anemia in Infants and Young Children (0-3 Years of Age)" (<http://pediatrics.aappublications.org/content/126/5/1040.full>).
25. For children at risk of lead exposure, see "Low Level Lead Exposure Harms Children: A Renewed Call for Primary Prevention" (http://www.cdc.gov/nceh/lead/ACCLPP/Final_Document_030712.pdf).
26. Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence areas.
27. Tuberculosis testing per recommendations of the AAP Committee on Infectious Diseases, published in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
28. See "Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents" (http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm).
29. Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*.
30. Adolescents should be screened for HIV according to the USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm>) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
31. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspscerv.htm>). Indications for pelvic examinations prior to age 21 are noted in "Gynecologic Examination for Adolescents in the Pediatric Office Setting" (<http://pediatrics.aappublications.org/content/126/3/583.full>).
32. Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See "Maintaining and Improving the Oral Health of Young Children" (<http://pediatrics.aappublications.org/content/134/6/1224>).
33. Perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>). See "Maintaining and Improving the Oral Health of Young Children" (<http://pediatrics.aappublications.org/content/134/6/1224>).
34. See USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspdsnch.htm>). Once teeth are present, fluoride varnish may be applied to all children every 3-6 months in the primary care or dental office. Indications for fluoride use are noted in "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://pediatrics.aappublications.org/content/134/3/626>).
35. If primary water source is deficient in fluoride, consider oral fluoride supplementation. See "Fluoride Use in Caries Prevention in the Primary Care Setting" (<http://pediatrics.aappublications.org/content/134/3/626>).

Summary of Changes Made to the Bright Futures/AAP Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)

This schedule reflects changes approved in February 2017 and published in April 2017.

For updates, visit www.aap.org/periodicityschedule.

For further information, see the *Bright Futures Guidelines*, 4th Edition, *Evidence and Rationale* chapter (https://brightfutures.aap.org/Bright%20Futures%20Documents/BF4_Evidence_Rationale.pdf).

CHANGES MADE IN FEBRUARY 2017

HEARING

- Timing and follow-up of the screening recommendations for hearing during the infancy visits have been delineated. Adolescent risk assessment has changed to screening once during each time period.
- Footnote 8 has been updated to read as follows: "Confirm initial screen was completed, verify results, and follow up, as appropriate. Newborns should be screened, per 'Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs' (<http://pediatrics.aappublications.org/content/120/4/898.full>)."
- Footnote 9 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."
- Footnote 10 has been added to read as follows: "Screen with audiometry including 6,000 and 8,000 Hz high frequencies once between 11 and 14 years, once between 15 and 17 years, and once between 18 and 21 years. See 'The Sensitivity of Adolescent Hearing Screens Significantly Improves by Adding High Frequencies' ([http://www.jahonline.org/article/S1054-139X\(16\)00048-3/fulltext](http://www.jahonline.org/article/S1054-139X(16)00048-3/fulltext))."

PSYCHOSOCIAL/BEHAVIORAL ASSESSMENT

- Footnote 13 has been added to read as follows: "This assessment should be family centered and may include an assessment of child social-emotional health, caregiver depression, and social determinants of health. See 'Promoting Optimal Development: Screening for Behavioral and Emotional Problems' (<http://pediatrics.aappublications.org/content/135/2/384>) and 'Poverty and Child Health in the United States' (<http://pediatrics.aappublications.org/content/137/4/e20160339>)."

TOBACCO, ALCOHOL, OR DRUG USE ASSESSMENT

- The header was updated to be consistent with recommendations.

DEPRESSION SCREENING

- Adolescent depression screening begins routinely at 12 years of age (to be consistent with recommendations of the US Preventive Services Task Force [USPSTF]).

MATERNAL DEPRESSION SCREENING

- Screening for maternal depression at 1-, 2-, 4-, and 6-month visits has been added.
- Footnote 16 was added to read as follows: "Screening should occur per 'Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice' (<http://pediatrics.aappublications.org/content/126/5/1032>)."

NEWBORN BLOOD

- Timing and follow-up of the newborn blood screening recommendations have been delineated.
- Footnote 19 has been updated to read as follows: "Confirm initial screen was accomplished, verify results, and follow up, as appropriate. The Recommended Uniform Newborn Screening Panel (<http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/uniformscreeningpanel.pdf>), as determined by The Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, and state newborn screening laws/regulations (<http://genes-r-us.uthscsa.edu/sites/genes-r-us/files/nbsdisorders.pdf>) establish the criteria for and coverage of newborn screening procedures and programs."
- Footnote 20 has been added to read as follows: "Verify results as soon as possible, and follow up, as appropriate."

NEWBORN BILIRUBIN

- Screening for bilirubin concentration at the newborn visit has been added.
- Footnote 21 has been added to read as follows: "Confirm initial screening was accomplished, verify results, and follow up, as appropriate. See 'Hyperbilirubinemia in the Newborn Infant \geq 35 Weeks' Gestation: An Update With Clarifications' (<http://pediatrics.aappublications.org/content/124/4/1193>)."

DYSLIPIDEMIA

- Screening for dyslipidemia has been updated to occur once between 9 and 11 years of age, and once between 17 and 21 years of age (to be consistent with guidelines of the National Heart, Lung, and Blood Institute).

SEXUALLY TRANSMITTED INFECTIONS

- Footnote 29 has been updated to read as follows: "Adolescents should be screened for sexually transmitted infections (STIs) per recommendations in the current edition of the AAP *Red Book: Report of the Committee on Infectious Diseases*."

HIV

- A subheading has been added for the HIV universal recommendation to avoid confusion with STIs selective screening recommendation.
- Screening for HIV has been updated to occur once between 15 and 18 years of age (to be consistent with recommendations of the USPSTF).
- Footnote 30 has been added to read as follows: "Adolescents should be screened for HIV according to the USPSTF recommendations (<http://www.uspreventiveservicestaskforce.org/uspstf/uspshivi.htm>) once between the ages of 15 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually."

ORAL HEALTH

- Assessing for a dental home has been updated to occur at the 12-month and 18-month through 6-year visits. A subheading has been added for fluoride supplementation, with a recommendation from the 6-month through 12-month and 18-month through 16-year visits.
- Footnote 32 has been updated to read as follows: "Assess whether the child has a dental home. If no dental home is identified, perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>) and refer to a dental home. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 'Maintaining and Improving the Oral Health of Young Children' (<http://pediatrics.aappublications.org/content/134/6/1224>)."
- Footnote 33 has been updated to read as follows: "Perform a risk assessment (<http://www2.aap.org/oralhealth/docs/RiskAssessmentTool.pdf>). See 'Maintaining and Improving the Oral Health of Young Children' (<http://pediatrics.aappublications.org/content/134/6/1224>)."
- Footnote 35 has been added to read as follows: "If primary water source is deficient in fluoride, consider oral fluoride supplementation. See 'Fluoride Use in Caries Prevention in the Primary Care Setting' (<http://pediatrics.aappublications.org/content/134/3/626>)."

Hearing Screening and Anticipatory Guidance

RATIONALE

The Child Health and Disability Prevention (CHDP) Program supports the early identification of all children with a hearing loss, in concert with the national initiative [Healthy People 2020](#) (United States Department of Health and Human Services, Public Health Service, 2010). One to three infants of every one-thousand live births are born deaf or hard of hearing.¹ These children must be identified as early as possible to ensure normal language, cognition, and psychosocial development. It is also imperative to maintain an ongoing program to monitor children for fluctuating hearing loss due to otitis media, progressive or late-onset hearing loss, or a permanent loss from childhood disease and/or loud noise.

The Joint Committee on Infant Hearing (JCIH) endorses early detection of and intervention for infants with hearing loss. The goal of early hearing detection and intervention (EHDI) is to maximize linguistic competence and literacy development for children who are deaf or hard of hearing. Without appropriate opportunities to learn language, these children will fall behind their hearing peers in communication, cognition, reading, and social-emotional development. To maximize the outcome for infants who are deaf or hard of hearing, the hearing of all infants should be screened at no later than 1 month of age. Those who do not pass screening should have a comprehensive audiological evaluation at no later than 3 months of age. Infants with confirmed hearing loss should receive appropriate intervention at no later than 6 months of age from health care and education professionals with expertise in hearing loss and deafness in infants and young children².

The state of California Child Health and Disability Prevention (CHDP) program is implementing CHDP periodicity schedules to conform with the American Academy of Pediatrics [Bright Futures Recommendations for Periodic Preventive Health Care](#) and will provide updated CHDP hearing screening guidelines as information becomes available.

SCREENING REQUIREMENTS

- Review family and medical history for indicators associated with hearing loss. See [Table 1](#): Risk Indicators Associated With Permanent Congenital, Delayed-Onset, Or Progressive Hearing Loss In Childhood.
- Examine ears, head, **and** neck for structural defects or abnormalities.
- At each assessment visit, monitor for auditory skills, middle ear status, and developmental milestones (from JCIH 2007 position statement)
- Assess auditory responsiveness and speech development of young children.

Hearing Screening and Anticipatory Guidance

- See [Table 2](#): Behaviors Indicating Possible Hearing Loss or Speech and Language Delay.
- Administer a validated global screening tool at 9, 18, and 24-30 months (from JCIH 2007 position statement)
- Screen for hearing of children age three to 21 years at each health assessment³ visit using a pure tone air conduction audiometer with intensity levels not exceeding 25 decibels (dB) at frequency levels of 1000, 2000, and (3000 Hz is optional) 4000 Hz.
See “Guidelines for Audiometric Testing.”

Bright Futures*

[Bright Futures, 3rd Edition Guidelines and Pocket Guide.](#)

OTOACOUSTIC EMISSIONS (OAE) TECHNOLOGY **

CHDP providers have questioned whether they can use OAE for screening hearing during a CHDP health assessment. OAE technology is sensitive to outer hair cell function in the inner ear. The technology can be used to assess inner ear hearing loss. OAE evaluations do not measure neural (i.e., eighth nerve or auditory brainstem pathway) function and the results of the OAE evaluation can be misinterpreted if outer or middle ear pathology is present. The procedure also requires a co-operative child in a quiet state with a properly fitted probe to ensure reliability of the stimulus presentation. See [Table 2](#). Behaviors Indicating Possible Hearing Loss Or Speech And Language Delay for age ranges.

Although use of OAE technology has application in the hearing screening of newborns and in the diagnosis of hearing loss, the CHDP Program does not recognize this procedure as standard of practice for screening of a child’s hearing as part of a CHDP health assessment. Therefore, CHDP Program will not reimburse for its use.

**See [CHDP Provider Information Notice 03-23](#) and [CHDP Provider Information Notice 03-25](#) November 14, 2003. Program Letter:

Qualifications of Personnel Performing an Audiometric Screening

- All persons administering a pure tone audiometric screening for the CHDP health assessment on children age three to six years using the [Audiometric Screening and Play Audiometry](#) method and on children age seven to twenty years using the traditional (hand raising) method must have completed a training course in Audiometric Screening and Play Audiometry and receive a certificate from their local CHDP program. Only those persons who complete the training and earn a certificate are qualified to conduct audiometric screening.

Hearing Screening and Anticipatory Guidance

- Play Audiometry method is the preferred method to administer an individualized pure tone air conduction audiometric screening test to children age three to six years immediately upon audiometric screening training certification.
- If a screener has not administered a hearing screening test within a year of their training course, the screener must repeat the training.
- Certification for Audiometric Screening and Play Audiometry is valid for four years. Recertification is required any time prior to the fourth year.

Guidelines for Audiometric Testing:

- For children 3 years and older use a pure tone audiometer to conduct hearing screening tests. The pure tone audiometer must meet or exceed specifications for type 4 audiometers as defined by the American National Standards Institute (ANSI) S3.6-1996 (revision of S2.6-1989). Each audiometer must be calibrated annually, be powered by alternation current (AC) as required for their accuracy and long life. The pure tone audiometer must have the minimum ability to:
 - Produce intensities between 0 to 80 dB.
 - Produce frequencies at 1000, 2000, and 4000 Hz with 3000 Hz being optional.
 - Have a headset with right and left earphones.
 - Be operated manually.
- When testing by air conduction, cover both ears with an earphone and cushion ANSI S3.6 2010.
- Do not use speech materials for the testing procedure because these materials fail to identify individuals with hearing in the frequency range above 500 Hz.
- It is also recommended, but not required, that the audiometer include the capacity to produce a pulse tone. If the audiometer does not have a pulsed tone option, create a pulse manually by pushing the tone control button multiple times.
- CHDP providers are responsible to secure non-colored blocks and non-noise producing basket as instructed at the Audiometric Screening and Play Audiometric Training.
- Test the audiometer each day prior to use to determine if it is working properly. A person with normal hearing should do this. Listen to the sounds from each earphone. If unwanted sounds or interruptions occur (e.g. crackling, static, buzzing, etc.) do not use the audiometer. Instead, arrange for the audiometer to be serviced.
- Assess the testing room for noise level prior to the start of testing. To ensure the testing room is quiet enough to perform the hearing screening, a person with

Hearing Screening and Anticipatory Guidance

normal hearing should put the earphones on and be able to hear each frequency (1000-4000 Hz) at 15 decibels.

- Perform an electroacoustic calibration check of an audiometer at least every 12 months or more frequently, if indicated. If the audiometer fails to meet any of the ANSI S3.6 2010, provide for electroacoustic adjustments so that all standards are met before using the audiometer for screening.
- Keep a calibration chart or sticker with the audiometer showing proof of performance.
- Clean earphones with non-alcoholic wipes in between screening each child.
- Earphones are not interchangeable with other audiometers. Earphones are calibrated with the specific audiometer.

CONSIDERATIONS FOR REFERRAL TREATMENT AND/OR FOLLOW-UP

- Repeat an audiometric screening when the pathology causing an initial failure of the screening has resolved.
- Refer children (3 years and older) who fail to respond to any frequency on two screenings separated by an interval of at least six weeks after the initial screening to an audiologist or California Children Services (CCS) See section for "[California Children Services](#)."
- Refer to an audiologist when children with special health care needs cannot be screened using standard testing procedures.

Table 1. RISK INDICATORS ASSOCIATED WITH PERMANENT CONGENITAL, DELAYED-ONSET, OR PROGRESSIVE HEARING LOSS IN CHILDHOOD ⁴

Age	Risk Indicators
<p>For use with neonates (birth through age 28 days) when universal screening is not available.</p>	<p><u>Risk indicators that are marked with a “§” are of greater concern for delayed-onset hearing loss.</u></p> <ol style="list-style-type: none"> 1. Caregiver concern§ regarding hearing, speech, language, or developmental delay. 2. Family history§ of permanent childhood hearing loss. 3. Neonatal intensive care of more than 5 days or any of the following regardless of length of stay: ECMO,§ assisted ventilation, exposure to ototoxic medications (gentamycin and tobramycin) or loop diuretics

Hearing Screening and Anticipatory Guidance

	<p>(furosemide/Lasix), and hyperbilirubinemia that requires exchange transfusion</p> <ol style="list-style-type: none"> 4. In utero infections, such as CMV, § herpes, rubella, syphilis, and toxoplasmosis. 5. Craniofacial anomalies, including those that involve the pinna, ear canal, ear tags, ear pits, and temporal bone anomalies. 6. Physical findings, such as white forelock, that are associated with a syndrome known to include a sensorineural or permanent conductive hearing loss 7. Syndromes associated with hearing loss or progressive or late-onset hearing loss, § such as neurofibromatosis, osteopetrosis, and Usher syndrome other frequently identified syndromes include Waardenburg, Alport, Pendred, and Jervell and Lange-Nielson. 8. Neurodegenerative disorders, § such as Hunter syndrome, or sensory motor neuropathies, such as Friedreich ataxia and Charcot-Marie-Tooth syndrome 9. Culture-positive postnatal infections associated with sensorineural hearing loss, § including confirmed bacterial and viral (especially herpes viruses and varicella) meningitis. 10. Head trauma, especially basal skull/temporal bone fracture § that requires hospitalization. 11. Chemotherapy §
<p>For use with infants (age 29 days through 2 years) when certain health conditions develop that require rescreening.</p>	<ol style="list-style-type: none"> 1. Parent/caregiver concern regarding hearing, speech, language, and/or developmental delay. 2. Bacterial meningitis and other infections associated with sensorineural hearing loss. 3. Head trauma associated with loss of consciousness or skull fracture. 4. Stigmata or other findings associated with a syndrome known to include a sensorineural and/or conductive hearing loss. 5. Ototoxic medications, including but not limited to chemotherapeutic agents or aminoglycosides, used in multiple courses or in

Hearing Screening and Anticipatory Guidance

	<p>combination with loop diuretics. 6. Recurrent or persistent otitis media with effusion for at least three months.</p>
<p>For use with infants (age 29 days through three years) who require periodic monitoring of hearing.</p> <p>Some newborns and infants may pass initial hearing screening but require periodic monitoring of hearing to detect delayed-onset sensorineural and/or conductive hearing loss. Infants with these indicators require hearing evaluation at least every six months until age three years and at appropriate intervals thereafter.</p>	<p>. Indicators associated with delayed-onset <u>sensorineural</u> hearing loss include:</p> <ul style="list-style-type: none"> • Family history of hereditary childhood hearing loss. • In utero infection, such as cytomegalovirus, rubella, syphilis, herpes, or toxoplasmosis. • Neurofibromatosis Type II and neurodegenerative disorders. <p>2. Indicators associated with <u>conductive</u> hearing loss include:</p> <ul style="list-style-type: none"> • Recurrent or persistent otitis media with effusion. • Anatomic deformities and other disorders that affect eustachian tube function. • Neurodegenerative disorders.

Source: JOINT COMMITTEE ON INFANT HEARING *Position Statement 2007*

Infant Diagnostic Hearing Evaluation

The diagnostic audiologic evaluation of an infant should include both developmentally appropriate behavioral measures, objective physiologic threshold measures using frequency specific (tonal/toneburst) stimuli and a measure of middle ear function.

Source: California Department of Health Care Services, Children’s Medical Services Branch, California Children’s Services Program.

Guidelines for Audiometric Testing for Children Over Six Years of Age:

- Use a pure tone audiometer to conduct hearing screening tests. The pure tone audiometer must meet or exceed specifications for type 4 audiometers as defined by the American National Standards Institute (ANSI) S3.6-1996 (revision of S2.6-1989). Each audiometer must be calibrated annually, be powered by alternation current (AC) as required for their accuracy and long life. The pure tone audiometer must have the minimum ability to:
 - Produce intensities between 0 to 80 dB.

Hearing Screening and Anticipatory Guidance

- Produce frequencies at 1000, 2000, and 4000 Hz with 3000 Hz being optional.
- Have a headset with right and left earphones.
- Be operated manually.

Screening Method:

- Patient will respond to the “beep” by raising their hand***.

***Refer to page 3, “Guidelines for Audiometric Testing” for further instructions.

Hearing Screening and Anticipatory Guidance

Table 2. BEHAVIORS INDICATING POSSIBLE HEARING LOSS OR SPEECH AND LANGUAGE DELAY ⁴

Age	Hearing, Speech, and Language	Auditory Test
Birth-3 months	No startle to loud sounds. Does not awaken to sounds. Does not blink or widens eyes in response (reflex) to noises.	OAE's Automated ABR
3-4 months	Does not quiet to mother's voice. Does not stop playing to listen to new sounds. Does not look for source of new sounds not in sight.	COR or VRA
6-9 months	Does not enjoy musical toys. Does not coo and gurgle with inflection. Does not say "mama"	COR or VRA
12-15 months	Does not respond to his or her name and "no" Does not follow simple requests. Does not use expressive vocabulary of 3 to 5 words. Does not imitate some sounds.	COR or VRA
18 to 24 months	Does not know body parts Does not use expressive vocabulary 2-word phrases (minimum of 20 to 50 words) 50% of speech intelligible to strangers.	COR or VRA
3 years	Does not use expressive vocabulary 4-5 word sentences (approximately 500 words) Speech is not 80% intelligible to strangers Does not understand some verbs	COR or VRA Play Audiometry
	Cannot carry on a simple conversation.	COR or VRA Play Audiometry

Hearing Screening and Anticipatory Guidance

4 years	< 1000 words. Says less than four word complex sentences. < 90 percent understandable.	
5 years	Has delayed speech and language.	COR or VRA Play Audiometry

Hearing Screening and Anticipatory Guidance

CALIBRATION SERVICES

It is recommended that audiometers be purchased through agencies that provide readily available repair and calibration services. The following is a partial list of resources specializing in audiometric equipment that are located throughout California.

Hearing Screening and Anticipatory Guidance

PURETONE ADIOMETERS, SALES, REPAIRS, AND CALIBRATION SERVICES

RESOURCES	PHONE NUMBERS	WEBSITE	CONTACTS
STATEWIDE			
AMBCO ELECTRONIC, INC. 15052 Redhill Avenue, Suite D Tustin, CA 92780	800-345-1079 Tel: 714-259-7930 Fax: 714-259-1688	http://www.ambco.com/	Aida Xiong
NORTHERN CALIFORNIA			
AUDIOLOGY SYSTEMS INC. (ASI) 4615 Glass Court, Suite D Modesto, CA 95356	800-227-1130 Tel: 209-549-9308 Fax: 209-549-9775	www.audiologysystems.com	John Brewer
MEDI 4814 East Second Street Benecia, CA 94510	800-736-6334 Tel: 707-746-6334 Fax: 707-746-6374	http://www.medi.cc/	Phil Korbas Donna Ward
HEALTH CARE INSTRUMENT (HCI) AUDIOMETRICS 2122 College Ave Modesto, CA 95350-3044	800-653-3277 Tel: 209-491-0420 Fax: 209-491-0413	http://www.manta.com/c/m/mlk67t/health-care-instruments-inc	Dan Hatch
SOUTHERN CALIFORNIA			
HEALTH CARE INSTRUMENT (HCI) AUDIOMETRICS 909 S. Tremont Street Oceanside, CA 92054	800-873-1222 Tel: 760-435-1034 Fax: 760-435-1334	http://www.audiometrics.net/	Jeff Pommier
ELECTRO-MEDICAL INSTRUMENTATION 8475 Arcadia Blvd, Suite 104 Buena Park, CA 90621	800-273-3340 Tel: 714-690-2970 Fax: 714-690-2921	No website	Jack Beard Robert Stewart
SAN-VAL ELECTRONIC LAB (Calibration Service Only) 215 Jeffries Avenue Monrovia, CA 91016	Tel: 626-574-5572 Fax: 626-574-5572	No website	Phillip A. Feola
HEAR & C Hearing Equipment, Audiometer Repairs & Calibration 14528 Jalisco Road La Mirada, CA 90638	Tel: 714-739-8121 Fax: 714-752-6428 Cell: 562-743-3997	daniel@hearandc.com	Daniel Gomez
AUDIOLOGY SYSTEMS INC. (ASI) 16037 Valley View Ave, Santa Fe Springs, CA 90670	800-982-7762 Tel: 562-921-1427		Tammy Dinan

Hearing Screening and Anticipatory Guidance

Resources:

- American Academy of Pediatrics. (2014). [Bright Futures American Academy of Pediatrics](#).
- Moeller M. [Early intervention and language development in children who are deaf and hard of hearing](#). Pediatrics. 2000 Sep; 106(3):e43.
- [Infant Audiology Assessment Guidelines](#), Department of Health Care Services, July 2010.

References:

- ¹ [Healthy People 2020: Hearing and Other Sensory or Communication Disorders](#).
- ² Joint Committee on Infant Hearing. AMERICAN ACADEMY OF PEDIATRICS: [Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs](#).
- ³ [Bright Futures/AAP Periodicity Schedule](#).
- ⁴ American Academy of Pediatrics: [Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening](#), Table 2 and Table 3.

*American Academy of Pediatrics materials linked to with permission for reference only. Use of these materials beyond the scope of these guidelines must be reviewed and approved by the American Academy of Pediatrics, who can be reached at marketing@aap.org.



Toby Douglas
Director

State of California—Health and Human Services Agency
Department of Health Care Services



Edmond G. Brown Jr
Governor

December 14, 2011

N.L.: 11-1211

Index: Benefits

Supersedes: NL 21-1299

TO: CALIFORNIA CHILDREN'S SERVICES (CCS) COUNTY ADMINISTRATORS, MEDICAL CONSULTANTS AND STATE CHILDREN'S MEDICAL SERVICES AND REGIONAL OFFICE STAFF

SUBJECT: AUTHORIZATION OF DIAGNOSTIC AUDIOLOGY AND TREATMENT SERVICES FOR CHILDREN WITH HEARING LOSS

This numbered letter supersedes CCS NL 21-1299 and clarifies the authorization of services for children suspected of having hearing loss and those subsequently diagnosed with hearing loss.

I. Background

The CCS Program's medical eligibility regulations, Title 22, Section 41518, delineate the California Code of Regulation (CCR) program eligibility for diagnostic services to determine the presence of a hearing loss when the applicant:

- A. Fails two pure tone audiometric screenings conducted six weeks apart;
- B. Fails to have a normal Auditory Brainstem Response (ABR);
- C. Fails Otoacoustic Emissions (OAEs) or behavioral responses two times, conducted six weeks apart;
- D. Exhibits symptoms such as poor speech for age or delay in age-appropriate behavioral milestones; or
- E. Has documentation of risk factors associated with a hearing loss.

When a screening is performed by an audiologist or an otolaryngologist, only one screen is necessary before a referral for diagnostic services. Children diagnosed with atresia of the external auditory canal and/or microtia of the pinna are medically eligible for further audiologic evaluations to determine the severity of the hearing loss and

treatment recommendations. Risk factors for hearing loss can be found in the most recent Joint Committee for Infant Hearing (JCIH) Position Paper (the Year 2007 position paper titled Principles and Guidelines for Early Hearing Detection and Intervention Programs), and include:

- A. Caregiver concern regarding hearing, speech, language, or developmental delay;
- B. Family history;
- C. Neonatal intensive care for more than five days;
- D. Regardless of length of stay: extracorporeal membrane oxygenation (ECMO), assisted ventilation, exposure to ototoxic medications, exposure to loop diuretics, and hyperbilirubinemia requiring exchange transfusion;
- E. In-utero infections;
- F. Culture-positive postnatal infections associated with hearing loss;
- G. Syndromes associated with hearing loss and physical findings associated with a syndrome known to include hearing loss;
- H. Neurodegenerative disorders;
- I. Head trauma requiring hospitalization;
- J. Chemotherapy.

Subsequent to the identification of a hearing loss, on-going services for monitoring and treatment are necessary. Often with very young children, multiple evaluations are necessary in order to further define the degree of the loss at specific frequencies. Periodic evaluations are also necessary to monitor children for fluctuating or progressive hearing loss. Regular treatment visits, including hearing aid monitoring and adjustments, as well as aural rehabilitation and speech therapy, are imperative for the continued language development of the child. Though some services may be offered in the public school system and Early Start Program, often these services are focused on the specific educational needs of the child and only complement those medically necessary services authorized by the CCS Program.

Following the implementation of the Enhancement 47 (E47) authorization system in 2004, Service Code Groupings (SCG) were developed to allow CCS-approved Special Care Centers access to all the appropriate Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes necessary for the care of children with specific medical conditions. The SCG 04 includes all the audiology diagnostic codes, as well as rehabilitation and speech therapy codes that a provider treating a child with hearing loss may need. Additionally, the SCG 01 can be authorized to a physician for further medical assessment and follow-up. With all the counties now using CMS Net, specific guidelines for the authorization of diagnostic and treatment services are necessary.

II. Policy

A. Eligibility for Diagnostic Evaluation

1. If a child is referred for a diagnostic evaluation and does not have a condition delineated in Title 22, Section 41518, or a risk factor indicated by the most current JCIH Position Paper, a referral for a hearing screening should be recommended. Children who are Medi-Cal beneficiaries may have periodic hearing examinations in an outpatient setting, subject to the availability of Medi-Service reservations, and do not require a Treatment Authorization Request (TAR).
2. An audiogram from a licensed audiologist performing the service in a facility not approved by CCS, or in a CCS-approved Communication Disorder Center (CDC) that is not appropriate for the age of the child, can be used to determine eligibility for the diagnostic referral to a CCS-approved provider and facility in lieu of the two screenings required.
3. When a child presents with a condition eligible to receive diagnostic services or a risk factor delineated by the most current JCIH Position Paper, as per Title 22, Section 41518, CCS shall authorize diagnostic services to an age-appropriate CDC for 180 days or through the program eligibility period. Children with unilateral or bilateral atresia of the external ear canal and/or microtia of the pinna are also eligible for diagnostic services and should be authorized the SCG 04 for 180 days or through the program eligibility period.

4. A child who presents to CCS with an evaluation by a CCS-approved, age appropriate type Communication Disorder Center that indicates medical eligibility for hearing loss may be determined eligible for treatment and does not require an additional authorization or evaluation for diagnostic services.

B. Eligibility for Treatment

1. Eligibility for the treatment of hearing loss must be determined by an evaluation completed by a CCS-paneled audiologist at an appropriate type Communication Disorder Center.
2. CCS medical eligibility for treatment is found in Title 22, Section 41518, and includes the audiometric criteria for hearing loss requiring audiologic treatment. Transient or temporary hearing loss caused by otitis media where medical intervention is the preferred choice of treatment is not considered medically eligible for the authorization of treatment services. If the transient or temporary hearing loss progresses to a long term hearing loss (consistently present for 3 or more months) and/or requires audiology treatment, the child is eligible for the authorization of treatment services.
3. Additional hearing diagnoses, (e.g. Central Auditory Processing Disorder), are not medically eligible conditions independent of the audiometric criteria in the regulations. Medical eligibility must be determined by the audiometric standards as delineated in Title 22, Section 41518.
4. Once medical eligibility has been determined by the CCS program, the SCG 04 must be authorized to an age-appropriate CDC and medical services must be authorized, including an otolaryngology (ENT) evaluation, ophthalmologic examination, and if requested, a genetics evaluation (see NL 08-1011). The ENT will provide medical clearance for hearing aids when appropriate, as well as conduct additional assessments to determine the etiology of the hearing loss and any associated conditions. The ophthalmologic examination is needed to identify visual deficits to ensure optimum environmental stimulation through vision given that hearing is deficient. The genetics evaluation is necessary to rule out genetic syndromes that are associated with vision and hearing problems. It is also appropriate to authorize the Primary Care Physician, or medical home, to provide ongoing care in the community for health problems that impact hearing loss.

5. Once a child has been identified with the type and degree of hearing loss and program eligibility has been established, the CCS Program shall authorize treatment services through the program eligibility date. The treatment authorization(s) shall be renewed annually, pending program eligibility.
6. Authorization for amplification devices should not be delayed if the ophthalmologic examination or genetics evaluation has not been completed. Amplification devices should be authorized separately according to Numbered Letters 12-0605 and 07-1011.

III. Policy Implementation

A. Authorization of Diagnostic Evaluations

1. The SCG 04 shall be issued to the appropriate type Communication Disorder Center, Special Care Center number, beginning with a 7.3..., for 180 days, and shall be issued under the diagnostic category. These authorizations should not have the EPSDT-SS box checked, regardless of the child's program eligibility.
2. For diagnostic authorizations originating from referrals through the Newborn Hearing Screening Program (NHSP) see NL 06-1008. An authorization to a CCS-approved ENT should be issued simultaneously for NHSP referrals.
3. An authorization issued to beneficiaries with private health insurance coverage must include all diagnostic testing and evaluation procedure codes contained in the SCG 04.

B. Authorizations for Treatment Services

Once program eligibility is established with the presence of a hearing loss, the following authorizations shall be issued through the program eligibility time period.

1. The SCG 04 to the CDC managing the audiologic care of the child. These authorizations should not have the EPSDT-SS box checked, regardless of the child's eligibility program.

N.L.: 11-1211

Page 6

December 14, 2011

2. The SCG 01 to the paneled ENT for the determination of hearing loss etiology and medical clearance of hearing aids, if indicated.
3. The SCG 01 to the ophthalmologist for vision assessment. If requested, the SCG 01 to the geneticist according to NL 08-1011.
4. The SCG 01 to the Primary Care Physician in the community managing the overall health of the child.
5. Separate authorizations are necessary for hearing aids, assistive listening devices, and hearing aid batteries and accessories, and should be reviewed and processed according to Numbered Letters 12-0605, 11-0807, and 07-1011.
6. If requested, a CCS-approved speech pathologist may be issued the appropriate CPT and HCPCS codes necessary for ongoing speech therapy as it relates to the hearing loss.
7. If requested, a CCS-approved Communication Disorder Center which is also a CCS-approved Cochlear Implant Center may be issued the SCG 05 to their Cochlear Implant Center number (7.36...) in lieu of the SCG 04 for audiological management and Cochlear Implant evaluation and post-surgical services. Please refer to related Cochlear Implant numbered letters for authorization instructions.

Should you have any questions regarding the authorization of audiology services, please contact the CCS Audiology Consultants at AudConsult@dhcs.ca.gov.

Thank you for your services to California's children.

Sincerely,

Original Signed by Robert Dimand, M.D.

Robert Dimand, M.D.
Chief Medical Officer
Children's Medical Services



Los Angeles County Children's Medical Services California Children's Services

Provider Bulletin

DATE: July 29, 2014

SUBJECT: FAX NUMBER, FAX COVER SHEET / CLIENT SEPARATOR PAGE, AND SERVICE AUTHORIZATION REQUEST REQUIREMENTS

FAX NUMBER AND FAX COVER SHEET/CLIENT SEPARATOR PAGE

Effective October 2013, providers were instructed to submit all fax requests for services and supporting medical documentation to Los Angeles County CCS at our new fax number 855-481-6821 using the new fax cover sheet/client separator page. This has enabled our office to a) implement a new fax system which digitally receives and processes your faxed documents to our CCS staff, and b) accurately track the status of all faxed documents.

In order to receive/process your faxed documents, they must:

- 1) **Be faxed to fax number (855) 481-6821; AND**
- 2) **Have a CCS Client Separator Page (fax cover sheet) for each CCS patient.**
 - a. The client separator page functions as a fax cover sheet for each individual patient. **Do not intermingle patients under one CCS Client Separator Page.**
 - b. **ALL OF THE PROVIDER INFORMATION AND CLIENT INFORMATION SECTIONS MUST BE COMPLETED AND MUST BE TYPED or PRINTED IN ALL CAPS.** Optical scanners are used to recognize and organize your documents for review by our staff. Whenever possible, please complete the PDF fillable form using your computer. Include the client's CCS# if known.
 - c. **To ensure that your documents are processed correctly, each letter and number must be entered separately into each box.** Please see attached samples for correctly completing the CCS Client Separator Page. You are not required to complete the Comments section, but that information will be used by our case management staff if provided. Faxes/Documents received that do not adhere to these requirements, will be delayed and may not be processed.
 - d. The CCS Client Separator Page is available as a PDF fillable form on our website at: <http://publichealth.lacounty.gov/cms/docs/CCSCSP.pdf>.

SERVICE AUTHORIZATION REQUESTS (SARs)

A Service Authorization Request (SAR) must accompany all requests/referrals from CCS providers for CCS services. These forms are available on the [State's website](#) under "Requesting Services". A SAR is considered incomplete and will not be processed if any of the following information is omitted:

- a) client's first and last name, date of birth, address, and telephone number;
- b) parent or legal guardian's first and last name;
- c) a statement listing the services requested for the client; and
- d) the name and address of the individual or agency requesting the CCS services.

A SAR is not required when submitting supplemental documents for an authorized service on an existing case.

If you have any questions about this process, please feel free to contact our office at 800-288-4584.



fax cover sheet

ONE COVER SHEET PER CLIENT - UPPERCASE ONLY

To: Los Angeles County California Children's Services

Fax: (855) 481-6821



Number of Pages: 10
(Including Cover Sheet)

Provider Information

Name: DR. SMITH

Organization: ABC CLINIC

Phone: 888-555-5555 Return Fax: 888-111-2222



Client Information

Last Name: JONES

First Name: ANGELA

Gender: F

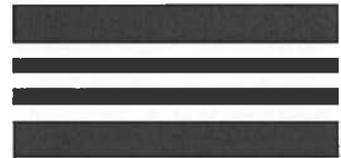
CCS #: 1234567



Date of Birth: 01-01-2000
(MM/DD/YYYY)

Comments:

Confidentiality Notice: This fax is intended for the exclusive use of the recipient named above. It contains information that is protected, privileged, or confidential, and it should not be disseminated, distributed, or copied to persons not authorized to receive such information. If you are not the intended recipient, any dissemination, distribution, or copying is strictly prohibited. If you received this fax in error, please notify the sender immediately. Thank you.



fax cover sheet

ONE COVER SHEET PER CLIENT - UPPERCASE ONLY

To: Los Angeles County California Children's Services

Fax: (855) 481-6821



Provider Information

Number of Pages:
(Including Cover Sheet)

1

Name:

Organization:

Phone:

- -

Return
Fax:

- -



Client Information

Last
Name:

First
Name:

Gender:

CCS #:



Date of Birth:
(MM/DD/YYYY)

- -

Comments:

Confidentiality Notice: This fax is intended for the exclusive use of the recipient named above. It contains information that is protected, privileged, or confidential, and it should not be disseminated, distributed, or copied to persons not authorized to receive such information. If you are not the intended recipient, any dissemination, distribution, or copying is strictly prohibited. If you received this fax in error, please notify the sender immediately. Thank you.

NEW REFERRAL CCS/GHPP CLIENT SERVICE AUTHORIZATION REQUEST (SAR)

Provider Information

1. Date of request	2. Provider name	3. Provider number
4. Address (number, street)		City State ZIP code
5. Contact person	6. Contact telephone number ()	7. Contact fax number ()

Client Information

8. Client name—last first middle	
9. Alias (AKA)	10. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
11. Date of birth (mm/dd/yy)	
12. CCS/GHPP case number	13. Medical record number (hospital or office)
14. Home phone number ()	15. Cell phone number ()
16. Work phone number ()	17. Email address
18. Residence address (number, street) (DO NOT USE P.O. BOX) City State ZIP code	
19. Mailing address (if different) (number, street, P.O. box number) City State ZIP code	
20. County of residence	21. Language spoken
22. Name of parent/legal guardian	
23. Mother's first name	24. Primary care physician (if known)
25. Primary care physician telephone number ()	

Insurance Information

26.a. Enrolled in Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No	26.b. If yes, client index number (CIN)	26.c. Client's Medi-Cal number
27. Enrolled in commercial insurance plan <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, type of commercial insurance plan <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Other	Name of plan

Diagnosis

28. Diagnosis (DX)/ICD-10: _____ DX/ICD-10: _____ DX/ICD-10: _____

Requested Services

29.* CPT-4/ HCPCS Code/NDC	30. Specific Description of Service/Procedure	31. From (mm/dd/yy)	To (mm/dd/yy)	32. Frequency/ Duration	33. Units	34. Quantity (Pharmacy Only)

* A specific procedure code/NDC is required in column 27 if services requested are other than ongoing physician authorizations, hospital days, or special care center authorizations.

35. Other documentation attached <input type="checkbox"/> Yes	36. Enter facility name (where requested services will be performed, if other than office).
--	---

Inpatient Hospital Services

37. Begin date	38. End date	39. Number of days
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Additional Services Requested from Other Health Care Provider

40. Provider's name		Provider number	Telephone number ()	Contact person
Address (number, street)		City	State	ZIP code
Description of services		Procedure code	Units	Quantity
Additional information				

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

41. Signature of physician/provider or authorized designee	42. Date
--	----------

Instructions

1. Date of the request: Date the request is being made.

Provider Information

2. Provider's name: Enter the name of the provider who is requesting services.
3. Provider number: Enter National Provider Identification (NPI) number (no group numbers).
4. Address: Enter the requesting provider's address.
5. Contact person: Enter the name of the person who can be contacted regarding the request; all authorizations should be addressed to the contact person.
6. Contact telephone number: Enter the phone number of the contact person.
7. Contact fax number: Enter the fax number for the provider's office or contact person.

Client Information

8. Client name: Enter the client's name—last, first, and middle.
9. Alias (AKA): Enter the patient's alias, if known.
10. Gender: Check the appropriate box.
11. Date of birth: Enter the client's date of birth.
12. CCS/GHPP case number: Enter the client's California Children's Services (CCS)/Genetically Handicapped Persons Program (GHPP) number. If not known, leave blank.
13. Medical record number: Enter the client's hospital or office medical record number.
14. Home phone number: Enter the home phone number where the client or client's legal guardian can be reached.
15. Cell phone number: Enter the cellular phone number where the client or client's legal guardian can be reached.
16. Work phone number: Enter the work phone number where the client or client's legal guardian can be reached.
17. Email address: Enter the email address of the client or client's legal guardian.
18. Residence address: Enter the address of the client. Do not use a P.O. Box number.
19. Mailing address: Enter the mailing address if it is different than number 18.
20. County of residence: Enter residential county of the client.
21. Language spoken: Enter the client's language spoken.
22. Name of parent/legal guardian: Enter the name of client's parent/legal guardian.
23. Mother's first name: Enter the client's mother's first name.
24. Primary care physician: Enter the client's primary care physician's name. If it is not known, enter NK (not known).
25. Primary care physician telephone number: Enter the client's primary care physician phone number.

Insurance Information

- 26a. Enrolled in Medi-Cal? Mark the appropriate box. If the answer is yes, enter the client's index number in box 26.b. and the client's Medi-Cal number in box 26.c.
27. Enrolled in a commercial insurance plan? Mark the appropriate box, if the answer is yes, mark the type of insurance plan and enter the name of the commercial insurance plan on the line provided.

Diagnosis

28. Diagnosis and/or ICD-10: Enter the diagnosis or ICD-10 code, if known, relating to the requested services.

Requested Services

29. CPT-4/HCPCS code/NDC: Enter the CPT-4, HCPCS code or NDC code being requested. This is only required if services requested are other than ongoing physician authorizations or special care center authorizations. Also not required for inpatient hospital stay requests.
30. Specific description of procedure/service: Enter the specific description of the procedure/service being requested.
31. From and to dates: Enter the date you would like the services to begin. Enter the date you would like the services to end. These dates are not necessarily the dates that will be authorized.
32. Frequency/duration: Enter the frequency or duration of the procedures/service being requested.
33. Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
34. Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
35. Other documentation attached: Check this box if attaching additional documentation.
36. Enter facility name: Complete this field with the name of the facility where you would like to perform the surgery you are requesting.

Inpatient Hospital Services

37. Begin date: Enter the date the requested inpatient stay shall begin.
38. End date: Enter the end date for the inpatient stay requested.
39. Number of days: Enter the number of days for the requested inpatient stay.

Additional Services Requested from Other Health Care Providers

40. Provider's name: Enter name of the provider you are referring services to.
Provider number: Enter the provider's National Provider Identification (NPI) number. Telephone: Enter provider's telephone number.
Contact person: Enter the name of the person who can be contacted regarding the request. Address: Enter address of the provider.
Description of services: Enter description of referred services.
Procedure code: Enter the procedure code for requested service other than ongoing physician services.
Units: For NDC, enter total number of fills plus refills. For all other codes, enter the total number/amount of services/supplies requested for SAR effective dates.
Quantity: Use only for products identified by NDC. For drugs, enter the amount to be dispensed (number, ml or cc, gms, etc.). For lancets or test strips, enter the number per month or per dispensing period.
Additional information: Include any written instructions/details here.

Signature

41. Signature of physician or provider: Form must be signed by the physician, pharmacist, or authorized representative.
42. Date: Enter the date the request is signed.

Play Audiometry Guide (For Screener)

A. CONDITIONING

1. Conditioning - *Screening Preparation*

- Position child on your dominant side
- Power on audiometer
- Set audiometer to right ear
- Keep earphones open on the table
- Set audiometer to 90 dB
- Set audiometer to 4000 Hz
- Set audiometer to pulse tone

2. Conditioning - *Present Beep*

- Introduce the game
- Ask child to listen
- Press tone for “1 Mississippi”
- Acknowledge that child heard the sound

3. Conditioning – *Demonstrate Game*

- Screener and child each get a block
- Instruct and prompt child to put block in the basket when beep is heard (screener points to ear and taps basket, but do not put the block in the basket)
- Give empty basket to child

4. Conditioning: *Present the tone, Demonstrate, Screener goes first.*

- Ask child to listen
- Press the tone
- Screener puts block in the basket first
- Child follows after
- Screener praises child: “Wonderful”, “Good Job”, “Awesome”.

A. CONDITIONING

5. Conditioning – *Present Tone, Let Child Win*

- Screener and child each get a block
- Screener: “Let’s see how fast you are.”
- Ask child to listen
- Press tone
- Let the child win (child puts block in the basket first)
- Screener follows after
- Screener praises child

6. Conditioning – *Child Plays Alone*

- Give child a block (screener does not get a block)
- Ask child to listen
- Press tone
- Child puts block in the basket
- Screener praises child

B. CONFIRM

1. Confirm

- Give child a block
- Set audiometer to 50dB, 4000 Hz
- Place earphones on child (red to right ear)
- Ask child to listen
- Press tone
 - a) If child puts block in the basket praise the child, start screening (follow steps C. Screening).
 - b) If child does not put the block in the basket, switch to left ear.
 - c) If child does not put the block in the basket, take off earphones and repeat conditioning (steps 1-6) and steps for confirm (B).
 - d) If child does not put the block in the basket after repeating conditioning (steps 1-6), schedule child for re screen in 2-6 weeks.

C. SCREENING

1. Screening

- Set audiometer to 25 dB, 4000 Hz and right ear
- Give child a block, start screening

2. Right Ear Screening

- Praise child each time they drop block into the basket
- 25 dB 4000 Hz “Listen.” Press tone. Child responds. Give child a block.
- 25 dB 3000 Hz “Listen.” Press tone. Child responds. Give child a block.
- 25 dB 2000 Hz “Listen.” Press tone. Child responds. Give child a block.
- 25 dB 1000 Hz “Listen.” Press tone. Child responds. Give child a block.

IF NO RESPONSE AT ANY OF THE FREQUENCIES (Hz), RECONDITION AT 50 dB (follow reconditioning steps).

3. Left Ear Screening

- Switch to left ear
- Praise child each time they drop block into the basket
- 25 dB 1000 Hz “Listen.” Press tone. Child responds. Give child a block.
- 25 dB 2000 Hz “Listen.” Press tone. Child responds. Give child a block.
- 25 dB 3000 Hz “Listen.” Press tone. Child responds. Give child a block.
- 25 dB 4000 Hz “Listen.” Press tone. Child responds.

IF NO RESPONSE AT ANY OF THE FREQUENCIES (Hz), RECONDITION AT 50 dB (follow reconditioning steps)

4. Remove earphones and thank the child.

5. Complete documentation: Document (√) pass, (-) not pass

If child fails:

- a) 1st time, document in the chart and schedule for a rescreen in 2-6 weeks.
- b) 2nd time, refer to a specialist.
- c) CCS referrals require 2 failed screenings at least 6 weeks apart.

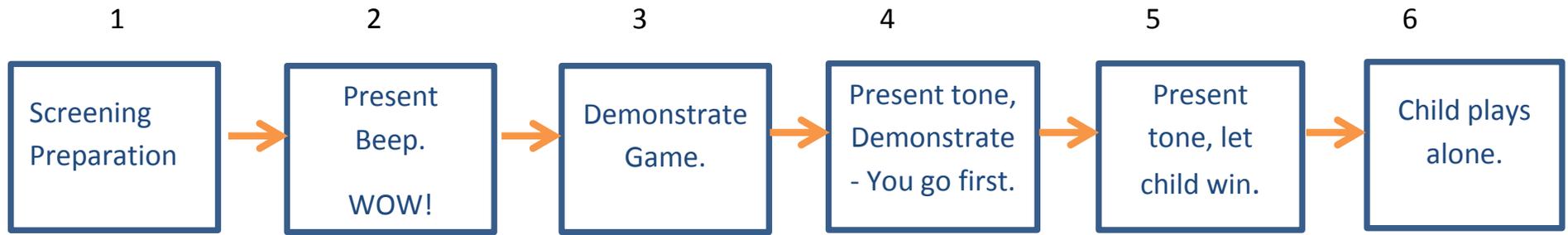
RECONDITIONING STEPS

IF NO RESPONSE AT ANY OF THE FREQUENCIES (1000, 2000, 3000, 4000)

- Stay at same frequency
- Set Audiometer to 50 dB
- Present the beep

If child puts block in the basket:	If child does not put block in the basket:
<ol style="list-style-type: none">1. Praise the child2. Give child a block3. Set audiometer to 25 dB4. Introduce the beep5. Child puts block in the basket<li style="color: red;">(If child does not put block in the basket, immediately document not pass (-) at this frequency)6. Praise the child7. Continue screening at next frequency	<ol style="list-style-type: none">1. Immediately document not pass (-) at this frequency while praising child2. Set audiometer to 25 dB3. Continue screening at next frequency

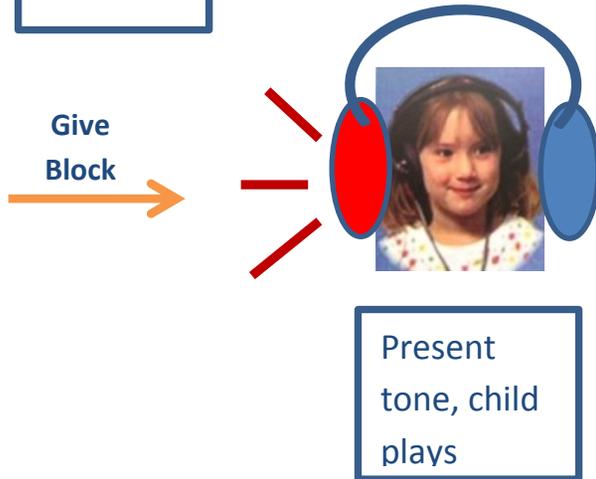
A. Condition: **90 dB**, 4000 Hz, headphones on table



B. Confirm:

50 dB!!

- a) If child puts the block in the basket, start screening.
- b) If child does not put block in the basket switch to left ear.
- c) If child does not put block in the basket, take off earphones and repeat conditioning steps (1-6).
- d) If child does not put block in the basket after conditioning steps 1-6, re screen in 2-6 weeks.

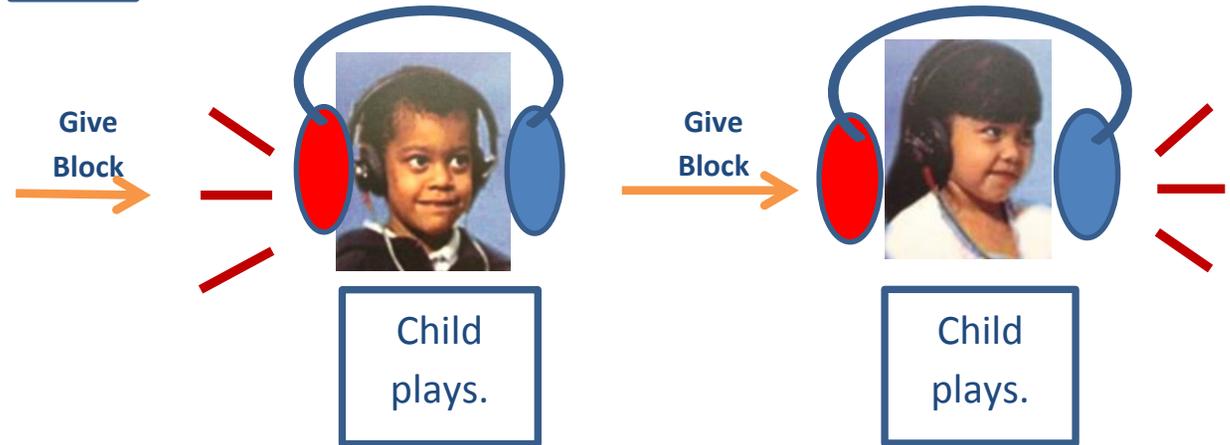


C. Screen:

20 or 25 dB

Give Block 4000 Hz
 Give Block 3000 Hz
 Give Block 2000 Hz
 Give Block 1000 Hz

Give Block 1000 Hz
 Give Block 2000 Hz
 Give Block 3000 Hz
 Give Block 4000 Hz



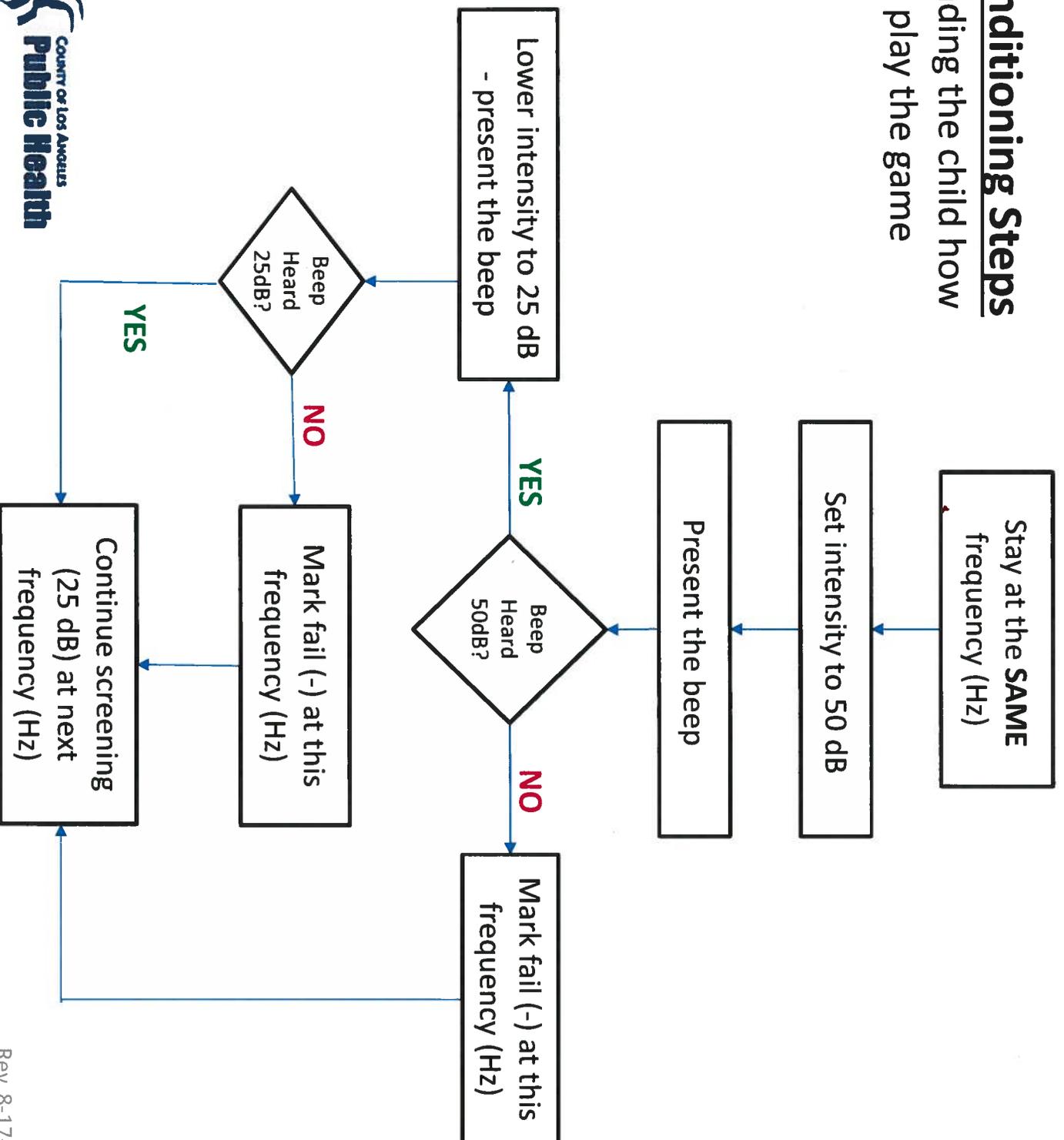
If no response at any of the frequencies (Hz), recondition at 50dB and continue screening

Play Audiometry Flow Sheet



Reconditioning Steps

Reminding the child how to play the game



Traditional Audiometric Screening Guide (For Screener)

A. CONDITIONING

1. Conditioning – *Screening Preparation*

- Position patient on your dominant side
- Power on audiometer
- Set audiometer to right ear
- Keep earphones open on table
- Set audiometer to 90 dB
- Set audiometer to 4000 Hz
- Set audiometer to pulse tone

2. Conditioning - *Present Beep*

- Introduce the test (instruct patient to raise hand when beep is heard)
- Ask patient to listen
- Press tone for “1 Mississippi”
- Acknowledge that patient heard sound (hand raised) “Good job”, “Awesome”

B. CONFIRM

1. Confirm

- Set Audiometer to 50 dB, 4000 Hz
- Place earphones on patient (red to right ear)
- Ask patient to listen
- Press tone
 - a) If patient raises hand, start screening (follow steps C. Screening)
 - b) If patient does not raise hand, switch to left ear and say, “listen” then press tone.
 - c) If patient does not raise hand after b, take earphones off and repeat conditioning steps (A) and confirm steps (B)
 - d) If patient does not raise hand after repeating conditioning steps (A) and confirm (B), schedule patient for rescreen in 2-6 weeks

C. SCREENING

1. Screening

- Set audiometer to 25 dB, 4000 Hz and right ear (7-10 y/o) OR
- Set audiometer to 25 dB, 8000 Hz and right ear (11-21 y/o)
- Start screening

2. Right Ear Screening (7-10 y/o)

- Praise patient each time hand is raised (right or left)
- 25 dB 4000 Hz "Listen." Press tone. Patient responds
- 25 dB 3000 Hz "Listen." Press tone. Patient responds
- 25 dB 2000 Hz "Listen." Press tone. Patient responds
- 25 dB 1000 Hz "Listen." Press tone. Patient responds

2. Right Ear Screening (11-21 y/o)

- Praise patient each time hand is raised (right or left)
- 25 dB 8000 Hz "Listen." Press tone. Patient responds
- 25 dB 6000 Hz "Listen." Press tone. Patient responds
- 25 dB 4000 Hz "Listen." Press tone. Patient responds
- 25 dB 3000 Hz "Listen." Press tone. Patient responds
- 25 dB 2000 Hz "Listen." Press tone. Patient responds
- 25 dB 1000 Hz "Listen." Press tone. Patient responds

IF NO RESPONSE AT ANY OF THE FREQUENCIES (Hz), RECONDITION AT 50 dB (follow reconditioning steps)

3. Left Ear Screening (7-10 y/o)

- Praise patient each time hand is raised (right or left)
- 25 dB 1000 Hz "Listen." Press tone. Patient responds
- 25 dB 2000 Hz "Listen." Press tone. Patient responds
- 25 dB 3000 Hz "Listen." Press tone. Patient responds
- 25 dB 4000 Hz "Listen." Press tone. Patient responds

3. Left Ear Screening (11-21 y/o)

- Praise patient each time hand is raised (right or left)
- 25 dB 1000 Hz "Listen." Press tone. Patient responds
- 25 dB 2000 Hz "Listen." Press tone. Patient responds
- 25 dB 3000 Hz "Listen." Press tone. Patient responds
- 25 dB 4000 Hz "Listen." Press tone. Patient responds

- 25 dB 6000 Hz “Listen.” Press tone. Patient responds
- 25 dB 8000 Hz “Listen.” Press tone. Patient responds

IF NO RESPONSE AT ANY OF THE FREQUENCIES (Hz), RECONDITION AT 50 dB (follow reconditioning steps)

4. Remove earphones and thank the patient.
5. Complete documentation: Document (√) pass and (-) not pass
If patient fails:
 - a) 1st time, document in the chart and schedule for a rescreen in 2-6 weeks.
 - b) 2nd time, refer to a specialist.
 - c) CCS referrals require 2 failed screenings at least 6 weeks apart.

RECONDITIONING STEPS

IF NO RESPONSE AT ANY OF THE FREQUENCIES (Hz)

(1000, 2000, 3000, 4000, 6000, 8000)

- Stay at the same frequency
- Set Audiometer to 50 dB
- Present the beep

If patient raises hand:	If patient does not raise hand:
<ul style="list-style-type: none"> • Set audiometer to 25dB • Introduce the beep • Patient raises hand (If patient does not raise hand, immediately document not pass (-) at this frequency) • Praise the patient • Continue screening at next frequency 	<ul style="list-style-type: none"> • Immediately document not pass (-) at this frequency • Set audiometer to 25dB • Continue screening at next frequency

Traditional Audio Screening

Position the child, Power On the audio
Set earphones on table
Set audio to 90 dB, 4000 Hz, right ear , pulse tone

Introduce the game
Present the beep

Beep heard ?

Lower to 50 dB
Place the earphones
Present the beep

Beep heard ?

Lower to 25 dB
Present beep

Beep heard ?

Continue screening 25 dB at 3000 Hz, 2000 Hz, 1000 Hz.
Then switch to other ear and continue screening at
1000 Hz, 2000 Hz, 3000 Hz, 4000 Hz.

*** 11-21 years old: Screen both ears at 6000 Hz and 8000 Hz once between 11-14 y/o, once between 15-17 y/o, and once between 18-21 y/o**

Reconditioning steps

Increase to 50 dB
(recondition)

Beep heard ?

Lower to 25 dB
Present beep

Beep heard ?

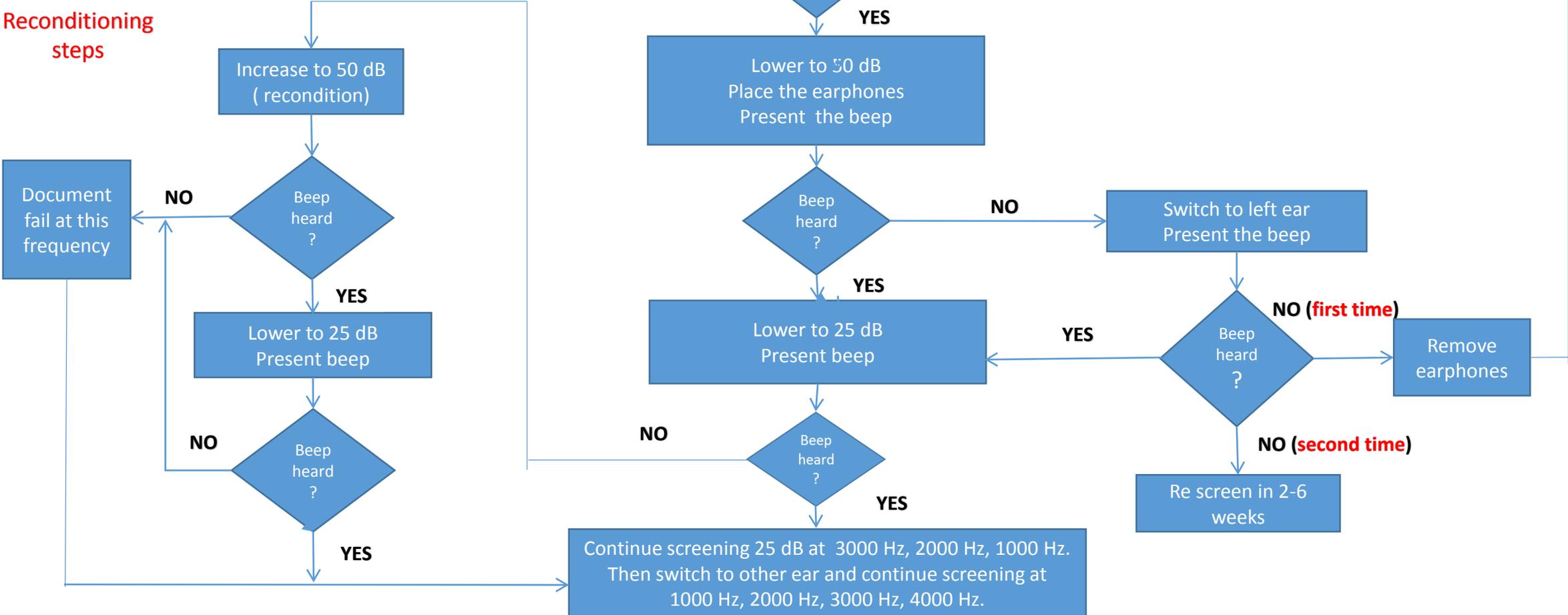
Document fail at this frequency

Switch to left ear
Present the beep

Beep heard ?

Remove earphones

Re screen in 2-6 weeks



Audiometric Screening Training

Tips for Audiometric Screening

- Positioning: Sit the child on the side of your dominant arm.
- Place the audiometer in the child's blind spot.
- Push back any hair covering the ears with your fingers as you put the headset on the child. If the child is wearing glasses, ask the child if he/she would like to remove them. (Removal of the glasses is for the comfort of the child and is optional.)
- Headset should not be too forward or too backward, it should be in the middle of the head, in line with the ears.
- Always press tone for "1 Mississippi."
- If problems are reported in the right ear, start the screening on the left ear, (the healthy ear.)
- If the child has a block in their hand at the end of the screening because they **did not** hear the last frequency, go back to a frequency they heard at 25 dB or 50 dB then press the tone to get them to drop it in the basket to end the "game" successfully.
- Avoid** Visual clues: Turning head to look at the child when pressing the tone, blinking when pressing the tone, smiling or obvious body movements immediately after pressing the tone.
- Avoid** Auditory clues: Asking, "Did you hear that?" when pressing the tone, saying, "Put the block in the basket" when pressing the tone, "Go on," "Put the block in," or "That's right!"
- Avoid** Patterning: Saying "Listen" and immediately pressing the tone each time. Instead, wait varying amounts of time before presenting the tone.
- Always** record failed audiometric screening results with a dash — immediately after screener reconditions at 50 dB and comes back to confirm at 25 dB.
- If a child fails, **always** praise the child when marking a dash — on the audiogram.

LAST NAME:	FIRST NAME:	AGE:
PLACE OF SCREENING:	SCORING:	Child responds at 25 dB: <input checked="" type="checkbox"/>
AUDIOMETER MODEL:	Child does not respond at 25 dB: <input type="checkbox"/>	
DATE OF LAST CALIBRATION:		

1st Screen

RIGHT EAR:

LEFT EAR:

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

2nd Screen

--	--	--	--	--	--

--	--	--	--	--	--

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

--	--	--	--	--	--

--	--	--	--	--	--

Comments: _____

Referred to: _____

LAST NAME:	FIRST NAME:	AGE:
PLACE OF SCREENING:	SCORING:	Child responds at 25 dB: <input checked="" type="checkbox"/>
AUDIOMETER MODEL:	Child does not respond at 25 dB: <input type="checkbox"/>	
DATE OF LAST CALIBRATION:		

1st Screen

RIGHT EAR:

LEFT EAR:

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

2nd Screen

--	--	--	--	--	--

--	--	--	--	--	--

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

--	--	--	--	--	--

--	--	--	--	--	--

Comments: _____

Referred to: _____

*Per AAP/Bright Futures Periodicity update February 2017, screen audiometry including 6,000 and 8,000 Hz high frequencies once between ages 11-14 years, once between 15-17 years, and once between 18-21 years.

LAST NAME:	FIRST NAME:	AGE:
PLACE OF SCREENING:	SCORING:	Child responds at 25 dB: <input checked="" type="checkbox"/>
AUDIOMETER MODEL:	Child does not respond at 25 dB: <input type="checkbox"/>	
DATE OF LAST CALIBRATION:		

1st Screen

RIGHT EAR:

LEFT EAR:

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

2nd Screen

--	--	--	--	--	--

--	--	--	--	--	--

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

--	--	--	--	--	--

--	--	--	--	--	--

Comments: _____

Referred to: _____

LAST NAME:	FIRST NAME:	AGE:
PLACE OF SCREENING:	SCORING:	Child responds at 25 dB: <input checked="" type="checkbox"/>
AUDIOMETER MODEL:	Child does not respond at 25 dB: <input type="checkbox"/>	
DATE OF LAST CALIBRATION:		

1st Screen

RIGHT EAR:

LEFT EAR:

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

2nd Screen

--	--	--	--	--	--

--	--	--	--	--	--

Date: _____

1000 2000 3000 4000 *6000 *8000

1000 2000 3000 4000 *6000 *8000

--	--	--	--	--	--

--	--	--	--	--	--

Comments: _____

Referred to: _____

*Per AAP/Bright Futures Periodicity update February 2017, screen audiometry including 6,000 and 8,000 Hz high frequencies once between ages 11-14 years, once between 15-17 years, and once between 18-21 years.