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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #01-58

DIGEST

Amends 405 IAC 5-2-17 to clarify the definition of medical necessity. Amends 405 IAC 5-7-1 to clarify policy regarding suspension of incomplete prior authorization requests. Amends 405 IAC 5-8-3 to clarify consultations policy. Amends 405 IAC 5-14 to revise policy and coverage for dental services, including removing coverage for dentures for adults. Amends 405 IAC 5-19 to revise policy and coverage for orthopedic shoes and corrective features. Amends 405 IAC 5-23 to remove coverage for eyeglasses, frames, and contact lenses for adults. Amends 405 IAC 5-37-3 to add dentists to the list of practitioners that may provide smoking cessation counseling services. Makes additional technical conforming changes. Effective 30 days after filing with the secretary of state.

405 IAC 5-2-17
405 IAC 5-3-4
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405 IAC 5-37-3

SECTION 1. 405 IAC 5-2-17 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-2-17 "Medically reasonable and necessary service" defined
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 17. "Medically reasonable and necessary service" means a service that ~~meets current professional standards commonly held to be applicable to the case.~~ **is essential for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must be medically reasonable and necessary, as determined by the office using generally accepted standards of medical or professional practice, and not listed in this title as a noncovered service, or excluded from coverage under other applicable state or federal law.** *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-17; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302)*

SECTION 2. 405 IAC 5-3-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-4 Audit
Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 4. Retrospective audit shall include postpayment review of the medical record to determine the medical necessity of service ~~based upon current professional standards held applicable.~~ **as defined in this article.** *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303)*

SECTION 3. 405 IAC 5-3-11 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-3-11 Criteria for prior authorization
Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 11. The office's decision to authorize, modify, or deny a given request for prior authorization shall include consideration of the following:

(1) Individual case-by-case review of the completed Medicaid prior review and authorization request form.

(2) The medical and social information provided on the request form or documentation accompanying the request form.

(3) Review of criteria set out in this section for the service requested.

(4) The medical necessity of the requested service ~~based upon current professional standards commonly held to be applicable to the case.~~ **as defined in this article.**

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305)

SECTION 4. 405 IAC 5-7-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-7-1 Appeals of prior authorization determinations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. (a) Medicaid recipients may appeal the denial or modification of prior authorization of any Medicaid covered service under 405 IAC 1.1.

(b) Any provider submitting a request for prior authorization under ~~405 IAC 3-3,~~ **405 IAC 5-3,** which has been denied either in whole or in part, may appeal the decision under 405 IAC 1.1 after exhausting the administrative remedies provided in this rule.

(c) ~~A prior authorization request will be rejected~~ When there is insufficient information submitted to render a decision, ~~It~~ **a prior authorization request will be suspended for up to thirty (30) days, and the office or its contractor will request additional information from the provider. Suspension** is not a final decision on the merits of the request and is not appealable. ~~A rejected request may be resubmitted with~~ **If the provider does not submit the** additional information **requested within thirty (30) days, the request shall be denied. Denial is a final decision and may be appealed pursuant to subsections (a) and (b).** *(Office of the Secretary of Family and Social Services; 405 IAC 5-7-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309)*

SECTION 5. 405 IAC 5-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-8-3 Restrictions
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) A consultation cannot be used for the evaluation of a nonphysician referred or self-referred recipient.

(b) ~~A~~ **An office or other outpatient** consultation must address a specific condition not previously diagnosed or managed by the consulting physician. **If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used by the consulting physician again.**

(c) Reimbursement for an initial consultation is limited to one (1) per consultant, per recipient, per inpatient hospital or nursing facility admission.

(d) ~~A second consultation provided by the same consultant physician to the same recipient must be for a new unrelated condition and clearly documented as such by the requesting physician.~~ **Follow-up inpatient consultations may be billed if visits are needed to complete the initial consultation, or if subsequent consultative visits are requested by the attending physician. These consultative visits include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status.**

(e) If a recipient is referred for management of a condition or the consulting physician assumes patient management,

consultation codes cannot be billed to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-8-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310)*

SECTION 6. 405 IAC 5-14-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-1 Policy
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. **(a)** Medicaid reimbursement is available only for those dental services listed in section 2 of this rule subject to the limitations set out in this rule. The dental portion of the Indiana Medicaid program places top priority on prevention, relief of pain, elimination of infection, and pathology.

(b) All dental services must be provided in accordance with criteria defined by the office, and documentation must substantiate that the criteria were followed. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319)*

SECTION 7. 405 IAC 5-14-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-2 Covered services
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. The following are covered dental services under the Indiana Medicaid program:
(1) Evaluations.
(2) Radiographs.
(3) Prophylaxis.
(4) Topical fluoride.
(5) Sealant.
(6) Amalgam.
(7) Unilateral and bilateral space maintainers.
(8) Resin anteriors and posteriors.
(9) Recement crowns.
(10) Steel crown primary.
(11) Stainless steel crown permanent.
(12) Pin retention.
(13) Pulpcap.
(14) Therapeutic pulpotomy.
(15) Extractions.
(16) Oral biopsies.
(17) Alveoplasty.
(18) Excision of lesions.
(19) Excision of benign tumor greater than one and twenty-five hundredths (1.25) centimeters.
(20) Odontogenic cyst removal.
(21) Nonodontogenic cyst removal.
(22) Incise and drain abscess.
(23) Sequestrectomy osteomyelitis.
(24) Fracture simple stabilize.
(25) Compound fracture of the mandible.
(26) Compound fracture of the maxilla.
(27) Repair of wounds.
(28) Suturing.
(29) Osteoplasty for orthognathic deformity.
(30) Emergency treatment dental pain.
(31) Analgesia.

(32) Therapeutic drug injection.
(33) Drugs and medicaments.
(34) Treatment of complications postsurgery.
(35) Periodontal surgery limited to drug-induced periodontal hyperplasia.
(36) Other dental services as medically necessary to treat recipients eligible for the EPSDT program.
(37) Confirmatory consultations.
(38) Periodontal root planing and scaling.
(39) General anesthesia.
(40) Intravenous (IV) sedation.
(41) Orthodontia only in cases of cranio-facial deformity or cleft palate.
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319)

SECTION 8. 405 IAC 5-14-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-4 Topical fluoride
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. Reimbursement is available for one (1) topical application of fluoride every six (6) months per recipient only for patients ~~who are eighteen (18) months of age or older but who are younger than nineteen (19)~~ **from birth through age twenty (20)** years of age. Topical applications of fluoride are not covered for recipients nineteen (19) years of age or older. Brush-in fluoride (topical application of fluoride phosphate) is not a covered service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320)*

SECTION 9. 405 IAC 5-14-6 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-6 Prophylaxis
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. Prophylaxis is a covered service in accordance with the following limitations:
(1) One (1) unit every six (6) months for noninstitutionalized recipients ~~over eighteen (18) months of age~~ **from birth** up to their twenty-first birthday.
(2) One (1) unit every twelve (12) months for noninstitutionalized recipients twenty-one (21) years of age and older.
(3) Institutionalized recipients may receive up to two (2) units every six (6) months.
~~(4) Prophylaxis is not covered for recipients under eighteen (18) months of age.~~
(Office of the Secretary of Family and Social Services; 405 IAC 5-14-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320)

SECTION 10. 405 IAC 5-14-14 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-14-14 Office visits
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 14. Payment for office visits **during regularly scheduled hours** is not covered. Reimbursement is available only for covered services actually performed. Covered services provided outside the office will be reimbursed at the fee allowed for the same service provided in the office. **An office visit provided after regularly scheduled hours when the office is opened specifically to provide treatment for a dental emergency is a covered service.** *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321)*

SECTION 11. 405 IAC 5-14-22 IS ADDED TO READ AS FOLLOWS:

405 IAC 5-14-22 Dentures and partial dentures
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 22. Dentures, partials, and services related to dentures and partials for adults, twenty-one (21) years of age and older are not a covered service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-22)*

SECTION 12. 405 IAC 5-19-7 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-7 Prior authorization criteria
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 7. Prior authorization requests for DME shall be reviewed on a case-by-case basis by the contractor, using **all of** the following criteria:

(1) The item must be medically **reasonable and** necessary, **as defined at 405 IAC 5-2-17,** for the treatment of an illness or injury or to improve the functioning of a body member.

(2) The item must be adequate for the medical need; however, items with unnecessary convenience or luxury features will not be authorized.

(3) The anticipated period of need, plus the cost of the item will be considered in determining whether the item shall be rented or purchased. This decision shall be made by the contractor based on the least expensive option available to meet the recipient's needs.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330)

SECTION 13. 405 IAC 5-19-10 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-10 Braces and orthopedic shoes
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) Medicaid reimbursement is available for the following:

(1) Braces for the leg, arm, back, and neck. ~~for recipients of all ages.~~

(2) Orthopedic shoes. ~~for recipients over twenty-one (21) years of age with severe diabetic foot disease or if the orthopedic shoe is connected to a brace.~~

(3) Corrective features built into shoes such as heels, lifts, and wedges. ~~only for recipients under twenty-one (21) years of age.~~

(b) All items specified in subsection (a) must be ordered in writing by a physician or podiatrist and be prior authorized by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330)*

SECTION 14. 405 IAC 5-23-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-23-4 Frames and lenses; limitations
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 4. The provision of frames and lenses are subject to the following limitations:

(1) Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars ($20) per pair except when medical necessity requires a more expensive frame. Situations where medical necessity for a more expensive frame may be indicated include, but are not limited to, the following:

(A) Frames to accommodate facial asymmetry or other anomalies of the head, neck, face, or nose.

(B) Allergy to standard frame materials.

(C) Specific lens prescription requirements.

(D) Frames with special modifications, such as a ptosis crutch.

(E) Provision of frames to an infant where special size frames must be prescribed that are unavailable for twenty dollars ($20) or less.

All Medicaid claim forms submitted for a more expensive frame must be accompanied by medical necessity documentation.

(2) Fashion tints, gradient tints, sunglasses, or photochromatic lenses are not covered. Tint numbers 1 and 2 are covered, for example, rose A, pink 1, soft lite, cruxite, and velvet lite.

(3) Except when medical necessity is documented, lenses larger than size 61 millimeters are not covered.

(4) All Medicaid claim forms submitted for vision materials must be accompanied by a valid copy of the laboratory invoices.
(5) Reimbursement for eyeglasses provided to a recipient under nineteen (19) years of age will be limited to a maximum of one (1) pair per year only if the criteria set out in subdivision (7) have been met. The office will provide reimbursement for repairs or replacements of eyeglasses only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the recipient's control, for example, fire, theft, or automobile accident. The documentation of the extenuating circumstances must be maintained in the provider's office and shall be subject to postpayment review and audit.
(6) Reimbursement for eyeglasses provided to a recipient **between** nineteen (19) **and twenty-one (21)** years of age ~~or over~~ is limited to a maximum of one (1) pair every two (2) years if the criteria set out in subdivision (7) have been met. Replacements will only be covered under subdivision (5).
(7) The office shall not provide reimbursement for an initial or subsequent pair of glasses unless the minimum prescription or change meets the following criteria:
(A) For one (1) eye, a minimum initial prescription or, for a subsequent pair of glasses, a change of seventy-five hundredths (.75) diopters for a patient six (6) to ~~forty-two (42)~~ **twenty-one** years ~~or~~ **of** age. ~~and fifty-hundredths (.50) diopters prescription or change for a patient over forty-two (42) years of age.~~
(B) An axis change of at least fifteen (15) degrees. When provided in accordance with subdivisions (5) and (6), glasses that meet the criteria of this subdivision may be provided without prior authorization.
(8) Safety lenses are covered only for corneal lacerations or other severe intractable ocular or ocular adnexal disease.
(Office of the Secretary of Family and Social Services; 405 IAC 5-23-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343)

SECTION 15. 405 IAC 5-23-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-23-5 Contact lenses
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 25-24-1-4

Sec. 5. **(a)** Contact lenses **for recipients under twenty-one (21) years of age** are covered only when medical necessity is documented and are not covered for cosmetic purposes. Documentation of such medical necessity must be maintained in the provider's office and shall be subject to postpayment review and audit.

(b) Contact lenses are not a covered service for recipients twenty-one (21) years of age and older. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3344)*

SECTION 16. 405 IAC 5-29-1, AS AMENDED AT 24 IR 15, SECTION 2, IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-29-1 Noncovered services
Authority: IC 12-8-6-3; IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. The following services are not covered by Medicaid:
(1) Services that are not medically reasonable or necessary ~~according to current professional standards commonly held to be applicable to the case.~~ **as defined in this article.**
(2) Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.
(3) Experimental drugs, treatments, or procedures, and all related services.
(4) Any new product, service, or technology not specifically covered in this article. The product, service, or technology will remain a noncovered product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This subdivision does not apply to legend drugs.
(5) Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.
(6) Services for the remediation of learning disabilities.
(7) Treatments or therapies of an educational nature.
(8) Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following:
(A) Acupuncture.
(B) Biofeedback therapy.
(C) Carbon dioxide five percent (5%) inhalator therapy for inner ear disease.
(D) Hyperthermia.

(E) Hypnotherapy.
(9) Hair transplants.
(10) Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas deferens). This procedure is covered only in conjunction with disease.
(11) Augmentation mammoplasties for cosmetic purposes.
(12) Dermabrasion surgery for acne pitting or marsupialization.
(13) Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem.
(14) Otoplasty for protruding ears unless one (1) of the following applies to the case:
(A) Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, for example, Pierre Robin Syndrome.
(B) A recipient has pending or actual employment where protruding ears would interfere with the wearing of required protective devices.
(15) Scar removals or tattoo removals by excision or abrasion.
(16) Ear lobe reconstruction.
(17) Removal of keloids caused from pierced ears unless one (1) of the following is present:
(A) Keloids are larger than three (3) centimeters.
(B) Obstruction of the ear canal is fifty percent (50%) or more.
(18) Rhytidectomy.
(19) Penile implants.
(20) Perineoplasty for sexual dysfunction.
(21) Reconstructive or plastic surgery unless related to disease or trauma deformity.
(22) Sliding mandibular osteotomies unless related to prognathism or micrognathism.
(23) Blepharoplasties when not related to a significant obstructive vision problem.
(24) Radial keratotomy.
(25) Miscellaneous procedures or modalities, including, but not limited to, the following:
(A) Autopsy.
(B) Cryosurgery for chloasma.
(C) Conray dye injection supervision.
(D) Day care or partial day care or partial hospitalization except when provided pursuant to 405 IAC 5-21.
(E) Formalized and predesigned rehabilitation programs, including, but not limited to, the following:
(i) Pulmonary.
(ii) Cardiovascular.
(iii) Work-hardening or strengthening.
(F) Telephone transmitter used for transtelephonic monitor.
(G) Telephone, or any other means of communication, consultation from one (1) doctor to another.
(H) Artificial insemination.
(I) Cognitive rehabilitation, except for treatment of traumatic brain injury.
(26) Ear piercing.
(27) Cybex evaluation or testing or treatment.
(28) High colonic irrigation.
(29) Services that are not prior authorized under the level-of-care methodology as required by 405 IAC 5-19.
(30) Amphetamines when prescribed for weight control or treatment of obesity.
(31) Under federal law, drug efficacy study implementation drugs not covered by Medicaid.
(32) All anorectics, except amphetamines, both legend and nonlegend.
(33) Physician samples.
(34) Dentures, partial dentures, and services related to dentures and partial dentures for adults, twenty-one (21) years of age and older.
(35) Eyeglasses, frames, and contact lenses for adults, twenty-one (21) years of age and older.

(Office of the Secretary of Family and Social Services; 405 IAC 5-29-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3356; filed Sep 27, 1999, 8:55 a.m.: 23 IR 320; filed Sep 1, 2000, 2:16 p.m.: 24 IR 15)

SECTION 17. 405 IAC 5-37-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-37-3 Smoking cessation counseling
Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3

Affected: IC 12-15

Sec. 3. (a) Reimbursement is available for smoking cessation counseling services rendered by licensed practitioners under applicable Indiana law participating in the Indiana Medicaid program and listed in subsection (b).

(b) The following may provide smoking cessation counseling services when prescribed by a practitioner within the scope of his license under Indiana law and within the limitations of this rule:

(1) A physician.
(2) A physician's assistant.
(3) A nurse practitioner.
(4) A registered nurse.
(5) A psychologist.
(6) A pharmacist.
(7) A dentist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-37-3; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on June 6, 2001 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Center Room A, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to clarify the definition of medical necessity, clarify policy regarding suspension of incomplete prior authorization requests, clarify consultations policy, revise policy and coverage for dental services, including removing coverage for dentures for adults, revise policy and coverage for orthopedic shoes and corrective features, remove coverage for eyeglasses, frames, and contact lenses for adults, and add dentists to the list of practitioners that may provide smoking cessation counseling services. Makes additional technical conforming changes. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W451 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Katherine Humphreys
Secretary
Office of the Secretary of Family and Social Services