

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

OAH No. 2013071309

CLAIMANT,

Claimant,

vs.

NORTH LOS ANGELES COUNTY REGIONAL
CENTER,

Service Agency.

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on May 5, 2014, in Santa Clarita, California. Claimant was represented by his mother and authorized representative.¹ North Los Angeles County Regional Center (NLACRC or Service Agency) was represented by Rhonda Campbell, Contract Manager.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on May 5, 2014.

While reviewing Claimant's Exhibit Q, the Administrative Law Judge noted that the exhibit cited to a NLACRC Report by Dr. Sandi Fischer, dated May 22, 2013 which was not submitted as evidence, but which could be helpful to the Administrative Law Judge in rendering a decision in this matter. Consequently, the Administrative Law Judge, on her own motion, re-opened the record and ordered NLACRC to file and serve Dr. Fischer's May 22, 2013 report/review by May 23, 2014. Additionally, the parties were afforded an opportunity to file and serve written comments/argument regarding that report/review by June 2, 2014. NLACRC timely filed and served the Fischer report, which was marked and admitted as Exhibit 36. Claimant did not file any comments/argument regarding Exhibit 36. NLACRC timely filed a Response to Order Opening the Record and Declaration of Dr. Fischer, which was marked as Exhibit 37 and lodged as argument. The record was re-closed,

¹ Claimant's and his mother's names are omitted to protect their privacy.

and the matter was re-submitted for decision on June 3, 2014.

ISSUE

Does Claimant have a developmental disability entitling him to receive regional center services?

FACTUAL FINDINGS

1. Claimant is an 11-year-old boy. He seeks eligibility for regional center services based on a diagnosis of Autism Spectrum Disorder, Intellectual Disability or under the “fifth category” of eligibility.²

2. On June 4, 2013, NLACRC sent a letter and a Notice of Proposed Action to Claimant’s mother, informing her that NLACRC had determined that Claimant is not eligible for regional center services. Claimant requested a fair hearing. (Exhibit 1.)

3. Claimant had previously received speech therapy services funded by the Service Agency under the Early Start Program.³ (Exhibit M.)

4. At the time he began the Early Start services in 2005, Claimant’s mother reported the following: Claimant walked at 16 months of age. He was able to run, climb stairs, feed himself with a spoon, and drink from a regular cup. Claimant responded to his name. He followed through with simple commands and directions. Claimant repeated words and used about 30 words, most of which were not clear. He communicated his needs in single words or by pointing, crying, screaming and/or throwing himself on the floor. He did not know body parts. He identified pictures in books. He did not pay attention to stories. Claimant loved to play with and line up toy cars. He was aggressive with his parents, siblings and other children at day care, and hit and bit other children. He did not have self-

² For an explanation of “fifth category” eligibility, see Legal Conclusion 5.

³ “Early Start” is the name used in California to refer to a federal program for children under age three who are at risk for certain disabilities. The governing law for Early Start is The Individuals with Disabilities Education Act (IDEA), Subchapter III, Infants and Toddlers with Disabilities (20 U.S.C. §§ 1431-1445) and the applicable federal regulations found in Title 34, Code of Federal Regulations (C.F.R.), section 303, et seq. Each state was given the opportunity to receive federal funds for providing services to eligible children 36 months of age and younger if the state complied with federal rules and regulations. California chose to participate, and the Legislature passed legislation necessary for that participation. The California Early Intervention Services Act is found at Government Code section 95000, et seq. California also adopted regulations to implement the statutory scheme. (Cal. Code Regs., tit. 17, sections 52000-52175.)

control, was easily distracted, and was not aware of dangerous situations. He demonstrated poor eye contact. (Exhibit M.)

5. In September 2005, he began receiving speech and language services through Clari T Therapy Services. In an Initial Speech and Language Evaluation Report from Clari T Therapy Services, the evaluator noted that Claimant “appeared to be comfortable in the testing environment as he freely played with the toys engaging his mother and the examiner with eye contact, smiles, laughter and 1-2 word phrases.” (Exhibit 3.) Claimant was 34 months old at the time of the evaluation. His receptive language skills were determined to be at the 15-month-old level with some scatter of skills at the 18-month level. His expressive language skills were determined to be at the 21-month-old level.

6(a). In a Speech and Language Assessment Report from Claimant’s school district, dated April 21, 2006, the evaluator noted that claimant (then 3 years, 5 months old) was referred for evaluation due to difficulty pronouncing sounds and language delays. Claimant’s mother reported that he sat at seven months and walked at nine months of age. Claimant’s mother also reported concern about his behavior because he was easily angered.

6(b). The evaluator noted that Claimant was a friendly boy who transitioned easily to testing. He was willing to sit at a small table with the evaluator and maintained adequate focus during the assessment. The evaluator found that Claimant displayed receptive/expressive language skills and phonological development within the norm for his age. He therefore did not qualify for special education services at that time. (Exhibit 4.)

7. In November 2007, Claimant was evaluated by his psychotherapist, Brad Wood, M.S.W., L.C.S.W., who opined that Claimant suffered from Attention Deficit Hyperactivity Disorder (ADHD), predominantly Hyperactive Impulsive Type. He referred Claimant to a medical doctor for evaluation for psychotropic medication. (Exhibit 5.)

8. In 2008, Claimant was evaluated at the M.C.L.A. Psychiatric Medical Group (MCLA), where his reported symptoms were: “Hyperactive, distractible, impulsive, runs around office and classroom, poor handwriting, bothers other children and multiple other ADHD symptoms.” His mother reported that he was “happy.” The evaluator noted “no perseveration,” and that Claimant had “good eye contact,” and was “engaging,” and “talkative.” (Exhibit 6.)

9. On March 13, 2008, progress notes by Claimant’s treating psychiatrist, Linda Woodall, M.D., at MCLA indicated that Claimant had a diagnosis of ADHD. Claimant began using a Daytrana transdermal patch, and his teachers reported that his behavior had improved. By May 24, 2008, Clonidine had been added to Claimant’s medication regimen, and by June 2008, Claimant was reported to be more focused with no complaints at school or daycare. In July 2008, Claimant was reportedly very hyperactive without his medications. In September 2008, Claimant’s medication was changed to Risperdal and Concerta; in October and November 2008, Claimant’s teacher noticed improvement following the medication change, and Claimant’s mother reported less tantrums. (Exhibit 6.)

10. In 2009, Claimant was found eligible for special education services under the category of Other Health Impairment (OHI) due to his ADHD diagnosis. (Exhibit 7.) Claimant generally did well in school, with some intermittent hyperactivity and trouble at school. (Exhibit 6.)

11. In May 2010, Claimant had moved to a new school. He was unhappy with the move and was exhibiting behavior problems. In July 2010, Claimant's medications were changed to non-stimulants due to his pediatrician's concerns about his slow growth. This medication change was not efficacious, and Claimant was again prescribed Ritalin and Clonidine. However, in October 2010, Claimant's mother stopped administering medications because she read that his "growth will be stunted, he'll be psychotic in seven years, and he'll grow up to be a drug addict." Claimant returned to being very hyperactive. Nevertheless, throughout 2011, Claimant's mother remained afraid to administer his medications, and Claimant continued being hyperactive and aggressive and doing poorly in school. (Exhibit 6.)

12. In a March 2011 psycho-educational evaluation, Claimant's school district noted that "test results indicate him to be functioning within the above average range of cognitive development, with verbal visual-spatial and non-verbal reasoning abilities being commensurate." (Exhibit 8.) However, other "diagnostic testing suggests continued deficits in processing speed, which falls within the below average range. Difficulties with processing speed are consistent with [Claimant's] diagnosed [ADHD]." (Exhibit 8.) The school district further noted:

[Claimant's] mother's responses to a standardized behavior rating scale yielded multiple clinically significant concerns with regards to [Claimant's] emotional and behavioral responses. His teacher's responses to the teacher specific version of the scale did not yield any specific clinically significant emotional or behavioral concerns other than a borderline clinically significant concern with regards to attention, which is consistent with his previously diagnosed [ADHD].

(Exhibit 8.)

13. In a March 2011 Individualized Education Plan (IEP), Claimant's school district found that he continued to be eligible for special education services under the category of OHI due to his ADHD diagnosis. The district noted that his academic skills, fine motor skills, and gross motor skills were in the average range. Additionally, his receptive and expressive language skills were in the average range. Regarding his Social Emotional/Behavioral skills, the district noted:

On medication [Claimant] is noted to get along well with peers and adults. His mother reports that she has seen recent improvements in his behavior with his medication, but expressed concerns regarding

tantruming (at a rate of approximately once every two weeks), difficulty playing fair (gets mad and runs away during games if he is not winning), and low frustration tolerance. [Claimant's] classroom teacher's responses to two behavior checklists do not yield any clinically significant concerns at the present time. Difficulties in these areas may be related to several factors including [claimant's] young age and his diagnosed [ADHD].

(Exhibit 9.)

14(a). In August 2011, a Licensed Clinical Social Worker with Facey Medical Group completed a one-page document entitled "Initial Assessment," which indicated that she had "diagnosed him with Autistic Spectrum Disorder." (Exhibit 10.)

14(b). The Initial Assessment does not indicate what testing had been administered to arrive at a diagnosis of Autistic Spectrum Disorder. Additionally, in 2011, Autistic Spectrum Disorder was not a recognized diagnosis under the then current manual of mental disorders.⁴ Consequently, the Facey diagnosis of Autistic Spectrum Disorder, by itself, is given little weight. However, it is considered along with the totality of the evidence which contains other references to Claimant's diagnosis of a disorder on the autism spectrum.

15(a). In a September 2, 2011 IEP, Claimant's school district found that he continued to be eligible for special education services under the category of OHI due to his ADHD diagnosis. (Exhibit 12.)

15(b). On September 7, 2011, a psycho-educational evaluation was conducted due to Claimant's behaviors, which included impulsively running off campus, lying on the ground outside and under his desk for long periods of time, ignoring school staff's redirection, and not completing class work. The evaluation determined the following:

Based on standardized rating scales completed by parent and teacher that assess an individual child's behavioral and emotional responses, [Claimant's] parent reported clinical concerns with regards to anxiety or depression, withdrawn or depressed behavior, problems with social relationships, thought problems, attention problems, rule-breaking behavior and problems of an aggressive nature while his teacher reported clinical concerns with anxiety or depression, withdrawn or depressed behavior, problems with social relationships, thought

⁴ The Administrative Law Judge takes official notice of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a generally accepted tool for diagnosing mental and developmental disorders. In 2011, the DSM-IV-TR was the edition being used. An updated edition, the DSM-V, was published in May 2013 and subsequently utilized as the current tool for diagnosing mental and developmental disorders.

problems, attention problems and problems of an aggressive nature. Based on current findings, [Claimant] does appear to meet the eligibility criteria for special education services as a student with Emotional Disturbance . . .

(Exhibit 13.)

15(c). At a September 29, 2011 IEP, Claimant's school district found that he continued to be eligible for special education services, but under the primary category of Emotional Disturbance (ED), and the secondary category of OHI due to his ADHD diagnosis. On November 28, 2011, Claimant transitioned to the Special Day Class (SDC) at his school. (Exhibits 15 and 17.)

16(a). On September 13, 2011, licensed psychologist Anna Levi, Psy.D., conducted a psychological assessment of Claimant to determine his current functioning level and to assess for possible Autistic characteristics. The evaluation included a review of previous testing and records, an interview with Claimant's parent, observations of Claimant, and administration of diagnostic tools for measuring cognitive functioning, and adaptive skills and for ascertaining characteristics of autism. (Exhibit 14.)

16(b). Dr. Levi obtained the following Background Information:

[Claimant] is a 8-year 9-month old boy who lives with his family. He has poor eye contact, does not smile back to others and has no variety in his facial expressions, appearing "very withdrawn" most of the time. He is "always by himself." He explodes and runs during a party. He cries because he thinks the kids fight with him. He sometimes does not respond well to peers' initiatives. . . . When he has a friend to play with, he plays briefly and then "goes to his world," losing interest in a friend after the initial 1 ½ hour. . . . [Claimant] shares or shows his interests and directs others' attention. He sometimes shares enjoyment with others. He does not offer to share his possessions. His mother reported that [Claimant] does not offer comfort to others, but he argued during the interview that he does give comfort to those in need. He does not look at the person well when he initiates. He needs an aide at school because he tries to run away, cries, "gets scared of new facts," and noises distract him.

[Claimant] uses somewhat limited gestures. He plays pretend with cars. He reported that he plays pretend zombies with a friend, but his mother reported that he does not imitate social play of others or play imaginatively with others. . . . He has no history of repetitive language, idiosyncratic or stereotyped language. When asked about his preoccupations, [he] suggested, "What about [T]ransformers and Power Rangers?" His mother reported that he plays appropriately with those

but excessively in terms of time. He reportedly plays with Lego for 3-4 hours since he was 6 years old and was preoccupied with cars previously. There are no nonfunctional routines reported. . . . His problems focusing, speech delay and immaturity were noted since kindergarten. There are no repetitive stereotyped movements reported. There is no history of repetitive use of objects or preoccupation with parts of objects.

(Exhibit 14.)

16(c). During her Behavioral Observation, Dr. Levi noted that Claimant “demonstrated very good make-believe play.” He was able to tell a story “with good spontaneous language and good understanding of humor and visual indications of social context.” Claimant “appeared to be impulsive and distracted as he touched things on the table, grabbing a cap from [Dr. Levi’s] bottle and a bathroom rod with keys among other objects that were clearly not for play.” Dr. Levi noticed that Claimant “changed his seat with another seat and moved a lot, fidgeting, lying with his head on the table, and thus, showing variable eye contact.” (Exhibit 14.)

16(d). To assess Claimant’s cognitive functioning, Dr. Levi administered the Wechsler Abbreviated Scale of Intelligence (WASI). Claimant complained of being tired, whined and refused to complete the full test. However, based on the two subtests he completed (vocabulary and block design) Dr. Levi determined that Claimant’s overall intellectual abilities were in the average range. (Exhibit 14.)

16(e). In the area of adaptive functioning, Dr. Levi administered the Vineland Adaptive Behavior Scales (VABS-II); Claimant’s mother provided the responses necessary for the completion of this test. Dr. Levi did not calculate an Adaptive Behavior Composite score for an overall measure of adaptive functioning due to the discrepancies between individual areas. Dr. Levi noted that Claimant’s communication skills are in the mild deficit range (standard score 64), his social skills are mildly deficient (standard score 59) and his daily living skills are in the low average range (standard score 85).

16(f). To address autism concerns, Dr. Levi administered the Autism Diagnostic Observation Schedule - Module 3 (ADOS-3), an observational assessment of Autism Spectrum Disorders, and the Autism Diagnostic Interview – Revised (ADI-R), with Claimant’s mother providing the necessary responses. On the ADOS-3, the scores in the communication and social interaction were at the autism-spectrum cutoff, but were below the autism cutoff. His overall score was below the autism and the autism-spectrum cutoff (i.e. not indicative of autism or autism spectrum). Based on Claimant’s mother’s report, his scores on the ADI-R indicated that communication and repetitive behaviors were below the autism cutoff and social interaction was well above the autism cutoff. (Exhibit 14.)

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16(g). In assessing whether Claimant had Mental Retardation, Dr. Levi noted:

The DSM-IV-TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; Washington, DC; American Psychiatric Association; 2000) diagnosis of mental retardation requires significantly sub-average intellectual functioning with concurrent deficits in adaptive functioning. [Claimant's] adaptive skills varied from low average to mildly deficient, but the abbreviated measure of overall intellectual abilities was in the average range, thus, he is not mentally retarded.

(Exhibit 14.)

16(h). In assessing whether Claimant had autistic disorder, Dr. Levi considered the 12 criteria set forth in the DSM-IV-TR for a diagnosis of autistic disorder, "six of which must be present (including at least two in the area of social interaction, and one each in communication and restricted or repetitive activities)." Dr. Levi found qualitative impairment in two areas of social interaction in that (1) he demonstrated a "failure to develop peer relationships appropriate to developmental level," based on his mother's report that he is "always by himself" and does not play for very long with another child; and (2) he demonstrated a "lack of social or emotional reciprocity," based on his mother's report that he does not offer comfort to others who are upset, does not socially reciprocate during a party, and misinterprets children's intentions as fighting with him. He also had difficulty reciprocating with Dr. Levi, in that he could not complete the cognitive testing and impulsively took personal items off Dr. Levi's desk despite redirection. Dr. Levi also found a qualitative impairment in one area of communication in that Claimant demonstrated "marked impairment in the ability to initiate or sustain a conversation with others." Dr. Levi noted:

[Claimant] appeared to have three impairments . . . which does not meet the DSM-IV-TR criteria for the diagnosis of Autistic Disorder. He has mild and few autistic-like symptoms, which meets the criteria for a mild Pervasive Developmental Disorder Not Otherwise Specified [(PDD NOS)].

(Exhibit 14.)

16(i). Dr. Levi diagnosed Claimant with PDD-NOS. (Exhibit 14.)

17. In 2011, the diagnosis of PDD-NOS was not one under which Claimant could qualify for regional center services under the category of "autism." At that time, a claimant needed to meet the specific criteria set forth in the DSM-IV-TR for a diagnosis of Autistic Disorder in order to qualify for regional center services. In 2011, autism spectrum disorder was not a recognized diagnosis, but rather an informal, descriptive term used to categorize a spectrum of specific and separate

developmental disabilities (called pervasive developmental disabilities), ranging from PDD-NOS to Autistic Disorder. Consequently, in November 2011, NLACRC's eligibility determination team found Claimant ineligible for regional center services. (Exhibit 22.)

18(a). Due to his ED, Claimant was eligible for educationally related mental health services through his school district. On December 10, 2011, he underwent an Educationally Related Mental Health Services Assessment through the Los Angeles County Department of Mental Health (DMH), which at that time, under AB3632, was the agency responsible for providing the educationally related mental health services to children with IEPs. The DMH assessment noted that Claimant was referred due to several behaviors including:

1. Poor frustration tolerance and poor coping skills. When frustrated, overwhelmed or if he thinks he is about to get in trouble, [Claimant] may run off the school campus, may lay on the ground and refuse to move or may fall limply under his desk and refuse to get up. [He] has required a one-on-one aide Special Circumstances Instructional Assistant or aide (SCIA) to be with him at all times to help him be contained on his school campus.
2. Poor peer interactions. [Claimant] has difficulty playing reciprocally with peers and tends to get overly competitive and sometimes verbally and physically aggressive with peers or he may isolate himself from peers.
3. Symptoms of [ADHD] including difficulty sustaining attention, difficulty remaining on task, difficulty following directions, difficulty completing class work and homework, disruptive and impulsive behaviors and need for constant redirection to task.
4. Possible symptoms of depression including shutting down emotionally, social withdrawal or ignoring adult directions and low self-esteem.

(Exhibit 16.)

18(b). During the DMH assessment, Claimant's mother reported that Claimant began receiving therapy at four years old, and from January 2011 to August 2011, he participated in family treatment with a therapist at Facey Medial Group. However, Claimant usually sat in the corner and played quietly, made little eye contact with the therapist and was very "clingy" with his mother. The therapist had opined that Claimant fell somewhere on the autistic spectrum. Claimant's mother also reported the Claimant's treating psychiatrist, Dr. Woodall, suspected that Claimant may have a developmental disability that falls on the autistic spectrum due to his history of speech delays, poor boundaries and difficulties with appropriate peer interactions. (Exhibit 16.)

18(c). During the mental status assessment, the DMH evaluator, Julie Criss-Hagerty, Ph.D., noted that she “did not see significant symptoms of autistic disorder during the interview, but that this should be further explored.” (Exhibit 16.)

19. In 2012, Claimant’s educationally related mental health services began and were delivered through the DMH on an outpatient basis, including individual therapy, family therapy, medication evaluation and follow-up by a psychiatrist if medications are prescribed. In 2013, the responsibility for providing those services shifted to Claimant’s school district. He began receiving educationally related intensive counseling services (ERICs) including individual counseling, group counseling, and parent/family counseling and training. (Exhibits 17 and 19.)

20. Throughout 2012 and 2013, Claimant continued to receive special education services through his school district under the primary category of ED and the secondary category of OHI due to his ADHD diagnosis. He continued to be described as a bright and capable of performing at grade level in all academic subjects. He also continued to display challenging behaviors such as tantrums, throwing chairs, yelling and use of excessive profanity in the classroom. Claimant remained highly distractible and unable to stay focused on the tasks/assignments at hand. His adaptive /daily living skills continued to be described as age appropriate. (Exhibits 17 and 19.)

21(a). Throughout 2012 and 2013, Claimant continued treatment with his psychiatrist, Dr. Woodall at MCLA. However, his mother remained noncompliant with his medication administration, and Claimant was intermittently hyperactive at school, which impaired his learning. Dr. Woodall also noted that Claimant was anxious, obsessive and rigid. (Exhibit 6.)

21(b). On February 11, 2013, Dr. Woodall wrote a note on her prescription pad indicating that Claimant “has been diagnosed with a developmental disorder on the autistic spectrum. He has anxiety, rigidity, hyperactivity, poor impulse control and other symptoms associated with the spectrum disorder.” (Exhibit 18.)

21(c). In a May 23, 2013 progress note, Claimant’s current diagnoses were listed as ADHD, Depressive Disorder and PDD-NOS. (Exhibit 6.)

22. In April 2013, Claimant sought a re-evaluation through NLACRC to determine regional center eligibility. (Exhibit 20.)

23. In a May 9, 2013 Interdisciplinary Note, NLACRC psychologist, Dr. Fischer, documented her telephone conversation with Claimant’s mother as follows:

[Explained] that the only new information that was provided as part of their re-application for Regional Center services is a note from Dr. Woodall that says that [Claimant] has an Autism Spectrum Disorder.

Testing by Dr. Levi in September 2011 indicated that [Claimant] has PDD NOS. Explained to mother that this is an Autism Spectrum Disorder so we agree with Dr. Woodall. This is not a Regional Center eligible diagnosis. . . .

(Exhibit 21.)

24(a). On May 22, 2013, Dr. Fischer conducted a record review regarding Claimant's application for regional center eligibility and issued a report regarding her findings. Dr. Fischer noted that Claimant had been referred to NLACRC to determine whether he had "Autistic Disorder," and that "to qualify for Regional Center services (from a psychological standpoint), an individual must have Autistic Disorder, Mental Retardation or a disabling condition closely related to Mental Retardation or requiring treatment similar to that required for individuals with Mental Retardation."

24(b). Dr. Fischer stated that, "Given that [Claimant] was previously assessed at the Regional Center and there are extensive records from his school district and the Department of Mental Health, it was decided that a Record Review could provide enough information in order to make an eligibility determination." (Exhibit 36.) Dr. Fischer reviewed the following documents: a March 2011 assessment from Claimant's school district (Exhibit 8); a March 2011 IEP (Exhibit 9); a 2011 application for Regional Center; a 2011 NLACRC Social Assessment; an August 2011 Initial Assessment from Facey (Exhibit 10); a September 2, 2011 IEP (Exhibit 12); Dr. Levi's 2011 Psychological Assessment (Exhibit 14); a December 2011 DMH assessment (Exhibit 16); a February 11, 2013 note from Dr. Woodall (Exhibit 18); a 2012 IEP (Exhibit 17); a 2013 IEP (Exhibit 19); an undated application for Regional Center services; and an April 23, 2013 NLACRC Social Assessment (Exhibit 20). (Exhibit 36.)

24(c). Following her review, Dr. Fischer stated the following Diagnostic Considerations:

Based on the current testing, interviews, behavioral observations, and previous reports, the most appropriate diagnoses are significant mental health issues including a mood disorder, most likely Major Depressive Disorder Severe with Psychotic Features, Psychotic Disorder Not Otherwise Specified, [ADHD] (by history), and Pervasive Developmental Disorder. A diagnosis of [PDD-NOS] is an Autism Spectrum Diagnosis but is not a diagnosis that makes one eligible for Regional Center services.

[¶] . . . [¶]

A review of [Claimant's] records suggests the presence of an Autism Spectrum Disorder, specifically [PDD-NOS].

(Exhibit 36.)

24(d). In reviewing Claimant's records to determine the presence of autistic characteristics, Dr. Fischer found:

[Claimant] was reported to make good eye contact with the interview during the [DMH] Assessment and during the April 2013 Social Assessment, however, a number of other professionals indicated that he has problems with eye contact including the person who conducted the July 2011 Social Assessment [⁵] and Dr. Levi in September 2011. Little information about [Claimant's] use of facial expressions and gestures to regulate social interactions was available in his records although his mother reported somewhat limited facial expressions and gestures [in 2011]. It is possible that he has problems using nonverbal communication to regulate social interactions.

Although [Claimant] reportedly has a friend, . . . his records include significant support to his having problems with social interactions with peers. There is a qualitative impairment in [Claimant's] development of appropriate peer relationships.

Information from [Claimant's] records suggests that he shares his interests, achievement and enjoyment with others. There is not a qualitative impairment in this area.

[Claimant] appears to have difficulty engaging in social and emotional reciprocity. His behavior suggests there is a qualitative impairment in this area.

[Claimant] experienced a delay in his language development.

Information from [Claimant's] school records and the [DMH] assessment describe him as "articulate." Additionally, his IEPs indicate that he has no difficulty in the area of communication. [Claimant's mother] reported that [Claimant] holds conversations but noted immaturity during [Dr. Levi's] Psychological Assessment. Dr. Levi indicated that he used "good spontaneous language" although she later indicated that he had problems initiating and sustaining conversation. There does not appear to be a qualitative impairment in his ability to initiate or sustain conversation.

(Exhibit 36.)

⁵ The 2011 Social Assessment was not submitted as evidence.

24(d). Based on the record review, Dr. Fischer did not find any qualitative impairment in the areas of stereotyped or repetitive language, make believe play, nonfunctional routines or rituals, stereotyped or repetitive motor movements, or persistent occupation with parts of objects. (Exhibit 36.)

25. On May 29, 2013, the NLACRC eligibility committee met, and using the criteria from the DSM-IV-TR, re-determined that Claimant is not eligible for regional center services. A handwritten comment on the Eligibility Re-Determination, stated, “New records available – supported PDD diagnosis which had been previously made by Dr. Levi. New information does not support a diagnosis of autistic disorder.” (Exhibit 22.)

26(a). Although at the time of its May 29, 2013 eligibility re-determination, NLACRC was still using the DSM-IV-TR to guide its eligibility determinations, in May 2013 a new version of the DSM, the DSM-V, was published. NLACRC’s eligibility committee began using DSM-V criteria to make eligibility decision in June 2013. (Testimony of Dr. Fischer.)

26(b). Under the DSM-V, claimants with a diagnosis of Autism Spectrum Disorder are eligible to receive regional center services under the qualifying category of autism. (See also Legal Conclusion 11.) The DSM-V states that “[i]ndividuals with a well-established DSM-IV diagnosis of . . . [PDD-NOS] should be given the diagnosis of autism spectrum disorder.”

26(c). Despite the change in the DSM, as noted in Factual Finding 2, on June 4, 2013, NLACRC notified Claimant’s mother that it had determined Claimant was not eligible for regional center services.

27. After Claimant’s mother requested a fair hearing, a September 2013 informal meeting took place, and NLACRC continued to deny eligibility. At that informal meeting, NLACRC recommended a school observation and teacher interview by an NLACRC psychologist and Claimant’s mother agreed.

28(a). On October 24, 2013, Dr. Fischer conducted a school observation from 11:25 a.m. until 12:10 p.m. In her report of that observation, Dr. Fischer noted Claimant’s numerous verbal exchanges with classmates and staff, which included Claimant’s making “good eye contact” with another student. Claimant also began making comments such as “this food is worthless” (to describe his lunch), and told a singing peer to “shut up.” His behavior deteriorated, and he began using very profane language.

28(b). Under her Diagnostic Impressions, Dr. Fischer noted:

[Claimant] was psychiatrically hospitalized in September 2013 and was diagnosed with Impulse Control Disorder Not Otherwise Specified, Mood Disorder Not Otherwise Specified, and rule out diagnosis of

Disruptive Behavior Disorder Not Otherwise Specified. Based on current testing, interviews, behavioral observations, and previous reports, these appear to be appropriate diagnoses.

(Exhibit 25.)

28(c). Although prior testing/psychological assessment was conducted using the DSM-IV-TR, Dr. Fischer conducted her October 2013 observations and records review utilizing DSM-V criteria for diagnosing Autism Spectrum Disorder. Dr. Fischer did not conduct any independent testing or psychological assessment of Claimant. Her report stated:

[Claimant] does not meet the eligibility criteria for a diagnosis of Autism Spectrum Disorder. Dr. Woodall, [Claimant's] previous psychiatrist, wrote one note where she included [the code for] a DSM-IV-TR diagnosis of Asperger's Disorder but she did not provide support for the diagnosis. It is reported that she made this diagnosis due to a history of speech delays (which are no longer considered symptomatic of ASD), problems with his boundaries (related to social/emotional reciprocity) and difficulties with peer relationships although these symptoms would not warrant a diagnosis of Autism Spectrum Disorder.

In order to receive a diagnosis of Autism Spectrum Disorder, one must have deficits in social-emotional reciprocity. [Claimant] has significant problems with social and emotional reciprocity. He interacted with his peers during class although he was often purposefully provocative even when he was reminded by adults that what he was saying was hurting the feelings of a peer. Problems with boundaries can be related to difficulties with social and emotional reciprocity. [Claimant] has significant impairment in social and emotional reciprocity.

[Claimant] made eye contact with his teacher and he used appropriate gestures in class (e.g. raising his hand when prompted to do so . . .). [Claimant's] eye contact during the Social Assessment was described as good although the previous Social Assessment indicated that his eye contact was fleeting. [Claimant's mother] said that his eye contact was poor (to Dr. Levi). There does not appear to be significant impairment in [Claimant's] use of nonverbal communication used to facilitate social interactions.

[Claimant's] ability to develop, maintain and understand relationships is significantly more limited than would be expected for a child of his developmental level. He reportedly has one friend . . . at school but he often excludes himself from social interactions. [Claimant's] records suggest a long history of problems with his peers. He was frequently

antagonistic toward his peers during the observation. [Claimant's] peer relationships are impaired.

[Claimant] did not engage in any stereotyped or repetitive motor movements, use of objects or speech during the observation. These types of behaviors are not described in his records.

[T]here was no suggestion of an insistence on sameness or inflexible adherence to routines or ritualized patterns of behavior.

[Claimant's] mother reported that he was obsessed with cars as a young child and now he is obsessed with Legos and perseverates on them. This was not discussed as a problem at school although there was one note reminding [Claimant's] mother that [Claimant] was not supposed to bring toys to school. It is possible that [Claimant] has a fixated interest although this was not reported [by school staff], was not included in his records and was no evident during the school observation.

[Claimant's] mother reported that he is sensitive to tags on his clothing. He did not exhibit any hyper or hypo-reactivity to sensory input during the observation. The classroom was sometimes noisy by he did not seem to be bothered by this. [Claimant] might have a slight sensory sensitivity.

(Exhibit 25.)

29. On November 18, 2013, the NLACRC eligibility committee met again, and using the criteria from the newly published DSM-V determined, based on a records review that Claimant is not eligible for regional center services. A handwritten comment on the Eligibility Re-Determination, stated "additional records and school observation does not support diagnosis of Autism Spectrum Disorder." (Exhibit 26.)

30(a). On February 24, 2014, Legal Advocates from the Southwestern Law School Children's Rights Clinic sent a letter to NLACRC stating, "[U]nder the new [DSM-V], Autism, Asperger's Syndrome, and PDD-NOS are now considered under the "Autism Spectrum Disorder" category. [Claimant's] diagnosis of PDD-NOS and current needs now makes him eligible for Regional Center services." (Exhibit 28.)

30(b). No response was sent to the Legal Advocates.

31(a). On February 27, 2014, a Supplemental Psycho-Educational Report was issued by the District. The report noted:

According to the findings of the psycho-educational assessment report shared on 1/27/14, at the time [Claimant's] triennial IEP meeting was

initiated, [Claimant] appeared to continue to manifest eligibility for special educational support services as a student with an identified emotional disturbance (ED), due to inappropriate types of behavior and feelings under normal circumstances, as his primary disability, and . . . other health impairment (OHI), due to attention-related behaviors, as his secondary disability. These behaviors were noted to have been evidenced to exist over a long period of time, to a marked degree and adversely affect [Claimant's] educational performance.

However, parent feels very strongly that [Claimant] has autism, and reports he has also been formally diagnosed with Autism Spectrum Disorder. Parent reported she provided this documentation to [Claimant's] previous schools, [but the current school] and the District Office did not have this documentation at the time of [Claimant's] triennial re-evaluation in January 2014. As per a triennial IEP dated 1/27/2014, Supervising Attorney on behalf of parent/student inquired whether this discussion regarding eligibility under autism (AUT) may be tabled, at that time, so parent may have another opportunity to complete the rating scales, and provide the school with the aforementioned documentation with respect to [Claimant's] diagnosis of autism. Parent reported she was willing to complete rating scales to be included in this supplemental evaluation, although she [had] expressed not feeling comfortable to initially complete rating scales for [Claimant's] triennial re-evaluation. Thus, per the IEP team agreement on 1/27/2014, supplemental psych-educational assessment, which is to include parent input, as well as documentation regarding [Claimant's] diagnosis of autism provided by parent, has been completed to further explore whether [Claimant] meets eligibility under that of autism (AUT).

(Exhibit Q.)

31(b). During the reevaluation, several tests were administered, including the Autism Diagnostic Observation Schedule – Second Edition (ADOS-2), the Gilliam Autism Rating Scale – Second Edition (GARS-2). Among the documents provided by Claimant's mother and reviewed by the IEP team were: “North Los Angeles County Regional Center Report (S.Fischer, Ph.D.; 5/22/2013), Psychological Assessment Report (A. Levi, Psy.D.; 9/13/2011), M.C.L.A. Psychiatric Medical Group Progress Notes (L.Woodall, M.D.; 6/25/2013), M.C.L.A. Psychiatric Medical Group (L.Woodall, M.D.; 2/115/2013), [and] Facey Medical Group Initial Assessment (R. Pazzoldan, LCSW; 8/9/2011).”

31(c). The February 2014 Supplemental Psycho-Educational Report noted:

According to a [NLACRC] Report completed by Dr. Sandi Fischer on 5/22/2013, [Claimant] was previously assessed at Regional Center in

September 2011, at which time he was diagnosed with Pervasive Developmental Disorder Not Otherwise Specified (NOS). Since his initial Regional Center assessment, Dr. Linda Woodall, [Claimant's] psychiatrist, diagnosed him with Autistic Spectrum Disorder in February 2013. More specifically, as per written documentation by Dr. Woodall on 2/11/2013, [Claimant] "has been diagnosed with a developmental disorder on the Autistic Spectrum. He has anxiety, rigidity, hyperactivity, poor impulse control and other symptoms associated with the spectrum disorder."

Further as per the [NLACRC] Report dated 5/22/2013, [Claimant] was referred for reassessment to determine his eligibility for Regional Center Services. Based on this re-evaluation, the most appropriate diagnoses were noted to be "significant mental health issues including a mood disorder, most likely Major Depressive Disorder Severe with Psychotic Features, Psychotic Disorder Not Otherwise Specified, Attention Deficit Hyperactivity Disorder (by history) and Pervasive Developmental Disorder NOS (by history)[.]" (S. Fischer, 5/22/2013). A diagnosis of Pervasive Developmental Disorder NOS was noted as an "Autism Spectrum Disorder, but this is not a diagnosis that makes one eligible for Regional Center services." (S. Fischer, 5/22/2013).

(Exhibit Q.)

31(d). Administration of the ADOS-2 elicited a score of 3 in the Social Affect Domain and a score of 0 in the Restricted and Repetitive Behavior Domain, with a combined/Comparison Score of 1. The Comparison Score fell within the minimal-to-no evidence of spectrum related behaviors, suggesting that Claimant did not demonstrate behaviors consistent with the special education eligibility category of Autism. (Exhibit Q.)

31(e). The GARS-2 was completed using Claimant's teacher and his mother as reporters. The GARS-2 is a behavioral checklist that helps gather information regarding possible autistic-like behavior. Claimant's teacher's responses regarding Claimant's stereotyped behavior, communication and social interaction reflected an "Unlikely" probability of autistic-like behavioral characteristics. Claimant's mother's responses reflected a "Very Likely" probability of autistic-like behavioral characteristics. (Exhibit Q.)

31(f). The school psychologist conducting the analysis in the Supplemental Psycho-Educational Report noted:

[A]ccording to documentation provided to the school by parent and advocate/attorney on behalf of student/parent, [Claimant] was diagnosed with [PDD-NOS] by the Regional Center in September 2011. In addition, documentation reveals that [Claimant's] psychiatrist, Dr. Linda Woodall, diagnosed him with Autism Spectrum Disorder in

February 2013. Although findings of the supplemental psycho-educational assessment reflect conflicting results in regards to [Claimant's] behavior within his educational setting in comparison with his behavior within the home with respect to autism, the IEP team may consider eligibility under autism (AUT), secondary to that of an emotional disturbance (ED).

(Exhibit Q.)

32(a). At the fair hearing, Dr. Fischer testified on behalf of the Service Agency. Dr. Fischer opined that based on Claimant's records and testing, he does not have Mental Retardation (now designated as Intellectual Disability under the DSM-V), since his intellectual functioning has been documented in the average range. This testimony is supported by all of Claimant's school and treatment records, which indicated that his cognitive functioning and adaptive living skills were in the average range.

32(b). The totality of the evidence did not establish that Claimant suffers from Mental Retardation/Intellectual Disability. Consequently, Claimant does not qualify for regional center services under the category of mental retardation.

32(c). Given his average cognition and adaptive living skills, the totality of the evidence did not establish that Claimant suffers from a condition similar to Mental Retardation or requiring treatment similar to that of people with Mental Retardation.

33(a). At the fair hearing, Dr. Fischer also opined that Claimant is not eligible for regional center services under the category of autism. She opined that Claimant does not exhibit behavior consistent with a diagnosis of Autism Spectrum Disorder under the DSM V. However, this was based solely on her records review and school observation, not any independent testing and psychological evaluation.

33(b). Dr. Fischer was asked to explain why Claimant's 2011 PDD-NOS diagnosis by NLACRC-vendored psychologist, Dr. Levi, did not provide Claimant with a diagnosis of Autism Spectrum Disorder under the DSM-V. Dr. Fischer asserted that Dr. Levi's diagnosis of PDD-NOS was not "well-established" because it was not correct. Dr. Fischer pointed out that, in the past, a PDD- NOS diagnosis had been used as a catch-all, "garbage can" diagnosis for what appeared to be some autistic like symptoms. Dr. Fischer did not believe that Claimant's behaviors met the DSM-IV description of PDD-NOS because Claimant did not exhibit any restricted repetitive behaviors.

33(c). Dr. Fischer's attempt to discredit Dr. Levi's 2011 PDD-NOS diagnosis and characterize it as not "well-established" was unpersuasive for the following reasons:

(1). Dr. Levi conducted independent testing and a psychological evaluation of Claimant which appeared to be thorough and appropriate and which were never shown to be

otherwise. Given that Dr. Levi's opinions and diagnosis were based on that thorough evaluation, her diagnosis is "well-established."

(2). A finding that Dr. Levi's PDD-NOS diagnosis is "well-established" is supported by the fact that the Regional Center relied on that diagnosis to deny Claimant's eligibility in 2011.

(3). A finding that Dr. Levi's PDD-NOS diagnosis is "well-established" is also supported by Dr. Fischer's findings in her May 22, 2013 report, which are contrary to her testimony. Those findings are that: "A review of [Claimant's] records suggests the presence of an Autism Spectrum Disorder, specifically [PDD-NOS];" and "Based on the current testing, interviews, behavioral observations, and previous reports, the most appropriate diagnoses are significant mental health issues including a mood disorder, most likely Major Depressive Disorder Severe with Psychotic Features, Psychotic Disorder Not Otherwise Specified, [ADHD] (by history), and Pervasive Developmental Disorder."

(4). A finding that Dr. Levi's PDD-NOS diagnosis is "well established" is also supported by the May 29, 2013 eligibility committee note that "[n]ew records . . . supported PDD diagnosis which had been previously made by Dr. Levi."

(5). Dr. Fischer's second-guessing of Dr. Levi's diagnosis was not persuasive. Under the section describing PDD-NOS, the DSM-IV-TR stated, "This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism" – presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomology, or subthreshold symptomatology, or all of these." (DSM-IV-TR, p. 84.) The description of PDD-NOS was not well-defined and appeared to have been left to professional discretion. Dr. Fischer's assertion that Claimant did not exhibit any restricted repetitive behaviors did not contradict Dr. Levi's findings, and Dr. Fischer's May 22, 2014 report noted that "[Claimant] has significant impairment in social and emotional reciprocity," which supports Dr. Levi's findings. Consequently, Dr. Fischer's testimony is insufficient to discredit Dr. Levi's diagnosis of PDD-NOS.

(6). Unlike Dr. Levi, Dr. Fischer did not conduct any independent testing and psychological evaluation on Claimant. Consequently, Dr. Fischer's disagreement with Dr. Levi's diagnosis is given less weight than Dr. Levi's well-founded diagnosis.

34. Given the foregoing, Claimant has a well-established diagnosis of PDD-NOS and therefore should be given the diagnosis of Autism Spectrum Disorder under the DSM-V.

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LEGAL CONCLUSIONS

1. Claimant established that he suffers from a developmental disability (Autism Spectrum Disorder) which would entitle him to regional center services under the Lanterman Developmental Disability Services Act (Lanterman Act).⁶ (Factual Findings 1 through 34.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code, §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish his eligibility for services, the burden is on the appealing claimant to demonstrate by a preponderance of evidence that the Service Agency's decision is incorrect. Claimant has met his burden of proof in this case.

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. As applicable to this case, Welfare and Institutions Code section 4512, subdivision (a), defines "developmental disability" as:

a disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. . . . This [includes] mental retardation, cerebral palsy, epilepsy and autism. [It also includes] disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4(a). To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a "substantial disability." Pursuant to Welfare and Institutions Code section 4512, subdivision (1):

"Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person:

- (1) Self-care.
- (2) Receptive and expressive language.
- (3) Learning.
- (4) Mobility.
- (5) Self-direction.
- (6) Capacity for independent living.
- (7) Economic self-sufficiency.

⁶ Welfare and Institutions Code section 4500 et seq.

4(b). Additionally, California Code of Regulations, title 17, section 54001 states, in pertinent part:

(a) “Substantial disability” means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

- (A) Receptive and expressive language;
- (B) Learning;
- (C) Self-care;
- (D) Mobility;
- (E) Self-direction;
- (F) Capacity for independent living;
- (G) Economic self-sufficiency.

5(a). In addition to proving a “substantial disability,” a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as “Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.” (Welf. & Inst. Code, § 4512.)

5(b). Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; under the Lanterman Act, the Service Agency does not have a duty to serve all of them.

5(c). The Legislature and Department of Developmental Services required that the qualifying condition be “closely related” (Welf. & Inst. Code, § 4512) or “similar” (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or “require treatment similar to that required for mentally retarded individuals.” (Welf. & Inst. Code, § 4512.) The definitive characteristics of mental retardation /intellectual disability include a significant degree of

cognitive and adaptive deficits. Thus, to be “closely related” or “similar” to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual’s disability like that of a person with mental retardation/intellectual disability. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant’s cognitive and adaptive functioning and a determination of whether the effect on his performance renders him like a person with mental retardation/intellectual disability. Furthermore, determining whether a claimant’s condition “requires treatment similar to that required for mentally retarded individuals” is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training, speech therapy, occupational therapy). The criterion is not whether someone would benefit. Rather, it is whether someone’s condition *requires* such treatment.

6. In order to establish eligibility, a claimant’s substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of “developmental disability” (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are *solely* physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities. Therefore, a person with a “dual diagnosis,” that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination) and who does *not* have a developmental disability would not be eligible.

7. The Lanterman Act and its implementing regulations contain no definition of the qualifying developmental disability of “mental retardation.” Consequently, when determining eligibility for services and supports on the basis of mental retardation, that qualifying disability had previously been defined as congruent to the DSM-IV-TR definition of “Mental Retardation.” Under the DSM-IV-TR, the essential features of Mental Retardation were identified as significantly sub-average general intellectual functioning accompanied by significant limitations in adaptive functioning in certain specified skill areas. (DSM-IV-TR at pp. 39-43.) With the May 2013 publication of DSM-V, the term mental retardation has been replaced with the diagnostic term “Intellectual Disability.”

8. The DSM-V describes Intellectual Disability as follows:

Intellectual disability . . . is a disorder with onset during the developmental period that includes both intellectual and adaptive functioning deficits in conceptual, social and practical domains. The following three criteria must be met:

A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.

B. Deficits in adaptive functioning that result in failure to meet developmental and socio-cultural standards for personal independence and social responsibility. Without ongoing support, the adaptive deficits limit functioning in one or more activities of daily life, such as communication, social participation, and independent living, across multiple environments, such as home, school, work, and community.

C. Onset of intellectual and adaptive deficits during the developmental period.

(DSM-V, p. 33.)

9. The DSM-V notes that the most significant change in diagnostic categorization accompanying the change from the DSM-IV-TR diagnosis of Mental Retardation to the DSM-V diagnosis of Intellectual Disability is the need for assessment of both cognitive capacity and adaptive functioning, and that the severity of intellectual disability is determined by adaptive functioning rather than IQ score. (*Id.* at 37.) The DSM-V notes no other significant changes. Furthermore, the DSM-V revisions do not appear to have altered the Lanterman Act's fifth category eligibility analysis. Therefore, in order to qualify for regional center services under the fifth category of eligibility, the evidence must establish that a claimant's disabling condition is one closely related to Mental Retardation/Intellectual Disability or requiring treatment similar to the treatment provided to individuals with Mental Retardation/Intellectual Disability.

10(a). Given his average cognitive abilities and average adaptive skills, Claimant does not meet the criteria under the DSM-V for a diagnosis of Intellectual Disability, and therefore does not qualify for regional center services under the category of mental retardation.

10(b). Additionally, Claimant has not established that he demonstrates deficits in cognitive and adaptive functioning such that he presents as a person suffering from a condition similar to Mental Retardation/Intellectual Disability. Moreover, the evidence did not establish that Claimant requires treatment similar to that required for individuals with Mental Retardation/Intellectual Disability. Based on the foregoing, Claimant does not fall under the fifth category of eligibility.

11. As with mental retardation, the Lanterman Act and its implementing regulations contain no definition of the qualifying developmental disability of "autism." Consequently, when determining eligibility for services and supports on the basis of autism, that qualifying disability had previously been defined as congruent to the DSM-IV-TR

definition of “Autistic Disorder.” With the May 2013 publication of the DSM-V, the qualifying disability of “autism” is defined as congruent to the DSM-V definition of “Autism Spectrum Disorder.” Autism Spectrum Disorder encompasses the DSM-IV-TR’s diagnoses of Autistic Disorder, Asperger’s Disorder, Childhood Disintegrative Disorder, Rhetts’s syndrome, and Pervasive Developmental Disability-Not Otherwise Specified (PDD-NOS). (DSM-V at p. 809.) Therefore, an individual with a well-established DSM-IV-TR diagnosis of Autistic Disorder, Asperger’s Disorder, or PDD-NOS is now given the diagnosis of Autism Spectrum Disorder. (*Id.* at 51.)

12. The DSM-V, section 299.00 discusses the diagnostic criteria which must be met to provide a specific diagnosis of Autism Spectrum Disorder, as follows:

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive; see text):
 - 1. Deficits in social-emotional reciprocity, ranging, for example from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
 - 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
 - 3. Deficits in developing, maintaining, and understanding relationships, ranging, for example from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

[¶] . . . [¶]

- B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 - 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic

phrases).

2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching objects, visual fascination with lights or movement).

[¶] . . . [¶]

- C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
- D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
- E. These disturbances are not better explained by intellectual disability (intellectual development disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.
(DSM-V at pp. 50-51.)

13(a). Claimant correctly maintains that he is eligible for regional center services under the category of “autism.” In 2011, after conducting psychological testing, Dr. Levi found that Claimant met the criteria for a DSM-IV-TR diagnosis of PDD-NOS. In 2011, that diagnosis was not one under which Claimant could qualify for regional center services as a person with “autism.” Therefore, in 2011, relying on Claimant’s PDD-NOS diagnosis, NLACRC found Claimant ineligible for regional center services. In May 2013, still utilizing

the DSM-IV-TR, NLACRC again determined Claimant ineligible for regional center services based on his PDD-NOS diagnosis. However, when NLACRC later applied the DSM-V in its analysis, Claimant, who had a well-established diagnosis of PDD-NOS, should have been given the diagnosis of Autism Spectrum Disorder and found eligible for regional center services under the category of “autism.” Although NLACRC conducted a records review and school observation, no testing or psychological evaluation was done by the psychologist seeking to render a diagnosis under the DSM-V and to discredit Dr. Levi’s prior diagnosis; this was insufficient to discount Claimant’s well-established PDD-NOS diagnosis.

13(b). Claimant has a well-established PDD-NOS diagnosis, which in turn satisfies the required DSM-V criteria for a diagnosis of Autism Spectrum Disorder. This diagnosis renders him eligible to receive regional center services under the category of “autism.”

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

The Service Agency’s determination that Claimant is not eligible for regional center services is overruled, and Claimant’s appeal of that determination is granted. The Service Agency shall accept Claimant as a consumer forthwith.

DATED: June 5, 2014

JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.