

TITLE 181 SPECIAL HEALTH PROGRAMS

CHAPTER 2 SCREENING OF INFANTS FOR METABOLIC DISEASES

2-001 SCOPE: These regulations implement the law governing screening of infants for metabolic diseases, Neb. Rev. Stat. §§ 71-519 to 71-524. These regulations define terms; state the requirements for screening for metabolic diseases; specify the diseases for which tests are required; ~~specify the diseases for which consent is required, and for which consent is not required;~~ specify the time periods for performance and reporting of results of the tests by physicians, hospitals, laboratories and births not attended by a physician; and prescribe the mechanism for determining tests, test methods and techniques, and such reports and reporting procedures as are necessary to implement the law.

2-002 DEFINITIONS: As used in these regulations, unless the context otherwise requires:

Argininosuccinic acidemia (ASA) means a disorder of amino acid metabolism in which an enzyme defect in the urea cycle results in elevated ammonemia and citrulline. If not identified and left untreated, infants develop failure to thrive, seizures, lethargy and coma, and later onset of mental retardation.

Beta-ketothiolase Deficiency (also known as Mitochondrial Acetoacetyl-CoA Thiolase Deficiency or 3-ketothiolase deficiency or BKT) means a disorder of organic acid metabolism in which an enzyme defect results in the accumulation of isoleucine and related metabolites. If not identified and left untreated, metabolic crisis may occur with coma or death, mental retardation, cardiac abnormalities and other physical problems.

Biotinidase Deficiency (BIOT) means a metabolic disease that results in an inability to recycle and conserve the vitamin biotin which, if not identified and left untreated, may lead to mental retardation, seizures, hearing loss, and dermatitis.

Carnitine Uptake Defect (CUD) means a disorder of fatty acid metabolism in which there is a defect in the transport of carnitine into the tissues. This prevents fatty acid metabolism and limits energy production. If left untreated, patients develop cardiomyopathy, fasting hypoglycemia and muscle disease. (Carnitine Uptake Defect might not be detected during the immediate newborn period.)

Citrullinemia (CIT) means a disorder of amino acid metabolism in which an enzyme defect in the urea cycle results in hyperammonemia and elevated citrulline. If not identified and left untreated, infants develop failure to thrive, vomiting, seizures, lethargy, coma and later onset of mental retardation.

Confirmatory Test means a test or a panel of tests performed following a presumptive positive screening test which provides additional, more specific diagnostic information concerning the existence or non-existence of diseases screened for.

Congenital Adrenal Hyperplasia (CAH) means a genetic disorder which results in the adrenal glands producing too little or no cortisol, insufficient aldosterone, and too much androgen. If left untreated, This can result in classical salt-losing CAH or an adrenal crisis that can result in sudden death.

Congenital Primary Hypothyroidism (CPH) means a ~~metabolic~~ disease characterized by a congenital deficiency or absence of thyroid hormone (thyroxine) which, if not identified and left untreated, may lead to mental and growth retardation.

Cutoff Value means a value on a screening test for a specific metabolic disease which gives a high degree of probability that all newborns with a greater or lower value, depending on the test method, will not have the metabolic disease.

Cystic Fibrosis (CF) means a genetic disorder in which mutations alter the structure, function, or production of a transmembrane chloride channel protein which in turn can affect the function of the lungs, upper respiratory tract, gastrointestinal tract, pancreas, liver, sweat glands, and genitourinary tract. Early diagnosis and treatment results in improved outcomes for affected patients.

Department means the Department of Health and Human Services ~~Regulation and Licensure~~ of the State of Nebraska.

Galactosemia (GALT) means a disease of galactose metabolism which, if not identified and left untreated, may lead to failure to thrive, vomiting, liver disease, cataracts, and mental retardation.

Glutaric acidemia type I (GAI) means a disorder of organic acid metabolism in which an enzyme defect results in increased glutaric acid and its metabolites. If not identified and left untreated children develop metabolic acidosis, failure to thrive, mental retardation and sudden onset of seizures, spasticity and movement problems.

Hemoglobinopathies (Hb SS, Hb S/βTh, Hb S/C) means a group of genetic disorders characterized by production of abnormal hemoglobin which may cause clinical disease including anemia or oxygen carrying difficulties.

Homocystinuria (HCY) means a disorder of amino acid metabolism in which an enzyme defect results in increased methionine and homocystine. If not identified, and left untreated children can develop mental retardation, vision problems, skeletal abnormalities and strokes.

Hospital means any facility defined under Neb. Rev. Stat. § 71-2017.01(2).

Isovaleric acidemia (IVA) means a disorder of amino acid metabolism in which an enzyme defect results in elevations of leucine and isovaleric acid. If not identified and left untreated, it can cause failure to thrive, metabolic acidosis, dehydration, hyperammonemia, and hypoglycemia.

Laboratory means a facility for the biological, microbiological, serological, chemical, immunological, hematological, biophysical, cytological, pathological or other examination of materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings. These examinations also include procedures to determine, measure, or otherwise describe the presence or absence of various substances or organisms in the body. Facilities only collecting or preparing specimens (or both) or only serving as a mailing service and not performing testing are not considered laboratories.

Long-chain hydroxyacyl-CoA dehydrogenase deficiency (also known as 3-hydroxy long-chain acyl-CoA dehydrogenase deficiency or LCHAD) means a disorder of fatty acid metabolism in which an enzyme defect results in metabolic derangement during periods of prolonged fasting. If not

identified and left untreated, it can result in failure to thrive, hypoglycemia, liver disease, cardiomyopathy and possibly death.

Maple Syrup Urine Disease (MSUD) means a disorder of amino acid metabolism in which an enzyme defect allows leucine, isoleucine and valine to accumulate to toxic levels. If not identified and left untreated, it can progress to mental retardation, failure to thrive, seizures, coma, cerebral edema and possibly death.

Medium Chain Acyl-CoA Dehydrogenase Deficiency ~~or~~ (MCAD) means a disorder of fatty acid metabolism that results in an inability to metabolize medium-chain fatty acids which, if ~~unrecognized~~ not identified and left untreated, under conditions of fasting may lead to hypoglycemia, seizures, developmental disability and/or sudden death.

Methylmalonic acidemia (mutase deficiency or MUT or MMA) means a disorder of amino acid metabolism in which various related enzyme defects result in increased methylmalonic acid. If not identified and left untreated, it can result in failure to thrive, metabolic acidosis, dehydration, hyperammonemia, hypoglycemia, mental retardation and possibly death.

Methylmalonic acidemia (Cbl A, B,) means a disorder of vitamin B12 (cobalamin) and amino acid metabolism in which an enzyme defect results in increased methylmalonic acid and homocystine. If not identified and left untreated, it can result in failure to thrive, metabolic acidosis, seizures, anemia, mental retardation and possibly death.

Multiple carboxylase deficiency (MCD) means a disorder of biotin vitamin metabolism in which an enzyme defect results in impaired biotin function leading to abnormal metabolism of amino acids, carbohydrates and lipids. If not identified and left untreated, infants develop metabolic acidosis, seizures, dermatitis, hearing loss, coma, mental retardation and possibly death.

Newborn means an infant who is 28 days old or less.

Newborn Screening means a laboratory test applied to newborn specimens in a search for newborns with metabolic diseases. Screening will detect a high proportion of newborns with the disease (true positive). Some newborns who do not have the disease will be identified by the screening test as possibly affected (false positive).

NNSP means the Nebraska Newborn Screening Program.

Newborn Screening Advisory Committee means a committee whose membership is determined by the Department Director which is comprised of a minimum of 15 and maximum of 25 stakeholders and representatives from but not limited to the following areas: newborn and pediatric primary health care providers; medical and allied professionals from the sub-specialities associated with treatment for the disorders screened, clinical laboratorians, and consumers with technical, professional and/or personal experience with newborn screening for congenital and inherited disorders.

Phenylketonuria ~~or~~ (PKU) means a disorder of amino acid metabolism in which an enzyme defect results in increased levels of phenylalanine. If left untreated, it may lead to mental retardation and seizures.

Propionic acidemia (PROP or PA) means a disorder of amino acid metabolism in which an enzyme

defect results in increased propionic acid. If not identified and left untreated, it can result in failure to thrive, metabolic acidosis, vomiting, dehydration, hyperammonemia, mental retardation and death.

Physician means a person licensed to practice medicine and surgery pursuant to Neb. Rev. Stat. §§ 71-1,102 to 71-1,104 or a person licensed as an osteopathic physician pursuant to Neb. Rev. Stat. §§ 71-1,137 to 71-1,146.

Presumptive Positive means a screening test result that is above or below the cutoff value and/or outside the normal range or value determined by an algorithm for assigning an interpretation of presumptive positive, depending on the test method.

Residual Dried Blood Spots means the portion of the initial or repeat dried blood spot specimen remaining, after all punches have been removed for testing of the specimen for newborn screening purposes.

Submitter means the person who sends the Collection and Reporting (CARE) Form to the testing laboratory for initial, repeat, or confirmatory screening tests, including, but not limited to, the hospital, the laboratory, or the physician.

Test Method means a laboratory examination which measures blood constituents associated with metabolic diseases.

Tyrosinemia (TYR) means a disorder of amino acid metabolism in which various related enzyme defects result in elevation of tyrosine. Effects of untreated disease may include failure to thrive, liver failure, skin and eye lesions, developmental delay or mental retardation. (Tyrosinemia type 1 might not be detected during the immediate newborn period).

Trifunctional protein deficiency (TFP) means a disorder of fatty acid metabolism in which a genetic defect results in deficiency of 3 enzymes that acts sequentially in fatty acid degradation. During periods of fasting, if not identified and left untreated children can develop hypoglycemia, failure to thrive, cardiomyopathy, liver disease and death.

Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD) means a disorder of fatty acid metabolism in which an enzyme defect results in an inability to degrade long-chain fatty acids. If not identified and left untreated, it may lead to fasting hypoglycemia, liver disease, seizures, skeletal myopathy, cardiomyopathy and sudden death.

3-Hydroxy-3-methyl glutaric aciduria (also known as 3-hydroxy-3-methylglutaryl-CoA lyase deficiency or HMG) means a disorder of organic acid metabolism in which an enzyme defect results in elevation of leucine in the blood and impaired production of ketones. If not identified and left untreated, it can result in mental retardation, metabolic acidosis, hypoglycemia, hyperammonemia, seizures, coma and death.

3-Methylcrotonyl-CoA carboxylase deficiency (3MCC) means a disorder of amino acid metabolism in which an enzyme defect results in an inability to metabolize leucine. If untreated, it can lead to vomiting, metabolic acidosis, apnea, hyptonia, seizures and possibly death.

2-003 SPECIFICATION OF DISEASES: All infants born in the state of Nebraska must be tested for the group of metabolic diseases of amino acid, fatty acid, vitamin and organic acid metabolism that may be detected from the acylcarnitine and amino acid profiles of tandem mass spectrometry including and in addition to the following diseases:

1. Argininosuccinic acidemia (beginning July 1, 2008)
2. Beta-ketothiolase Deficiency (also known as Mitochondrial Acetoacetyl-CoA Thiolase Deficiency or 3-ketothiolase deficiency) (beginning July 1, 2008)
3. Biotinidase Deficiency;
4. Carnitine Uptake Defect (beginning July 1, 2008)
5. Citrullinemia (beginning July 1, 2008)
6. Congenital Adrenal Hyperplasia (~~for specimens received at the newborn screening laboratory on or after January 2, 2006~~);
7. Congenital Primary Hypothyroidism;
8. Cystic Fibrosis (~~for specimens received at the newborn screening laboratory on or after January 2, 2006~~);
9. Galactosemia;
10. Glutaric Acidemia type 1 (beginning July 1, 2008)
11. Hemoglobinopathies;
12. Homocystinuria (beginning July 1, 2008)
13. Isovaleric Acidemia (beginning July 1, 2008)
14. Long-chain hydroxyacyl-CoA Dehydrogenase deficiency also known as 3-hydroxy long chain Acyl-CoA dehydrogenase deficiency (beginning July 1, 2008)
15. Maple Syrup Urine Disease (beginning July 1, 2008)
16. Medium Chain Acyl-CoA Dehydrogenase Deficiency; and
17. Methylmalonic acidemia (mutase deficiency) (beginning July 1, 2008)
18. Methylmalonic acidemia (Cbl A,B and C) (Beginning July 1, 2008)
19. Multiple carboxylase deficiency (beginning July 1, 2008)
20. Phenylketonuria.
21. Propionic Acidemia
22. Tyrosinemia (tyrosinemia type 1 might not be detected during the immediate newborn period) (beginning July 1, 2008)
23. Trifunctional protein deficiency (beginning July 1, 2008)
24. Very long-chain acyl-CoA Dehydrogenase deficiency (beginning July 1, 2008)
25. 3-Hydroxy 3-methyl glutaric aciduria (beginning July 1, 2008)
26. 3-Methylcrotonyl-CoA carboxylase deficiency (beginning July 1, 2008)

2-004 SPECIMEN COLLECTION

2-004.01 Specimen Requirements

2-004.01A The specimen requirements of the testing laboratory for each specific analyte must be followed. The testing laboratory must accept only specimens that are dried blood spots that have been collected on the CARE Form.

2-004.01B Collection of dried blood spot specimens must comply with National Committee for Clinical Laboratory Standards (NCCLS) (now Clinical and Laboratory Standards Institute CLSI) procedure, which is attached to these regulations as Attachment 1 and incorporated herein by reference, and the submitter must forward the

dried blood spots to the testing laboratory within 24 hours of specimen collection. On weekends and holidays when no transport service is available, the next earliest available transport service must be used.

2-004.01C Umbilical cord blood must not be used.

2-004.01D Urine must not be substituted for blood specimens.

2-004.02 Collection and Reporting Form (CARE Form): The Collection and Reporting Form (CARE Form), which is attached to these regulations as Attachment 2 and incorporated herein by reference, must be the sole method of dried blood spot specimen collection for all newborn screening. Forms must be obtained from the Department at cost.

2-005 PHYSICIAN DUTIES

2-005.01 Specimen Collection: For all live births, the newborn's physician must cause the collection for testing of a newborn screening specimen for metabolic diseases between 24 to 48 hours of age or immediately prior to the newborn's discharge, whichever occurs first.

2-005.01A Prior to 24 Hours of Age: If the initial specimen for any infant is collected prior to 24 hours of age, the newborn's physician or designee must collect or cause to be collected a repeat PKU and hypothyroidism screening specimen by 7 days of age, regardless of prior test results.

2-005.01B Sick or Premature Infants: The specimen may be collected prior to 24 hours of age if the infant is sick or premature, or if suspected of having one of the diseases screened for. The newborn's physician or designee must collect or cause to be collected a repeat PKU and hypothyroidism screening specimen by 7 days of age, regardless of prior test results.

2-005.01C Blood Transfusion: If a newborn requires a blood transfusion prior to 24 hours of age, the specimen must be collected before the blood transfusion. The specimen should be collected at the time blood is collected for the typing and cross match prior to transfusion. The newborn's physician or designee must collect or cause to be collected a repeat PKU and hypothyroidism screening specimen by 7 days of age, regardless of prior test results.

2-005.01D No Specimen Collected: Upon notification by the hospital that a newborn was discharged before a screening sample was collected, the newborn's physician or designee must collect or cause to be collected a screening specimen within 48 hours of parental notification.

2-005.01E Newborn Transfer To Another Hospital

2-005.01E1 Before 24 Hours of Age: The physician at the hospital of birth must collect or cause to be collected a blood specimen immediately prior to discharge for testing for metabolic diseases if the newborn is transferred to another hospital, either in- or out-of-state, before the infant is 24 hours of age. The physician or designee at the hospital of birth must document and inform the

receiving physician that a specimen for testing for metabolic diseases was collected prior to 24 hours of birth and notify the receiving physician that another specimen must be collected between 24 and 48 hours of age, or immediately prior to discharge, whichever occurs first, at the receiving hospital.

2-005.01E2 After 24 Hours of Age: The physician at the hospital of birth must collect or cause to be collected a blood specimen for testing for metabolic diseases from any newborn being transferred to another hospital after the newborn is 24 hours of age and notify the physician upon transfer that a blood specimen for metabolic diseases has been collected. The transferring physician must immediately notify the receiving physician if the specimen needs to be repeated, or if confirmatory testing is required.

2-005.01E3 Transfer Forms: All physicians transferring newborns to another hospital or the physician's designee at the hospital must notify the receiving physician in writing of the following information and provide a copy of the written information to the NNSP within 24 hours:

1. Date of transfer;
2. Person completing form or other written notification;
3. Hospital of birth;
4. Infant's name;
5. Date and time of birth;
6. Date and time of specimen collection;
7. Transferring physician;
8. Whether the newborn screening specimen was or was not collected at the hospital of birth;
9. Whether the newborn screening specimen was or was not collected prior to 24 hours of age;
10. Whether the newborn was transfused, and if so, whether the specimen was collected prior to transfusion;
11. The type and time of transfusion if the specimen was collected post-transfusion;
12. Test results for each disease, if available;
13. If the tests have not been performed and an initial specimen needs to be collected;
14. If the specimen was collected prior to 24 hours, or following transfusion, and a repeat specimen needs to be collected;
15. Receiving hospital; and
16. Receiving physician, if known.

The Transfer Form, Attachment 3 of these regulations, may be used to notify the receiving physician and is included as a convenience for the transferring physician.

2-005.02 Unsatisfactory Specimen: Upon receiving notice from the testing laboratory that a specimen is unsatisfactory, the newborn's physician or designee must collect or cause to be collected a repeat specimen within 48 hours of parental notification.

2-005.02A The physician or designee must make a reasonable attempt to cause the

collection of a repeat specimen. A reasonable attempt includes that the physician or designee must:

1. Immediately notify the parent, guardian, or custodian by telephone, if possible, and in writing;
2. If there has been no response within 5 days, notify the parent, guardian, or custodian in writing by certified mail, return receipt requested, or equivalent; and
3. If there has been no response within 10 days of first notification, notify the Nebraska Newborn Screening Program (NNSP) in writing that obtaining a repeat specimen was not accomplished.

2-005.03 Screening Test Results Received: Once the physician receives the results of the newborn screening tests, the physician or designee must place or cause to be placed the results in the newborn's patient record.

2-005.04 Presumptive Positive Screening Test Result: The newborn's physician or designee must obtain a repeat specimen for repeat or confirmatory testing from the newborn within 48 hours after notification by the testing laboratory of a any presumptive positive screening result, for ~~biotinidase deficiency, congenital primary hypothyroidism, galactosemia, hemoglobinopathies, medium chain acyl-CoA dehydrogenase deficiency or phenylketonuria.~~

2-005.04A The physician or designee must make a reasonable attempt to cause the collection of a repeat specimen. A reasonable attempt includes that the physician or designee must:

1. Immediately notify the parent, guardian, or custodian by telephone, if possible, and in writing;
2. If there has been no response within 5 days, notify the parent, guardian, or custodian in writing by certified mail, return receipt requested, or equivalent; and
3. If there has been no response within 10 days of first notification, notify the NNSP in writing that obtaining a repeat specimen was not accomplished.

2-005.04B Specific Responses to Presumptive Positive Screening Test Results

2-005.04B1 Congenital Adrenal Hyperplasia (CAH): If screening test results are positive for CAH, the physician must monitor the newborn for vomiting, poor weight gain, and elevated potassium, and collect or cause to be collected a specimen for a confirmatory test.

2-005.04B2 Congenital Primary Hypothyroidism (CPH): If screening test results are positive for congenital primary hypothyroidism, thyroxine therapy must not be given prior to obtaining confirmatory testing.

2-005.04B3 Cystic Fibrosis: If screening test results are positive for Cystic

Fibrosis, the physician must order a repeat or confirmatory test as indicated.

2-005.04B4 Galactosemia: If screening test results are positive for galactosemia, the physician must take the child off milk, place the child on a powder-based soy formula, and then collect or cause to be collected a specimen for a confirmatory test.

2-005.04B5 Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD): If screening test results are positive for MCAD, parent(s) should be advised to avoid fasting of the newborn for greater than 4 hours, and the physician should consider carnitine supplementation until confirmatory results are known.

2-005.04B6 Phenylketonuria: If screening test results are positive for phenylketonuria, formula with reduced or absent phenylalanine must not be given prior to obtaining positive confirmatory phenylalanine and tyrosine levels and other necessary confirmatory tests.

- a. Phenylalanine levels of 20 mg/dL (or 1210 μ mol/L) or greater on 2 occasions 24 hours or more apart while the infant is on full feeding and a phenylalanine to tyrosine ratio of 10 to 1 or higher is indicative of classical phenylketonuria.
- b. Phenylalanine levels of greater than 3.0 mg/dL (or 182 μ mol/L) but less than 20 mg/dL (or 1210 μ mol/L) on 2 occasions 24 hours or more apart while the infant is on full feeding, and a phenylalanine to tyrosine ratio of 5 to 1 or higher is indicative of nonclassical or variant phenylketonuria.

2-005.05 Enforcement: In the event that a parent fails to respond to notification, the physician must assure that such steps are taken as indicated in 181 NAC 2-009 and Neb. Rev. Stat. § 71-524.

2-005.06 Patient Education: The physician or an individual to whom the physician has delegated authority, must:

2-005.06A Provide information to the newborn's parent/legal guardian about the diseases for which newborn screening tests are required. Patient education materials provided by the Department about the required tests must be used to aid in informing the parent/legal guardian. There is no provision for dissent from or refusal of the required newborn screening tests specified at 181 NAC 2-003.

~~2-005.06B Inform the newborn's parent/legal guardian about the additional optional newborn screening genetic test results that they may consent to, or dissent from having their newborn tested for. Optional newborn screening tests requiring consent are limited to non-mandated screening tests using tandem mass spectrometry and as defined in the Department's contract with the newborn screening laboratory, and described in patient education materials provided by the Department. Patient education materials provided by the Department about the optional supplementary testing may be used to aid in informing the newborn's parent/legal guardian. The model informed consent form developed by the Department pursuant to Neb. Rev. Stat.~~

~~§ 71-1,104.01 may be used to document consent for or dissent from the optional newborn screening genetic test results.~~

2-006 HOSPITAL OR OTHER SUBMITTER DUTIES

2-006.01 Collection and Reporting Form (CARE Form): The hospital or other submitter designated by the newborn's attending physician must complete all information and collect the specimen on the CARE Form. The hospital or other submitter must retain the designated copy for inclusion into the newborn's medical record and send the remaining copies to the testing laboratory designated by the Department within 24 hours after specimen collection.

2-006.02 No Specimen Collected: The hospital or other submitter designated by the newborn's attending physician must immediately notify the newborn's physician or designee by telephone and in writing if the newborn was discharged before a screening sample was collected, and document this notification in the newborn's medical record.

2-006.03 No Test Results: If test results are not received by the hospital or other submitter within 10 days after the specimen was submitted to the testing laboratory, the hospital or other submitter must immediately contact the testing laboratory to determine if the testing laboratory received the specimen and performed the appropriate analyses, and document this contact in the newborn's medical record:

2-006.03A If the testing laboratory did not receive a specimen, the hospital or other submitter must immediately notify the physician by telephone and in writing, and document this notification in the newborn's medical record.

2-006.03B If the testing laboratory did receive the specimen and completed the appropriate analyses, a duplicate report must be obtained and placed in the newborn's medical record.

2-006.03C If the testing laboratory did receive the specimen but has not yet performed the appropriate analyses, the hospital or other submitter must immediately notify the NNSP.

2-006.04 Screening Test Results Received: When the hospital or other submitter receives the completed copy of the CARE Form or other record of screening test results from the testing laboratory, the hospital or other submitter must place the screening test results in the newborn's medical record and appropriately retain those results for 25 years from the newborn's date of birth.

2-006.05 Contact Person: The hospital must keep the NNSP informed of the contact person responsible for newborn screening.

2-007 TESTING LABORATORY DUTIES

2-007.01 General Rules

2-007.01A Electronic Transmission: The testing laboratory must report all of the information on the CARE Form electronically, at its own expense, to the NNSP central

database utilizing software developed and provided by the Department or in electronic format that provides complete demographic and test results records for each infant and that provides the reporting functions as specified by the Department in 181 NAC 2-007.02A and in contract. The testing laboratory must provide, at its own expense, the necessary hardware.

2-007.01B Test Performance: The testing laboratory must perform all tests required in the contract between the Department and the laboratory at least ~~3~~ 6 days a week. ~~except galactosemia which must be performed at least every other calendar day.~~

2-007.01C Contact Person: The testing laboratory must keep the NNSP informed of the contact person responsible for newborn screening.

2-007.01D Screening Tests: Except as provided in the disaster preparedness plan as required in the contract, the screening tests must be completed only by the laboratory designated by contract with the Department beginning with the effective date of the contract.

2-007.01E Confirmatory Tests: Confirmatory tests may be done by any laboratory including the laboratory designated by the Department as long as it is certified under the Clinical Laboratory Improvement Amendments (CLIA). The contracted newborn screening laboratory will append to the laboratory report for all presumptive positive screening results, disorder specific recommendations for immediate testing and clinical follow-up, as approved by the Department and the Newborn Screening Advisory Committee.

2-007.02 Record Keeping and Reporting: Testing laboratories must maintain records and make reports in the following manner:

2-007.02A Electronic Report: The laboratory must make an electronic report to the Department which includes the following information:

1. All information contained on the CARE Form;
2. The serial number located on the CARE Form;
3. If applicable, identification of any unsatisfactory specimen and the reason for its unsatisfactory nature;
4. Screening, repeat, and confirmatory test results, including numerical data where applicable; and
5. Any notifications to the physician, NNSP, or the submitter.

2-007.02B When Receiving a Specimen: The testing laboratory must enter the data identified in 181 NAC 2-007.02A, items 1 and 2, into the electronic database specified at 181 NAC 2-007.01A at the time of receiving the specimen.

2-007.02C After Individual Test Completion: Tests results must be entered into the database within 24 hours of individual completion.

2-007.02D Transfer of Electronic Report: The testing laboratory must transmit to the Department's electronic database or allow electronic access by the NNSP to all data identified in 181 NAC 2-007.02A at least once every 24 hours.

2-007.02E Transfer of Screening Test Results: Within 24 hours of completing all screening tests on each newborn, the laboratory must return a copy of the completed CARE Form or other record of test results to the hospital or other submitter.

2-007.02F Blood Spot Storage, Use and Disposal Records: The testing laboratory must maintain for 25 years an index or catalog of the residual dried blood spots processed in the laboratory that includes the following information:

1. The serial number or unique identifier of each specimen processed;
2. The test results of each specimen processed;
3. Verification of disposal of specimens not released for research or diagnostic purposes. This information may be batched by test completion date so long as each serial number or unique identifier can be linked with its test completion date;
4. Date of disposal;
5. Location of disposal if other than the laboratory;
6. For specimens released for research, documentation as required at 181 NAC 2-007.08; and
7. Signature of the person who released for research, disposed of or witnessed the disposal of the specimen; or for specimens disposed of by a contractor, written evidence that the contract for disposal of residual dried blood spots requires disposal be done in accordance with 181 NAC 2-007.02F, 3, 4, and 5.

2-007.02G Quality Assurance Reports: The testing laboratory must provide to the NNSP, copies of written reports of participation in and results of appropriate quality assurance proficiency testing programs offered by the Centers for Disease Control and Prevention of the United States Department of Health and Human Services and any other professional laboratory organization.

2-007.03 Unsatisfactory Specimen: If a specimen is unsatisfactory for any reason for any test(s), including but not limited to, being of insufficient volume or quality, the testing laboratory must reject it. Within 24 hours of receiving any unsatisfactory specimen, the testing laboratory must:

1. Notify the submitter and physician or designee by telephone and in writing that the specimen was unsatisfactory and that a repeat specimen must be collected within 48 hours of notification to the parent, guardian, or custodian;
2. Schedule any tests possible on the specimen received in accordance with the testing laboratory's standard operating procedure and testing times; and
3. Enter the applicable information identified in 181 NAC 2-007.02A into the Department's electronic database.

2-007.04 Negative Screening, Negative Repeat Screening, and Negative Confirmatory Test Results: Within 24 hours of obtaining a negative screening, negative repeat screening, or negative confirmatory test result, the testing laboratory must:

1. Send a copy of the CARE Form or other record of test results to the submitter; and
2. Enter the applicable information identified in 181 NAC 2-007.02A into the Department's electronic database.

2-007.05 Presumptive Positive Screening, Positive Repeat Screening, or Positive Confirmatory Test Results: Immediately after obtaining any presumptive positive screening, positive repeat screening, or positive confirmatory test result, the testing laboratory must:

1. Provide test result information to the submitter and physician or designee by telephone and in writing;
2. Utilize the NNSP telephone number provided by the Department and relay the information on the CARE Form and the presumptive positive or positive results; and
3. Enter the applicable information identified in 181 NAC 2-007.02A into the Department's electronic database.

2-007.06 Standardized Laboratory Test Methods: The testing laboratory must use only the standardized test methods provided for in the contract with the Department and the methods used must produce results for which the specified cutoff value and/or algorithms for assigning presumptive positive results is/are appropriate. The screening test approved analytical method, cutoff value and/or algorithms for assigning presumptive positive results (identification protocol) will be specified in the contract between the Department and the laboratory conducting newborn screening testing for the diseases specified in these regulations. Identification protocols used by the performing laboratory must be agreed upon in contract by the Department with the advice of the Newborn Screening Advisory Committee.

The Newborn Screening Advisory Committee is responsible for reviewing technical aspects of the identification protocol for the initial screening test relevant to repeat and confirmatory testing. The Committee must make recommendations for approval, disapproval or revision to identification protocols. The Department has final decision authority for contractually agreed upon tests, analytic methods and identification protocols for normal and abnormal results and reporting specifications.

2-007.07 Storage of Residual Dried Blood Spots: The testing laboratory must store the residual dried blood spots for 90 days. Specimens must be refrigerated in sealed bags of low gas permeability.

2-007.08 Use of Residual Dried Blood Spots: Residual dried blood spots may be used for research only when the following conditions have been met:

1. The laboratory has on file a copy of the full report of the review and approval of the research by a Human Subjects Review or Institutional Review Board;
2. For every specimen released for research, with or without patient identifying information, the laboratory must document:

- a. Who had access to the specimen;
- b. The title of the research protocol/title of file where the documentation authorizing the use of the specimen for research can be found;
- c. To whom the specimen was released;
- d. The amount of specimen released; and
- e. Evidence that written consents were obtained from the legally responsible parent or guardian of the individuals whose specimens were released.

2-007.09 Disposal of Residual Dried Blood Spots: Residual dried blood spots not released for research or diagnostic purposes for the patient must be disposed of within 30 days of the end of the retention period specified at 181 NAC 2-007.07. Destruction of the specimens, by incineration, by autoclaving and shredding, or by some other reasonable and prudent means, must ensure that identifying information cannot be linked to the residual dried blood spots.

2-007.10 Laboratory Provision of Access: Records required at 181 NAC 2-007.02F, 2-007.08 and 2-007.09 must be made available to the Department for inspection upon request.

2-008 BIRTHS NOT ATTENDED BY A PHYSICIAN: In the event a birth is not attended by a physician, the person registering the birth (who may be the parent) must ensure that:

1. The newborn has a newborn screening blood spot specimen collected as set out in 181 NAC 2-005.01 (between 24 and 48 hours of birth); and
2. The specimen is submitted to the testing laboratory designated by the Department as set out in 181 NAC 2-006.01 (within 24 hours of collection).

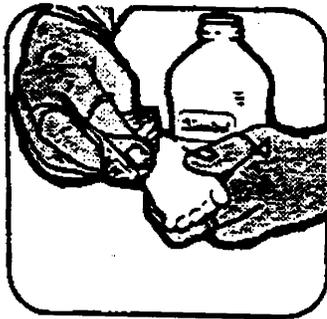
2-009 ENFORCEMENT: Neb. Rev. Stat. § 71-524 provides as follows: In addition to any other remedies which may be available by law, a civil proceeding to enforce section 71-519 may be brought in the district court of the county where the infant is domiciled or found. The attending physician, the hospital or other birthing facility, the Attorney General, or the county attorney of the county where the infant is domiciled or found may institute such proceedings as are necessary to enforce such section. It shall be the duty of the Attorney General or the county attorney to whom the Director of Regulation and Licensure reports a violation to cause appropriate proceedings to be initiated without delay. A hearing on any action brought pursuant to this section shall be held within 72 hours of the filing of such action, and a decision shall be rendered by the court within 24 hours of the close of the hearing.

2-010 LABORATORY COLLECTION AND REMITTANCE OF FEES: There is hereby assessed a fee of \$10 for each infant screened for the diseases specified in 181 NAC 2-003. The laboratory conducting the tests for such diseases must collect a fee of \$10 per infant screened, and submit the amounts collected to the Department for credit to the Department of Health and Human Services Regulation and Licensure Cash Fund on a monthly basis.

ATTACHMENT 1

HOW TO COLLECT AN ACCEPTABLE BLOOD SPOT SPECIMEN

1.0 SAMPLING TECHNIQUE

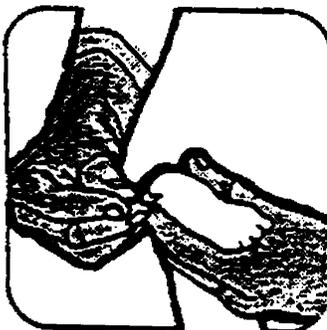


1.1 Cleanse infant's heel with 70% isopropyl alcohol (use only rubbing alcohol).

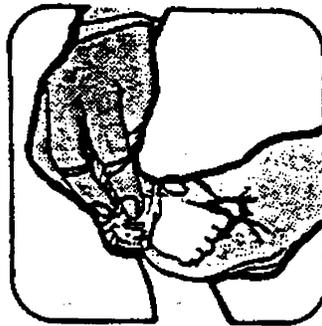
1.2 Allow heel to air dry.



1.3 The puncture should be made within the shaded area in the drawing above.



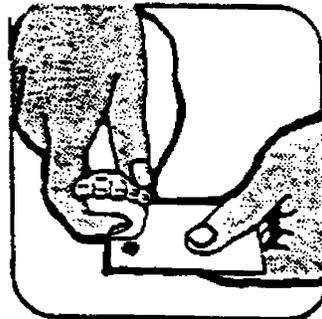
1.4 Using lancet provided, perform puncture as illustrated.
WEARING GLOVES



1.5 Gently wipe off first drop of blood with sterile gauze or cotton ball. (Initial drop contains tissue fluids which may dilute sample.)

1.6 Wait for spontaneous free flow of blood.

1.7 Apply gentle pressure with thumb and ease intermittently as drops of blood form.



1.8 Touch printed side of filter paper card to the blood drop and fill each printed circle with a SINGLE application of blood. Observe the saturation of each printed circle as the blood flows through the filter paper. Spotting should be done *only* on the printed side.

1.9 Allow blood specimen to AIR DRY THOROUGHLY on level non-absorbent open surface, such as a plastic-coated test tube rack, for 2-6 hours at ambient temperature (Do not stack or heat).

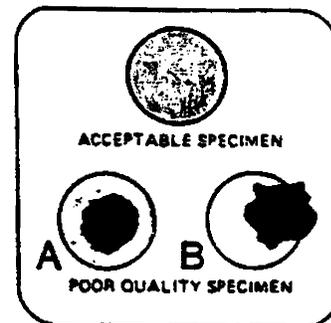
1.10 Place *direct filter paper* in mailing envelope provided for this purpose.

2.0 PITFALLS

2.1 Failure to wipe off alcohol residue may dilute the specimen and adversely affect test results.

2.2 Puncturing the heel on posterior curvature will permit blood to flow away from puncture, making proper spotting difficult. **DO NOT LANCE ON PREVIOUS PUNCTURE.**

2.3 *Milking* or squeezing the puncture may cause hemolysis and admixture of tissue fluids with specimen.



2.4 Do not layer successive drops of blood on the circle spot (Example A). If blood flow diminishes to incompletely fill circles, REPEAT sampling technique 1.1 thru 1.10. Note Example B for poor quality specimen with inadequate blood.

2.5 Avoid touching area within circle before collection and blood spots after collection on filter paper. Do not allow water, feeding formulas, antiseptic solutions, etc., to come in contact with the sample.

2.6 Do not place filter paper in the envelop until thoroughly dry.

2.7 **INSUFFICIENT DRYING ADVERSELY AFFECTS TEST RESULTS.**



NATIONAL
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LABORATORY
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Attachment 2

COLLECTION AND REPORTING (CARE) FORM – NEBRASKA NEWBORN SCREENING PROGRAM	
Birth: Date: ___/___/___ Time: ___:___ (Military) Collection: Date: ___/___/___ Time: ___:___ (Military) Initial <input type="checkbox"/> Repeat <input type="checkbox"/> Confirmatory <input type="checkbox"/> <input type="checkbox"/> Transfused prior to specimen collection. If <input type="checkbox"/> 'd specify type: _____ & time: _____ <input type="checkbox"/> TPN <input type="checkbox"/> Baby on antibiotics Gestational age ___ (wks) Birth Weight: _____	NEWBORN'S PHYSICIAN INFORMATION NAME _____ Last, _____ First _____ Telephone: () _____ - _____ BEFORE SUBMITTING SPECIMEN TO SCREENING LAB, MUST COMPLETE: Parent consents to optional/supplemental testing <input type="checkbox"/> (Signed Consent on file at hospital) Parent dissents from optional/supplemental testing <input type="checkbox"/> (Signed Dissent on file at hospital)
NEWBORN'S INFORMATION: Name _____ Last First Middle Patient Record Number _____ Place of Birth _____ Home Birth: Yes <input type="checkbox"/> No <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>	TESTING LAB REQUIRED DATA: SATISFACTORY SPECIMEN? Yes No IF NO, WHY: _____ TEST RESULTS: Normal / Abnormal Biotinidase Deficiency: _____ Galactosemia: _____ Congenital Primary Hypothyroidism _____ T4 _____ TSH _____ Hemoglobinopathies: Result: _____ Medium Chain acyl-CoA Dehydrogenase _____ PKU: Value _____
MOTHER'S INFORMATION: Name _____ Last First Middle Address _____ Telephone: () _____ - _____ Birthdate / /	
SUBMITTER'S INFORMATION: Name: _____ Address: _____ Telephone: _____	

COLLECTION AND REPORTING (CARE) FORM – NEBRASKA NEWBORN SCREENING PROGRAM

Serial # 1234567 BAR CODE with check digit	Birth: Date: ___/___/___ Time: ___:___ (Military) Collection: Date: ___/___/___ Time: ___:___ (Military) Collector's initials: _____ Initial <input type="checkbox"/> Repeat <input type="checkbox"/> <input type="checkbox"/> Specimen collected prior to 24 hours <input type="checkbox"/> Transfused prior to specimen collected If <input checked="" type="checkbox"/> 'd specify type: _____ date: ___/___/___ time: ___:___ <input type="checkbox"/> TPN <input type="checkbox"/> Baby on antibiotics Gestational age _____ (wks) Birth weight: _____	SUBMITTER'S INFORMATION:	SERIAL # 1234567	RECEIVED SERIAL #
	Name _____ Address: _____ Telephone (____) _____ - _____	NEWBORN'S PHYSICIAN INFORMATION:		
Name _____ Last _____ First _____ Telephone (____) _____ - _____	(Name of Manufacturer & Printer of filter paper forms) (Expiration date: _____)			
Patient Record Number: _____ Place of Birth: _____ Home Birth: Yes <input type="checkbox"/> No <input type="checkbox"/> Sex: M <input type="checkbox"/> F <input type="checkbox"/>	Allow to air dry for at least 3 hours and ship within 24 hours (when transport available) to:			
Name _____ Last _____ First _____ Middle _____ Address _____ Telephone (____) _____ - _____ Birthdate ___/___/___	(Name and address of newborn screening laboratory)			

Note: Filter paper form not to scale. Size of filter paper to remain the same as previous versions.

**ATTACHMENT 3
NEBRASKA NEWBORN SCREENING PROGRAM
NEWBORN TRANSFER FORM**

Date of Transfer: _____ Person Completing Form: _____

Hospital of Birth: _____

Infant's Name: _____

Date of Birth: _____ Time of Birth: _____

Date of specimen collection: _____ Time of specimen collection: _____

Transferring Physician: _____

Newborn Screening Specimen Collected at Hospital of Birth: Yes No

Newborn Screening Specimen collected prior to 24 hours of age: Yes No

Infant transfused?: Yes No

If yes, was specimen collected prior to transfusion? Yes No

If collected post-transfusion indicate type: _____ & time of transfusion____:____.

Are test results available now? ~~Yes~~ No

If yes, please record the test results below:

Biotinidase Deficiency _____ (Normal Abnormal)

Congenital Adrenal Hyperplasia _____ (Normal Abnormal)

Congenital Primary Hypothyroidism:

T₄ _____ (Value. If abnormal, record TSH)

TSH _____ (Value)

Free T₄ _____ (Value, if done)

Cystic Fibrosis _____ (Normal Abnormal)

Galactosemia _____ (Normal Abnormal)

Hemoglobinopathies _____ (Normal Abnormal)

MCAD _____ (Normal Abnormal)

PKU _____ (Normal Abnormal)

Receiving Hospital: _____

Receiving Physician: _____

Person Receiving Form: _____

ATTENTION RECEIVING PHYSICIAN: If the above tests have not been performed or tests need to be repeated when you take charge of the infant, you are responsible for ordering a specimen and

DRAFT
7/24/07

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

181 NAC 2

returning the results recorded on this form to the hospital of birth.

Forward one copy of this form to the receiving hospital and one copy to:
Nebraska Newborn Screening Program
Department of Health & Human Services ~~Regulation & Licensure~~
P.O. Box ~~95007~~ 95026
Lincoln, NE 68509