

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT,

v.

KERN REGIONAL CENTER,

Service Agency.

OAH Case No. 2015030191

DECISION

Humberto Flores, Administrative Law Judge with the Office of Administrative Hearings, heard this matter on June 10, 2015, in Bakersfield, California.

Claimant was represented by Mario Espinoza, Client's Right's Advocate. Celia Pinal, MSW, Program Manager, represented the Kern Service agency (service agency).

Evidence was received and the record was left open to allow the parties to submit written closing briefs. Claimant's Closing Brief was received on June 25, 2015, and marked Exhibit 46 for identification only. The service agency's Closing Argument was received on July 9, 2015, and marked Exhibit G for identification only. Claimant's Reply Brief was received on July 15, 2015, and marked Exhibit 47 for identification only. The matter was submitted for decision on July 15, 2015.

ISSUE

Should the service agency fund vision therapy services for claimant?

FACTUAL FINDINGS

1. Claimant is a five-year-old boy who is a service agency consumer based on a diagnoses of epilepsy and profound intellectual disability. He also has other serious and related medical conditions including sensorineural hearing loss.

2. Claimant was born prematurely on July 14, 2009. Upon delivery, claimant was found to have left side hypotonia, hyperbilirubinemia, and respiratory distress. Claimant was treated in the Neonatal Intensive Care Unit (NICU) of the hospital for two months after birth. Claimant developed seizures after being discharged from the hospital. (Exhibit 11)

3. Claimant experienced a seizure in March 2010, which required hospitalization. Claimant's treating physician diagnosed claimant with epilepsy (Exhibit 4). Claimant's seizures progressed from one per month to five per month. Numerous attempts were made to control these seizures with medication adjustments, but these efforts were unsuccessful. (Exhibit 11)

4. In 2011, claimant was determined to be eligible for Early Start services with the service agency. His acceptance into the Early Start program was based on claimant's delays in his cognitive, social, language and self-help skills, as well as a delay in gross motor skills. (Exhibit 5)

5. Claimant was admitted to Children's Hospital Central California on January 12, 2012, for observation of his seizures. His seizures were variable including apneic seizures, grand mal, and partial. His seizures involved lip, arm and leg twitching, nystagmus and tongue fasciculations. His seizures progressively worsened so he was transferred to UCLA Medical Center and admitted to the Pediatric Intensive Care Unit (PICU) for status epilepticus on January 26, 2012. During this hospitalization, numerous procedures were performed on claimant, including a right frontal lobectomy, anterior corpuscallosotomy, ventriculostomy, and a cranioplasty. However, claimant continued to have seizures post-operatively. Claimant underwent the same procedures on April 26, 2012. In May 2012, claimant required intubation for status epilepticus and multiple times thereafter throughout his hospital stay. On May 24, 2012, a tracheostomy was performed on claimant. He currently has a trachea collar. On May 29, 2012, a G-tube was placed on claimant and a ketogenic diet was initiated. After six months in the hospital, claimant was discharged on July 23, 2012. The discharge summary indicates that claimant was prescribed and began taking anti-convulsant and/or anti-seizure medications including Potiga (generic name: ezogabine) and Vimpat (generic name: lacosamide). (Exhibit 6) According to the Physicians' Desk Reference (2014), cited by the service agency, and according to claimant's Exhibit 33, one of the potential side effects of Potiga is blurred vision, while Vimpat may cause double vision. Claimant's mother testified at the hearing that the dosages of these anti-convulsant medications have been decreased over time. Exhibit 32 contains claimant's current list of medications.

6. Claimant's mother testified that claimant started to learn sign language at two years of age to compensate for his hearing loss and so that he could communicate his needs to his parents. At about age three, after claimant's hospitalization, claimant's mother noticed that his ability to communicate with sign language regressed because he could no longer track or follow objects with his eyes unless the objects were within three inches from his face. Claimant developed his vision problems after undergoing his brain surgeries at UCLA.

Therefore, claimant asserts, these brain surgeries and claimant's resulting loss of vision are directly related to his qualifying condition of epilepsy.

7. In October 2014, claimant's mother consulted with Dr. Penelope Suter, an optometrist who specializes in and is a recognized expert in rehabilitation vision therapy. Dr. Suter informed claimant's mother that rehabilitation vision therapy and the utilization of orthoptic techniques could improve claimant's vision. Dr. Suter explained that these treatments have benefitted individuals who have suffered traumatic brain injury resulting from partial brain removal surgery.

8. Dr. Suter examined claimant on October 27, 2014, and determined that claimant suffers from "Convergence Insufficiency, and Saccadic and Pursuit Dysfunctions." Convergence Insufficiency is described as having difficulty in pulling the eyes inward, which is necessary for binocular fixation on near targets. "Saccades" are the fast eye movements one makes to change the object of fixation; the eyes seem to jump from object to another. "Pursuits" are the smooth eye movements used to follow a moving object and hold a clear image of it stationary on the retina. Dr. Suter submitted a treatment authorization request to parent's private insurance carrier for Orthoptic Vision Therapy and Rehabilitation Vision Therapy (Exhibit 16). The insurance request stated that the purpose of the treatment was to "remediate claimant's visual special neglect and improve his visual special processing." In addition, the therapy would help claimant regain his ability to "pursue and saccade." According to Dr. Suter, with improvement in these abilities, claimant could once again look, reach and grasp; and eventually sign again. On or about November 19, 2014, claimant's parents received a written denial from their insurance company stating that their insurance plan does not provide coverage for vision therapy services (Exhibit 16). Claimant's parents did not appeal the decision of their insurance carrier though the denial letter provides for an appeal process.

9. After receiving the denial from their insurance carrier, claimant's parents obtained donations from friends and family to pay for two consultations and six vision therapy sessions with Dr. Suter. Claimant's mother and Dr. Suter testified that these sessions resulted in significant improvement in claimant's vision. Dr. Suter further testified that without vision therapy, claimant's ability to sign and communicate will continue to regress making it impossible for claimant to communicate with family and caregivers.

10. After claimant's sessions with Dr. Suter, claimant's parents requested that the service agency provide funding for claimant to continue to receive vision therapy from Dr. Suter.

11. On February 17, 2015, the service agency issued a Notice of Proposed Action (NPA) denying funding for the requested vision therapy, indicating that vision therapy is considered experimental. In support of the NPA, the service agency cited Welfare and Institutions Code section 4648, subdivision (a)(16), which states in pertinent part: "Notwithstanding any other law or regulation, effective July 1, 2009, regional centers shall not purchase experimental treatment, therapeutic services, or devices that have not been

clinically determined or scientifically proven to be effective or safe, or for which risks or complications are unknown. Experimental treatments or therapeutic services include experimental medical or nutritional therapy when the use of the product for that purpose is not a general physician practice.” Claimant filed his request for hearing on February 25, 2015.

12. Dr. Suter testified at the hearing that the two brain surgeries that claimant underwent at UCLA to control his seizures adversely affected his vision. She testified that when claimant’s front portion of his brain was removed, surgeons cut the anterior of his corpus colloseum, which is the pathway that connects his two hemispheres of the brain. According to Dr. Suter, this caused claimant to lose fixation of the frontal lobe, which controls eye movement. Claimant also lost fixation of the parietal lobe, which prevented claimant from moving his eyes to pursue moving objects. In addition, claimant suffers from a particularly bad case of convergence interference.

13. In support of Dr. Suter’s testimony, claimant cites Exhibit 35, which is a publication entitled Traumatic Brain Injury – Rehabilitative Treatment and Case Management. This publication discusses the prevalence and impact of visual dysfunction in patients with traumatic brain injury (TBI) and states that “[M]any of the therapeutic approaches used with TBI patients were developed for other special needs vision patient populations. For this reason, much of the information provided here is applicable not only to the TBI patient, but also to other patients who have suffered organic insult to the brain.” This publication discusses the effects vision dysfunctions resulting from TBI as follows:

Because of the multi-faceted nature of visual dysfunction and the broad distribution of visual functional areas in the brain, many if not most TBI patients suffer from some sort of visual dysfunction. Transient changes in refractive error, which may last for months or years are common after TBI. Accommodative (i.e., focusing) dysfunctions are also common and may interfere with reading, fine depth discrimination, rehabilitative therapies which are performed at nearpoint. Nearpoint tasks, as well as balance, orientation, mobility, and daily living skills may be affected by visual field defects and binocular disorders, as well as by dysfunctions in visual perception and special organization.

14. Dr. Suter testified that optometrists specializing in vision rehabilitation therapy are trained in the diagnosis and non-surgical treatment of complex fixation, eye movement, or eye teaming (binocular) disorders, as well as perceptual dysfunctions in the visual system. In addition, vision therapy has been proven effective for treatment of many visual disorders such as accommodative dysfunctions, eye movement disorders, non-strabismic binocular dysfunctions, such as convergence insufficiency, strabismus, nystagmus and some visual-perceptual disorders in both adults and children.

15. In her testimony, Dr. Suter gave a detailed explanation of fixations dysfunction, binocular dysfunction, and convergence insufficiency in relation to claimant's current vision problems, and also explained claimant's visual field loss, using her own publication on vision rehabilitation (Exhibit 36 and 37)¹ to aid in her explanation. Exhibit 36, a chapter entitled Spatial Vision, sets forth the numerous parts of the brain that have an effect on the saccades and the pursuits of an individual with a traumatic brain injury. Page 18 of Exhibit 36 states in pertinent part:

Saccades are frequently affected in brain injury because of the complex nature and significant number of areas scattered throughout the brain involved with the control and monitoring of saccadic eye movements. Interference with the optional functioning of any one of these areas can have on the generation of appropriate and accurate saccades. The areas involved with saccades include frontal eye fields, supplementary eye fields of the posterior parietal and frontal lobes, dorsomedial supplementary motor cortex, dorsolateral prefrontal motor cortex, middle temporal lobe, pulvinar, superior colliculus, brainstem reticular formation, pontine nuclei pathway to the cerebellum, eyefield of the anterior cingulate cortex, caudate nucleus, substantia nigra, and the parahippocampal cortex.

16. Dr. Suter is a nationally recognized expert in vision therapy and vision rehabilitation for people who suffer traumatic brain injuries. Dr. Suter has authored publications in the various optometry and vision therapy books and professional journals. In addition, Dr. Suter has extensive research experience in the field of vision therapy and has made over 20 research presentations. Dr. Suter also has extensive clinical experience dating back to 1985. Since 2009, she has been the consulting optometrist to the Kaweah Rehabilitation Delta Hospital. She was also the consulting optometrist with the Centre for Neuro Skills, Post-Acute Rehabilitation Center from 1992 to 2011, and continues to provide consults on an intermittent basis. Dr. Suter testified that vision therapy is not experimental; rather, it is an effective treatment for the vision problems that currently affect claimant. Dr. Suter's testimony was detailed and convincing.

17. Claimant's mother testified that since 2010, claimant has been taking medications to control his seizures. She further testified that in 2011, claimant began learning sign language and was progressing with sign language during this period. It was after claimant's brain surgeries that claimant suffered loss of vision and lost his ability to focus. Thereafter, claimant began to regress in his ability to sign. Because claimant also suffers from profound hearing loss, it is imperative that claimant receive vision therapy to enhance his ability to see and focus so that he can continue to communicate with sign

¹ Vision Rehabilitation – Multidisciplinary Care of the Patient Following a Brain Injury: Edited by Penelope H. Suter and Lisa H. Harvey; CRC Press; Third Edition 2011.

language. Otherwise he will not be able to communicate at all. Finally, claimant's mother asserted that without vision therapy, claimant will not be able to meet the stated communication goal in his current Individual Program Plan (IPP), which states: "Over the next 12 months, [claimant] will use sign language to communicate with his family and care givers 7 out of 7 day per week from a baseline of 0 times 7 out of 7 [days] per week" (Exhibit E).

18. Fidel Huerta, M.D., testified that there is no connection between the requested vision therapy and claimant's qualifying conditions of epilepsy and profound intellectual disability. Further, vision therapy will not ameliorate either of claimant's qualifying conditions. Dr. Huerta also testified that vision therapy is not generally accepted as an effective treatment.

19. Based on Dr. Huerta's testimony and on publications by the American Optometric Association (Exhibits F-1, F-2 and F-3), the American Medical Association (Exhibit F-4), the American Academy of Pediatrics (Exhibit F-7), and the American Academy of Ophthalmology (exhibit F-8), the service agency asserts that vision therapy is an experimental treatment.

20. Exhibit F-7 is a February 2011 publication from the Official Journal of the American Pediatric Association entitled Joint Technical Report, Learning Disabilities, Dyslexia and Vision. This publication concludes:

Currently there is inadequate scientific evidence to support the view that subtle eye or vision problems cause or increase the severity of learning disabilities. Because they are difficult for the public to understand and for educators to treat, learning disabilities have spawned a wide variety of unsupported vision-based diagnostic and treatment procedures. Scientific evidence does not support the claim that visual training, muscle exercises, ocular pursuit and tracking exercises, behavioral/perceptive vision therapy, training glasses, prisms, and colored lenses and filters are effective direct or indirect treatments for learning disabilities.

21. Exhibit F-8 is a 2001 publication from the American Academy of Ophthalmology entitled Complimentary Therapy Assessment, Vision Therapy for Learning Disabilities. This publication concludes:

[T]here appears to be no scientific evidence that supports behavioral vision therapy, orthoptic vision therapy, or colored overlays and lenses as effective treatments for learning disabilities. . . . [S]everal studies in the literature demonstrate that eye movements and visual perception are not critical factors

in reading impairment found in dyslexia, but that brain processing of language plays a greater role.

22. In addition to the above referenced publications, the service agency also notes that the publication referenced in Factual Finding 13 (claimant's Exhibit 35) states that expertise of "an ophthalmologist will often be needed to provide medical treatment/surgical treatment of the hardware, or anatomical and physiological aspect of the visual system before the optometrist can provide rehabilitation of the software or functional aspect of the vision system." This publication also noted that the area of rehabilitation for TBI patients is still in its infancy. Therefore, the service agency contends that there is not enough research that supports vision therapy as a form of rehabilitation for TBI patients.

23. At the hearing, the service agency also contended that claimant's request for funding should be denied because claimant did not pursue funding from a generic source. The service agency asserts that although claimant's parents requested coverage for vision therapy from their insurance carrier, their failure to appeal the denial of coverage provides a basis to deny funding in this case. It is noted that the service agency did not include this contention in the NPA. Claimant asserts that the service agency's failure to include this basis for denial in the NPA precludes the service agency from raising the issue now because claimant did not have sufficient notice to adequately address this issue at the hearing.

DISCUSSION

Vision Rehabilitative Therapy

24. The evidence established that vision rehabilitation therapy is not an experimental treatment. Dr. Suter's expertise in this area of practice is impressive. She has published numerous articles on the subject over the past 20 years. She has edited a book on the subject. Since 1995, Dr. Suter has lectured on the subject of rehabilitation and recovery following traumatic brain injury, including lectures for the Department of Defense and the Veteran's Administration. She has engaged in this area of practice for more than 20 years and is currently the Consulting Optometrist for the Kaweah Delta Rehabilitation Hospital and for the Centre for Neuro Skills Post-Acute Rehabilitation Center. Dr. Suter's testimony was detailed and thorough; and because she has treated claimant with vision rehabilitation therapy, her testimony was specific to claimant's vision problems. It is also noted that her treatment of claimant resulted in an improvement of claimant's vision.

25. The service agency's expert witness, Dr. Fidel Huerta, is an excellent physician who has been the consulting physician for the service agency for many years. However, Dr. Huerta is not an ophthalmologist and therefore does not have the specific expertise in the care and treatment of vision loss due to traumatic brain injury or vision loss resulting from brain surgery.

26. The service agency also contends that published reports contained in Exhibit F-7 and F-8 provide a basis to deny funding for vision therapy in that these publications both conclude that there is no consistent scientific evidence that vision therapy is an effective treatment for learning disabilities. The service agency's contention is not persuasive. Claimant is not basing his request for vision therapy to address a learning disability. Rather, claimant is requesting the service to treat vision problems resulting by his brain surgeries that were performed to address his epileptic seizures.

27. The service agency asserted in its closing argument that the improvement in claimant's eyesight during the period that he was being treated by Dr. Suter could have been caused the by the decrease in dosage of claimant's anti-convulsant medications. Therefore, according to the service agency, it is unknown whether claimant's progress in his ability to sign is due to the decrease in the dosage of anti-convulsant medications or due to vision therapy or a combination of both factors. The service agency's argument assumes that the vision problems experienced by claimant have been caused by claimant's anti-convulsant medications. This assumption was not established at the hearing. Rather, the preponderance of the evidence based on Dr. Suter's testimony and supporting publications, proved that claimant's vision loss was caused by effects of claimant's brain surgery. In any event, regardless of the reason for claimant's vision loss, claimant made "great progress" during his vision therapy sessions according to Dr. Suter and corroborated by claimant's mother.

Generic Resources

28. At the hearing, the service agency contended that claimant has not pursued and exhausted all avenues of funding from generic resources. The only denial for vision therapy was from the family's insurance carrier. Further, claimant's parents did not appeal this denial. This issue cannot be addressed in this hearing because the service agency did not include this basis for denial of the requested service in its NPA. In fact, the service agency only raised this issue for the first time during the hearing. Claimant objected to the inclusion of this issue in the present case because he had no notice that this issue would be litigated. It would be a violation of claimant's due process rights to affirm a denial of a requested service based on a contention which had not been included in the NPA as a basis for denial, and where claimant had no notice of this issue until the day of hearing.

Claimant's Contention that the Service Agency Act Arbitrarily

29. Claimant contends that the service agency acted arbitrarily when it denied claimant's request for funding of vision therapy. In support of his position, claimant cites a previous decision issued by an Administrative Law Judge (ALJ) after a hearing on the issue of the effectiveness of vision therapy. In that case, the ALJ found that "vision therapy is an appropriate modality to treat claimant's particular ocular conditions." Claimant contention is not persuasive. Each case is unique and must be decided based on the evidence presented and on its own merits.

LEGAL CONCLUSIONS

1. In 1977, the California Legislature enacted the Lanterman Developmental Disabilities Services Act (the Lanterman Act) “to prevent or minimize the institutionalization of developmentally disabled persons and their dislocation from family and community . . . and to enable them to approximate the pattern of everyday living of nondisabled persons of the same age and to lead more independent and productive lives in the community.” (See, *Association for Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.). Under the Lanterman Act, the State of California has accepted responsibility for persons with developmental disabilities. (Welf. & Inst. Code, § 4501.)

2. Cause exists to grant Claimant’s appeal and reverse the decision of the Kern Regional Center to deny funding for vision rehabilitation therapy for claimant, based on Factual Finding numbers 1 through 28, and Legal Conclusion numbers 3 through 5, below.

3. The Lanterman Act incorporated under Welfare and Institutions Code section 4500 et seq., acknowledges the state’s responsibility to provide services and supports for developmentally disabled individuals. It also recognizes that services and supports should be established to meet the needs and choices of each person with developmental disabilities. (Welf. & Inst. Code, § 4501.)

4. The Lanterman Act also provides that “[t]he determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer, or when appropriate, the consumer’s family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option.” (Welf. & Inst. Code, § 4512, subd. (b).)

5. Applying the above provisions here, claimant’s appeal must be granted. Kern Regional Center did not establish that Vision Rehabilitation Therapy is an experimental treatment without scientific support. However, the service agency did raise valid concerns regarding time limitations of the service, the cost effectiveness of the service, and alternative sources of funding. To address these concerns, the order for vision therapy shall be limited to one year. This time-period should be sufficient to determine whether vision therapy is indeed an effective treatment for claimant’s specific vision problems and to determine his level of progress. During this one-year period, claimant’s parents and the service agency are encouraged to work together to seek other generic funding sources. At the conclusion of the one-year period, the parties will be in better position to determine the effectiveness of claimant’s vision therapy and to discuss the possibility of continuing this service beyond one- year period in the event that claimant is unable to secure alternative funding.

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ORDER

1. The decision of the Kern Regional Center to deny funding for Vision Rehabilitation Therapy for claimant is overruled. Claimant's appeal is granted.
2. The Kern Regional Center shall provide funding for Vision Rehabilitation Therapy for claimant for one year.

Dated: July 27, 2015


HUMBERTO FLORES
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.