1999 HOUSE HUMAN SERVICES

HB 1478

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1478

House Human Services Committee

❑ Conference Committee

Hearing Date January 25, 1999

Tape Number	Side A	Side B	Meter #
1	X		31.7 - End
1		X	0.0 - 14.6
Committee Clerk Signature	Susann Lindteigen		

Minutes:

Rep. ROXANNE JENSEN testified and read the fact sheet (attached) into the record. I have an amendment (attached) to propose to the bill, which affects adds a new section on application. There are only 15 counties in ND where there were births greater than 100 in that time period. This would allow the rural areas to have some catch up time before they have to comply.

Rep.WILLIAM DEVLIN asked for clarification on the amendment whether its the place of birth or the residence of birth. Would it go to where the hospital is? Rep. ROXANNE JENSEN deferred the question.

STEPHEN McDONOUGH, MD, Chief Medical Officer, ND Department of Health, testified (Testimony attached). The Health Department says children get hearing aids around the age of 5. So this says there is no early detection. Costs have decreased for automated hearing screening and the test is high quality. In summary, the adoption of this legislation would result in more

rapid screening of newborns for hearing loss. I would like to explain one technical thing on page 1, line 10, for phenylketonuria, galactosemia, and other metabolic diseases. That's because this legislation was put in the part of NDCC that currently requires all newborns be screened for these metabolic diseases.

In answer to Rep. WILLIAM DEVLIN's question, the amendment refers to the county in which the child was born and not the county where the child resides.

Rep. CLARA SUE PRICE asked what is the rationale to do it within 90 days of birth rather than before discharge? What authority will the physician have over the parents once the baby is gone for them to come in? STEPHEN McDONOUGH stated the intent of the 90 days is in reference to the rural areas where they do not have the technology right in that hospital. In the larger facilities it will be done when the child is born. The intent of our department is to make it the physicians obligation but it would not be our intent to penalize or sanction them if they could not follow through with it because the child moved, etc. Rep. CLARA SUE PRICE asked who pays the cost now for those who do it. STEPHEN McDONOUGH stated no additional reimbursement or separate charge. The hospitals that are doing it absorb the cost. Rep. CLARA SUE PRICE asked if we mandate something, will they usually request reimbursement? STEPHEN McDONOUGH said if the service is provided at the time of discharge for a newborn, it will be part of the reimbursement the insurers provide to the hospital. We specifically recommended this not be a mandate for insurance companies or for hospitals to provide this service.

Rep. TODD PORTER asked that if this isn't a mandate and the hospitals and insurance companies will eventually work toward this, why do we need this bill? STEPHEN McDONOUGH stated it would accelerate the process. Rep. TODD PORTER asked what is the

cost of equipment and who is authorized to use the devices. STEPHEN McDONOUGH stated the approximate cost is between $5,000-$10,000 depending on the type of technology and that technicians can be trained under supervision of an audiologist to perform the automated test.

Rep. TODD PORTER expressed concern on the additional cost of training, audiology personnel, and the impact on the rural communities. STEPHEN McDONOUGH stated that the rural facilities will develop network with larger facilities. Rep. TODD PORTER asked how many ND births are not in the hospital now? STEPHEN McDONOUGH stated its less than 100 per year with 8,400 births in the hospital.

Rep. CAROL NIEMEIER stated Section 1 mandates fees to cover metabolic testing. STEPHEN McDONOUGH stated that is a technical change to NDCC. There is no intent to create a new charge for metabolic diseases. Its new language to clarify. The Health Department doesn't charge.

Rep. ROBIN WEISZ asked how many infants with hearing loss are detected now? STEPHEN McDONOUGH said he didn't know. There are 8 -10 children per year with an average age of 5 that get hearing aids through the department of human services. Rep. ROBIN WEISZ referred to part of the testimony where some hospitals are greater than 90%, there's a significant number of age 12 children and asked why they're not covered now? STEPHEN McDONOUGH said they started screening last year.

Rep. CLARA SUE PRICE asked about the reporting. STEPHEN McDONOUGH stated that in order for a birth defect condition to be reported it would have to be included on the birth certificate. The diagnosis of hearing loss is not made within the first two days. Rep. CLARA

SUE PRICE asked if this bill could be changed so there would be screening at birth. STEPHEN McDONOUGH stated on page 1, Section 2, line 21 asks for the report.

MEREDITH CARLSON, Intern, Department of Human Services, testified in regard to clarification of "*coverage and payment is approved service...*"

PATRICIA KRAMER, letter to LaVonne Boucher read as testimony (Testimony attached).

DAVID PESKE, Director, Government Relations, ND Medical Association, testified in support of the concept of the bill but we're not sure of the details. The problem we identified is what can physicians do and what do I tell them to do once the child is discharged. We discussed some educational amendments to the bill or possibly develop an informational brochure. Some family physicians do screening when the child comes back for the wellness test. EMT doctors say some nerve channels are not fully developed by the end of 90 days. The testing can be expensive. We need a clearer way to implement the bill.

Rep. ROBIN WEISZ asked is it possible to have 100% screening by the time this bill takes effect if we went from 0% last session to 90% this session. DAVID PESKE didn't know and deferred the question.

NEUTRAL TESTIMONY

DAN ULMER, Director, Government Relations, Blue Cross Blue Shield of ND, testified they are not opposed to mandating the screening but we are opposed to mandating the coverage. In 1997, we had 46 screenings and $1,749.00. In 1998, we had 44 screenings and $2,007.61. Now, if its medically indicated, whether or not family has history of heredity, infection, birth weight, enure, or conductive hearing loss, we don't ask a lot of questions. The price runs from $20 -$50

per test. Someone's going to have to come with $160,000 to cover 8,400 births per year at $20 each.

NO POSITION

ARNOLD THOMAS, President, Health Care Association, appeared for reasons of answering any questions.

Rep. CLARA SUE PRICE asked do you see an increase in the hospitals that are automatically doing this? ARNOLD THOMAS stated the urban facilities and protocol is determined by the aggressiveness of the medical staff.

Hearing closed.

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1478

House Human Services Committee

❑ Conference Committee

Hearing Date February 3, 1999

Tape Number	Side A	Side B	Meter #
1	X		57.3 - End
1		X	0.0 - 5.0
Committee Clerk Signature	Susan Lindteigen		

Minutes:

Committee Discussion.

Rep. ROXANNE JENSEN discussed two amendments: (1) the one on the back of Steve McDonough's testimony, and (2) the one passed out to the committee.

Rep. ROXANNE JENSEN moved to ADOPT AMENDMENT presented by Steve McDonough

Rep. TODD PORTER second the motion.

VOICE VOTE #1: 15 yeas, 0 nays, 0 absent

Rep. CAROL NIEMEIER asked does the amendment go into effect after July 1, 1999?

Rep. ROXANNE JENSEN moved to ADOPT AMENDMENT No. 2.

VOICE VOTE #2: 15 yeas, 0 nays, 0 absent

Further Committee Discussion.

Rep. ROXANNE JENSEN moved DO PASS As AMENDED.

Rep. WANDA ROSE second the motion

Rep. TODD PORTER asked is there a need for this statute when testimony was given that this issue will be taken care of in two years?

Rep. ROXANNE JENSEN explained that Dr. McDonough stated there is a need. A child may be missed in the screening process now.

ROLL CALL VOTE #1: 12 yeas, 3 nays, 0 absent

CARRIER: Rep. SALLY SANDVIG

1999 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1478

House Human Services Committee

❑ Conference Committee

Hearing Date February 10, 1999

Tape Number	Side A	Side B	Meter #
1		X	38.4 - 58.0
Committee Clerk Signature Susann Lindteigen			

Minutes:

Rep. ROXANNE JENSEN stated this bill is before you again because there was a great deal of unexpected opposition to the amendment that we put on the bill. The amendment did not require the rural hospitals to comply with the hearing screening practice until the year 2001. Arnold Thomas, ND Medical and Health Care Association, objected heartily to that, saying that raised two levels of care, a rural standard and an urban standard. He also objected strenuously to the last amendment on the bill indicating that this cannot not be used as a mandate for reimbursement. I brought it back to remove those amendments.

Rep. ROXANNE JENSEN moved to ADOPT AMENDMENTS on Engrossed HB 1478.

Rep. WANDA ROSE second the motion.

Further Committee Discussion

VOICE VOTE: 14 yeas, 1 nay (Thoreson), 0 absent

Rep. ROXANNE JENSEN moved DO PASS As AMENDED to Engrossed HB 1478

Rep. WANDA ROSE second the motion

Further Committee Discussion.

ROLL CALL VOTE #1: 6 yeas, 9 nays, 0 absent

Motion Failed

Rep. TODD PORTER moved DO NOT PASS As AMENDED to Engrossed HB 1478

Rep. DALE HENEGAR second the motion

ROLL CALL VOTE #2: 9 yeas, 6 nays, 0 absent

CARRIER: Rep. CHET POLLERT

FISCAL NOTE

(Return original and 10 copies)

Bill/Resolution No.: HB 1478 Amendment to: _____

Requested by Legislative Council Date of Request: 1-20-99

1. Please estimate the fiscal impact (in dollar amounts) of the above measure for state general or special funds, counties, cities, and school districts.

Narrative:

This bill requests that the physician, nurse midwife, nurse practitioner or other individual attending a newborn infant shall have that infant's hearing tested within 90 days of birth. Any hearing impairment shall be reported to the State Department of Health as described. The State Department of Health and Human Services shall jointly provide information in written or other form to health care providers and state residents regarding the need for early detection of hearing impairment, treatments and government services available to this population. We anticipate all children born in a biennium (approximately 16,000) will receive brochures. Education for professionals and the public will be provided also. The costs of providing the brochures and education will be absorbed by the State Department of Health within existing appropriations.

2. **State** fiscal effect in dollar amounts:

	1997-99 Biennium		1999-2001 Biennium		2001-03 Biennium	
	General Fund	Special Funds	General Fund	Special Funds	General Fund	Special Funds
Revenues:	-0-	-0-	-0-	-0-	-0-	-0-
Expenditures:	-0-	-0-	-0-	-0-	-0-	-0-

3. What, if any, is the effect of this measure on the appropriation for your agency or department:
   a. For rest of 1997-99 biennium: N/A
   b. For the 1999-2001 biennium: < $5,000
   c. For the 2001-03 biennium: < $5,000

4. **County, City, and School District** fiscal effect in dollar amounts:

1997-99 Biennium			1999-2001 Biennium			2001-03 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts
	-0-			-0-			-0-	

If additional space is needed, attach a supplemental sheet.

Signed _____

Typed Name Robert A. Barnett

Date Prepared 1-22-99

Department State Department of Health

Phone Number 328-2392

Proposed amendment to HB 1478

On page 2, after line 21, add a new paragraph

"6. Nothing in this section can be construed to require an insurer to provide coverage for these services.

PROPOSED AMENDMENT TO HOUSE BILL NO. 1478 [Offered by Rep. Jensen]

On page 2, after line 21, insert:

SECTION 2. APPLICATION. This Act does not apply to any infant born in a county that had fewer than 100 births in 1998, or an average of fewer than 100 births in the years 1996 through 1998 as reported by the state department of health, if that infant is born before July 1, 2001.

Adopted by the Human Services Committee
February 3, 1999

VK 2/3/99

HOUSE AMENDMENTS TO HOUSE BILL NO. 1478 **HUMSER 2-4-99**

Page 2, after line 21, insert:

"6. This section does not require an insurer to provide coverage for any service provided for under this section.

SECTION 3. APPLICATION. This Act does not apply to any infant born in a county that had fewer than 100 births in 1998, or an average of fewer than 100 births in the years 1996 through 1998 as reported by the state department of health, if that infant is born before July 1, 2001."

Renumber accordingly

Date:
Roll Call Vote #: 2-3-99

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken DO PASS AS AMENDED

Motion Made By Roxanne Jensen Seconded By Wanda Rose

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	X		Bruce A. Eckre	X	
Robin Weisz - Vice Chairman		X	Ralph Metcalf	X	
William R. Devlin		X	Carol A. Niemeier	X	
Pat Galvin	X		Wanda Rose	X	
Dale L. Henegar	X		Sally M. Sandvig	X	
Roxanne Jensen	X				
Amy N. Kliniske	X				
Chet Pollert	X				
Todd Porter		X			
Blair Thoreson	X				

Total Yes 12 No 3
Absent 0

Floor Assignment Sally Sandvig

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1478: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (12 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1478 was placed on the Sixth order on the calendar.

Page 2, after line 21, insert:

"6. This section does not require an insurer to provide coverage for any service provided for under this section.

SECTION 3. APPLICATION. This Act does not apply to any infant born in a county that had fewer than 100 births in 1998, or an average of fewer than 100 births in the years 1996 through 1998 as reported by the state department of health, if that infant is born before July 1, 2001."

Renumber accordingly

Adopted by the Human Services Committee
February 10, 1999

HOUSE AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1478 **HUMSER 2-11-99**

Page 2, remove lines 22 through 27

Renumber accordingly

Date: 2-10-99
Roll Call Vote #: 1

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

House Human Services Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Pass as Amended

Motion Made By Roxanne Jensen Seconded By Wanda Rose

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman	X		Bruce A. Eckre	X	
Robin Weisz - Vice Chairman		X	Ralph Metcalf		X
William R. Devlin		X	Carol A. Niemeier	X	
Pat Galvin		X	Wanda Rose	X	
Dale L. Henegar		X	Sally M. Sandvig	X	
Roxanne Jensen	X				
Amy N. Kliniske		X			
Chet Pollert		X			
Todd Porter		X			
Blair Thoreson		X			

Total Yes 6 No 9 Failed
Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 2-10-99
Roll Call Vote #: 2

1999 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1478

House Human Services Committee

☐ Subcommittee on _____
or
☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass As Amended

Motion Made By Todd Porter Seconded By Dale Henegar

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price - Chairwoman		X	Bruce A. Eckre		X
Robin Weisz - Vice Chairman	X		Ralph Metcalf	X	
William R. Devlin	X		Carol A. Niemeier		X
Pat Galvin	X		Wanda Rose		X
Dale L. Henegar	X		Sally M. Sandvig		X
Roxanne Jensen		X			
Amy N. Kliniske	X				
Chet Pollert	X				
Todd Porter	X				
Blair Thoreson	X				

Total Yes 9 No 6
Absent 0

Floor Assignment Chet Pollert

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1478, as engrossed: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO NOT PASS** (9 YEAS, 6 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1478 was placed on the Sixth order on the calendar.

Page 2, remove lines 22 through 27

Renumber accordingly

1999 TESTIMONY

HB 1478

ND House of Representatives
Representative
Roxanne Jensen

UNIVERSAL NEWBORN HEARING SCREENING

NCHAM National Center for Hearing Assessment and Management Utah State University™

HB 1478

FACT SHEET

Fact 1 Every day, 33 babies (or 12,000 each year) are born in the United States with permanent hearing loss. Hearing loss is present in 3 of every 1,000 births, making it the most frequently occurring birth defect.

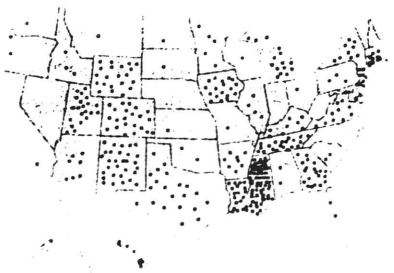
Fact 2 In a 1988 report to Congress and the President, the Commission on Education of the Deaf estimated that in the United States, the average age that children with congenital hearing loss were identified was 2-1/2 to 3 years of age, with many children not being identified until 5 or 6 years of age.

Fact 3 "If hearing impaired children are not identified early, it is difficult, if not impossible, for many of them to acquire the fundamental language, social, and cognitive skills that provide the foundation for later schooling and success in society."

Fact 4 The National Institutes of Health, American Academy of Pediatrics, American Academy of Audiology, the Joint Committee on Infant Hearing, and the Healthy People 2000 Report have all recommended that children with congenital hearing loss be identified before 6 months of age.

Fact 5 In 1993, a Consensus Panel convened by the National Institutes of Health concluded "that all infants should be screened for hearing impairment. . . . This will be accomplished most efficiently by screening prior to discharge. . . . Infants who fail . . . should have a comprehensive hearing evaluation no later than 6 months of age."

Fact 6 "When early identification and intervention occurs, hearing impaired children make dramatic progress, are more successful in school, and become more productive members of society."



LOCATION OF UNIVERSAL NEWBORN HEARING SCREENING PROGRAMS

Fact 7 The practicability and cost-efficiency of hospital-based universal newborn hearing screening is demonstrated by the fact that over 400 hospitals in 41 states are operating successful universal newborn hearing screening programs.

Fact 8 The cost for hospital-based universal newborn hearing screening is very inexpensive and continues to decrease. Using current technology, the cost ranges from $10-$60 per baby depending on the protocol and technology used.

For more information, including free telephone consultations and program development material, call 435/797-3584.
Visit our web site at www.usu.edu/~ncham/

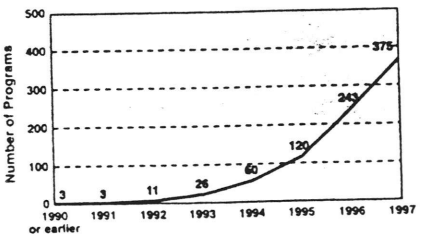
Fact 9 The cost per child identified with congenital hearing loss is about 1/10th the cost per child identified with PKU, hypothyroidism, or sickle cell anemia in metabolic disorder screening programs. Such metabolic disorder screening programs are required in all 50 states.

Fact 10 Research has compared children with hearing loss who receive early intervention and amplification before 6 months of age versus after 6 months of age. By the time they enter first grade, children identified earlier are 1-2 years ahead of their later-identified peers in language, cognitive, and social skills.

Fact 11 Infants with hearing loss can be fit with amplification as young as 4 weeks of age. With appropriate family-centered intervention, normal language, cognitive, and social development for such infants is likely.

Fact 12 The evidence for the benefits, practicability, and cost-efficiency of universal newborn hearing screening is so compelling that eight states (HI, RI, MS, CT, CO, UT, VA, and WV) have passed legislative mandates requiring hospitals to screen all newborns for hearing loss. Similar legislation is pending in several other states.

Fact 13 More than 95% of all babies should be screened for hearing loss in the birth hospital, and comprehensive, family-centered service should be available for identified children and families. Such statewide early hearing detection and intervention programs are now operational in at least three states (HI, MS, and RI), and others are rapidly approaching such statewide systems (WY, UT, CO, IA, NM, and CT).



UNIVERSAL NEWBORN HEARING SCREENING PROGRAMS IN THE USA BY YEAR OF IMPLEMENTATION

Fact 14 The number of hospitals implementing universal newborn hearing screening has increased more than thirty-fold in the last 5 years. Nonetheless, only about 20% of the babies in this country are born in hospitals with universal newborn hearing screening programs, and more than 90% of all hospitals do not screen hearing prior to discharge.

Fact 15 If it remains undetected, even mild hearing loss or hearing loss in only one ear has substantial detrimental consequences. For example, research shows that children with hearing loss in one ear are ten times as likely to be held back at least one grade compared to a matched group of children with normal hearing.

Fact 16 Research shows that by the time a child with hearing loss graduates from high school, as much as $421,000 per child can be saved in special education costs. If the child is identified early and given appropriate early intervention, these savings in special education costs will pay for universal newborn hearing screening, detection, and intervention many times over.

Statement of

Stephen McDonough MD
Chief Medical Officer
State Department of Health

on
House Bill No. 1478

Regarding
Screening Infants for Congenital Hearing Loss

Before the
House Human Services Committee

January 25, 1999

Good morning, Madame Chairman, and members of the Committee. I am Dr. Stephen McDonough, Chief Medical Officer of the North Dakota Department of Health. Our Department is very pleased to provide information about newborn hearing screening, which is the subject of HB 1478.

In January 1995, the American Academy of Pediatrics recommended that "all infants with hearing loss should be identified before 3 months of age, and receive intervention by 6 months of age." Under HB 1478, newborn hearing screening would be required for each infant born in North Dakota within the first months of life.

Severe congenital hearing loss occurs in an estimated 8-12 North Dakota newborn infants each year. The incidence of congenital hearing loss is ten times as common as phenylketonuria (PKU) and three to four times as common as congenital hypothyroidism, two conditions currently screened by newborn metabolic screening programs. Early diagnosis and treatment of hearing loss — before six months of age— results in improved speech development. Although several large North Dakota hospitals are screening most newborns for congenital hearing loss, a review of the records of 25 children receiving services from the Children's Special Health Services for

congenital hearing loss shows that the average age at which these children were diagnosed was five years of age. Only one child was diagnosed in the first six months of life.

What is the prevalence of congenital hearing loss?

The prevalence of newborn and infant hearing loss is estimated to range from 1.5 to 6.0 per 1,000 live births. Risk factor screening (i.e. those with a family history of hearing loss, premature infant, etc.) identifies only 50 percent of infants with significant hearing loss. Failure to identify the remaining 50 percent of children with congenital hearing loss may result in diagnosis and intervention at a later age—after speech development has begun in children with normal hearing.

Why is it important to detect hearing loss at an early age?

Children whose hearing loss is identified by six months of age demonstrated significantly better language scores than children identified after six months of age.

What types of screening tests are available and what do they cost?

Hearing loss of 30 *dB* (decibels) and greater in the frequency region important for speech recognition (500 through 4000 Hz) will interfere with the normal development of speech and language. Two tests (auditory brainstem response [ABR] and otoacoustic emissions [OAE]) are able to detect significant hearing loss in the newborn period. The ABR method utilizes a series of soft clicks delivered through foam-cushioned earphones. The newborn's brain responds with brainwaves detected by delicate sensors placed on the baby's head. The OAE method utilizes a speaker and microphone within a probe. The probe is placed in the ear canal. A sound is transmitted from the speaker and the microphone detects a resulting secondary sound from the inner ear (cochlea).

Successful screening in the nursery before a newborn infant leaves the hospital can be achieved for 96 percent of infants. The failure rate for hearing testing is approximately four percent. The incidence of bilateral loss requiring amplification is approximately 1.4/1000. The false-positive rate is approximately 3.5 percent after the initial screening and 0.2 percent when a two-stage screening procedure is used. The cost of screening is roughly $17 per infant, and the cost to identify each true bilateral hearing loss is $17,750.

The cost of newborn hearing screening compares favorably to existing screening tests. The cost to identify a hearing-impaired newborn is estimated to range from $9,600 to $17,750 which compares favorably to the costs to identify metabolic disorders: hypothyroidism, $10,800; phenylketonuria, $40,000; and cystic fibrosis, $6,000. Residential education for hearing impaired children can cost more than $35,000 a year, while nonresidential training costs approximately $9,700 a year per child in a class of hearing-impaired children or $3,300 a year for a child in regular classes.

Are North Dakota hospitals providing newborn hearing screening?

A telephone survey of North Dakota's largest hospitals was conducted in August 1998. Approximately 35 percent of newborns delivered in these hospitals were screened for hearing loss. Considerable variation existed in screening rates across the state. Nearly all newborns at Altru Health System in Grand Forks were screened while approximately 5 percent of newborns in Bismarck (MedCenter One, St. Alexius) were screened. High screening rates were reported at Trinity Hospital in Minot (>90 percent) and Meritcare in Fargo (>90 percent). Moderate screening rates were reported at Unimed in Minot (<50 percent) and Dakota Hospital in Fargo (33 percent).

A previous survey of North Dakota hospitals in November 1997 showed nearly one quarter (seven out of 29 hospitals with nursery services) providing newborn hearing screening. Meritcare screened only 20 percent of newborns while Altru screened 16 percent. Trinity screened 65 percent.

How many states have hearing screening laws?

Ten states have passed universal newborn hearing screening laws, including Colorado (1997), and Utah (1998). Also in 1998, the California legislature approved a substantial appropriation that required newborn hearing screening for 70 percent of the state's 550,000 annual births.

Summary

Newborns hearing screening has been adopted by many hospitals and states as a comprehensive method to identify infants that need treatment to correct severe hearing loss and prevent speech development delay. Mild, moderate, and severe bilateral, persistent hearing loss can be identified in the hospital nursery or in the first three months of life by high quality, low-cost testing. And, as previously noted, if amplification (hearing aids) is provided before the age of six months, speech and language development will be optimized.

* * *

Madame Chairman, that completes my testimony. I will be happy to answer any questions that you or other Committee members have about hearing screening programs.

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
STATE CAPITOL - JUDICIAL WING
600 E BOULEVARD AVE DEPT 325
BISMARCK, NORTH DAKOTA 58505-0250

Carol K. Olson, Executive Director

Edward T. Schafer, Governor

November 9, 1998

LaVonne Boucher
Physician Services
Trinity Medical Center
PO Box 5010
Minot, ND 58702-5010

RE: Newborn hearing testing

Dear LaVonne:

This is in response to your letter of October 12, 1998 that you sent to Deb Dietz of this department concerning coverage and payment for newborn hearing testing.

Coverage and payment is approved for this service with testing occuring before inpatient discharge included in the DRG and with testing occuring after inpatient discharge being billed with CPT-4 code with modifier 92587-26.

If you have any question you can contact me at 701-328-4893.

Sincerely,

Patricia A. Kramer, R.Ph.
Director, Utilization Management
Medical Services

c: Deb Dietz, Claims Supervisor

GENERAL INFORMATION (701) 328-2310
FAX (701) 328-2359
TDD 1-800-366-6888

ECONOMIC ASSISTANCE (701) 328-2332
EXECUTIVE OFFICE (701) 328-2538
FIELD SERVICES (701) 328-2310
PROGRAM & POLICY (701) 328-2310