

BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

KERN REGIONAL CENTER,

Service Agency.

OAH No. 2015031097

DECISION

On July 20, 2015, Jennifer M. Russell, Administrative Law Judge with the Office of Administrative Hearings, heard this matter in Bakersfield, California. Parent represented Claimant,¹ who was not present at the hearing. Karina Proffer, Kern Regional Center Program Manager/Fair Hearing Officer, represented the Kern Regional Center (KRC or service agency).

The matter was submitted for decision on July 20, 2015. The Administrative Law Judge makes the following Factual Findings, Legal Conclusions, and Order.

ISSUE

The issue for determination is whether the service agency should fund vision therapy for Claimant.

FACTUAL FINDINGS

1. Claimant is a four-year old consumer of KRC due to his qualifying diagnosis of Autism Spectrum Disorder (ASD). Among other things, Claimant has demonstrated deficient levels of attention to and processing of visual stimulation in that he eschews visual information about his environment and surroundings in favor of tactile information. For example, when in a crowd, Claimant will not look at the crowd (visual perception) to navigate his way through it; rather, Claimant will extend his hands to feel his way through

¹ Claimant and Parents are not identified by name to preserve confidentiality.

the crowd. Claimant engages in lateral glancing—he visually fixates on objects by turning his head in one direction as he rotates his pupils to the opposite direction in the extreme corner of his eye socket. Claimant’s saccadic eye movements are atypical in that he is unable to fixate on and pursue a moving target with his eyes without moving his head.

2. In December 2013, Virginie F. Dang, O.D. provided Claimant with a bifocal prescription. On January 22, 2015, Dr. Dang again examined Claimant’s eyes, and she reported the following clinical findings: “[Claimant] still had a difficult time accommodating, even with a bifocal prescription. During the examination, he demonstrated poor fixation and pursuits and appeared to favor tactile behaviors over visual.” (Ex. F.) Dr. Dang recommended new glasses prescription to help with Claimant’s accommodative paresis and “at least 6 weeks of 3X weekly vision therapy sessions to work on the accommodative paresis, hand-eye coordination, oculomotor function and visual attention.” (Ex. F.) According to Dr. Dang, “With [Claimant’s] recent diagnosis of autism spectrum disorder and history of accommodative paresis, vision therapy could help enhance better peripheral awareness and visual attention.” (Ex. F.)² Thereafter, Dr. Dang’s colleague, Penelope S. Suter, O.D. commenced treating Claimant with vision therapy.

3. Aetna, Claimant’s medical insurer, declined to pay for these services. Aetna informed Claimant’s Parent that “Aetna plans specifically exclude benefits for vision therapy (orthoptic training: CPT code 92065). Under these plans, charges for orthoptic pleoptic training (eye exercise) and training aids or vision therapy for any diagnosis are denied based on this contractual exclusion.” (Ex. E1.)

4. Aetna’s Clinical Policy Bulletins: Vision Therapy, Number: 0489, states, “Some Aetna plans specifically exclude benefits for vision therapy (orthoptic training). . . . Under these plans, charges for orthoptic and/or pleoptic training (eye exercises) and training aids or vision therapy for any diagnosis should be denied based on this contractual exclusion.” The policy bulletin explains, “Vision therapy encompasses a wide variety of non-surgical methods to correct or improve specific visual dysfunctions. It may include eye exercises, as well as the use of eye patches, penlights, mirrors, lenses, prisms, and patches. Other modalities in use by vision therapy proponents include sensory, motor, and perceptual activities.” (Ex. E2.) According to the policy bulletin, “There is a broad range of vision therapy techniques and methods among practitioners who perform vision therapy making the practice of vision therapy difficult to standardize and evaluate.” (Ex. E2.) Based on a review of the literature, the policy bulletin identifies several general conclusions about vision therapy including the following: that assessing the effectiveness of vision therapy has been extremely difficult due to a small number and general low quality of clinical studies as well as a lack of standard treatment methods or protocols; that many studies cited in support of vision therapy are antiquated; that proponents reviewing the literature are uncritical of the evidence or cite to abstracts, unpublished manuscripts, and doctoral dissertations, documents

² Dr. Dang did not testify at the administrative hearing.

which are not widely available, which frequently do not meet rigorous research standards, and which have not been peer-reviewed. (Ex. E2.)

5. On February 17, 2015, Parents wrote KRC requesting “help in getting vision therapy covered for our son[.]” The letter explains that Claimant “has a very difficult time sustaining visual concentration for very long and also struggles with tracking things. It is difficult to see how he struggles with even following a fun toy like a rocket, open[ing] a door, isn’t confident walking down the stairs, or even read[ing] a book with us because he simply can’t sustain or track for very long. We are hoping vision therapy will help with these difficulties. However, vision therapy is also very expensive at \$80 a session. We are currently doing two sessions a week, so we are looking at paying \$640 a month.” (Ex. D.)

6. By letter dated February 26, 2015, KRC informed Parents that their request “for the experimental treatment for vision therapy funding for [Claimant] has been denied.” According to the February 26, 2015 letter, the denial was based on the determination of Dr. Fidel Huerta, KRC’s Director of Medical Services, that section 4648, subdivision (a)(16) of the Lanterman Developmental Disabilities Services Act (Lanterman Act)³ precludes regional centers from purchasing “experimental treatment, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective.” (Ex. A3.)

7. On April 6, 2015, Parents and relevant KRC personnel participated an informal meeting where they discussed KRC’s determination not to fund Claimant’s vision therapy services. The parties disagreed about the applicability of section 4648, subdivision (a)(16). As a consequence, Parents filed a Fair Hearing Request, and these proceedings ensued.

8. Dr. Penelope S. Suter earned an undergraduate degree in biology from California State University Bakersfield (CSUB) and a doctorate degree in optometry from University of California Berkeley. Dr. Suter pursued post-doctorate training in vision therapy, rehabilitation, and development at the College of Optometrists and the Neuro-Optometric Rehabilitation Association (NORA). As a fellow at NORA, Dr. Suter spent eight years supervising publications in and developing and teaching courses regarding the scientific, conceptual, and clinical underpinnings of neuro-optometric rehabilitation.

Dr. Suter is certified in vision development and vision therapy. For the past two decades, Dr. Suter has maintained a clinical practice while also functioning as the co-director of a vision lab at CSUB where she studies and conducts research on how the brains of infants and children develop and respond to visual stimuli. She has been the primary consultant to the Center for Neuro-Skills where she trains other professionals, including occupational therapists, on how to conduct vision therapy. Dr. Suter treats individuals with ASD in her clinical practice. Dr. Suter is the author of “Rehabilitation and Management of Visual Dysfunction Following Traumatic Brain Injury,” which appears in Chapter Nine of *Thematic Brain Injury* (3d. Ed.), and she is the primary editor of *Vision Rehabilitation*

³ Welfare and Institutions Code section 4500 et seq.

Multidisciplinary Care of the Patient Following Brain Injury (2011), a treatise synthesizing scientific and clinical data on vision impairments originating from, among other things, strokes, traumatic injury, or neurological abnormalities and how to rehabilitate the visual system. This treatise serves as *the* current text reference in vision rehabilitation for practitioners in the field.

9. At the administrative hearing, Dr. Suter drew a distinction between scientific and clinical data regarding the visual system. According to Dr. Suter, the visual system is probably the most researched neural system of any sensory motor or cognitive system of humans and primates because it is easy to access for the purpose of introducing complicated stimuli which is then recorded in a variety of ways. The visual system is extremely complex, it is pervasive throughout the brain, and it reveals a lot about other sensory systems. For example, the optic nerves of the eyes provide 70 percent of all the sensory input into the brain. At least five different areas of the brain are involved in the processing of visual stimuli. There are probably one hundred different sensory perceptual motor integrative aspects of function in the visual system that all have to work properly for the visual system to work. The visual system has over 300 bi-directional pathways in the brain. Hence, there are many areas for research in the visual system. Consequently, the science behind vision therapy extends beyond optometry; the science is necessarily multi-disciplinary encompassing, among other things, research and investigation in psychology, neurophysiology, neuroanatomy, neurology, ophthalmology, occupational therapy, and other scientific areas. The clinical information on vision therapy generally comes from professionals practicing in the fields of ophthalmology, optometry, and occupational therapy. “It is an extremely complex area, which is why people find it so easy to say this is experimental because if you are not in the area you cannot grasp how big it is and how complicated it is and how much there is to know and that the literature is there.”

10. Dr. Suter explained that vision therapy is premised on neurophysiologic principles and the science of visual function and rehabilitation. Vision therapy is a programmatic approach to treating deficits in the visual system. Vision therapy is comparable to speech and language therapy or occupational therapy, all of which address deficits that have been identified through testing. There are different types of vision therapies, three of which Dr. Suter practices in her office: a) orthoptic therapy, which is for eye movements and focusing and eye teaming, i.e. pointing both eyes at the same object at the same time; b) vision rehabilitation for individuals with neurologic compromise in areas involving, among other things, visual acuity, visual field, peripheral vision, detailed vision, ability to understand and remember what was seen, ability to generate outputs from what was seen, and motor and other sensory integration; and c) functional therapy, which examines the functional deficits in daily living that are attributable to the visual system, and which is goal-directed.⁴

⁴ Dr Suter noted that her practice does not involve a fourth type of vision therapy—behavioral vision therapy—which arose from clinical practices rather than from neurophysiologic principles and the science of visual functions. According to Dr. Suter, practitioners of behavioral vision therapy do a lot of good, but behavioral vision therapy is

11. Dr. Suter, explained the history and development of vision therapy as follows: Ophthalmologists in the 1800s developed orthoptic therapy as a medical management component, as opposed to a surgical component, of ophthalmology. There has been an explosion of knowledge in all of the health care professions, including ophthalmology, which in turn has resulted in increasing specialization. Optometrists, whose training is more functional than ophthalmologists, took over the practice of orthoptic therapy. Synthesis of the knowledge base underlying vision rehabilitation therapy occurred later. Consequently, vision rehabilitation therapy developed over the last three decades. Nonetheless, there is a wealth of information supplying the basic conceptual guidelines regarding the identification and treatment of visual dysfunction in neurologically compromised individuals. Functional therapy is about giving a patient a better quality of life—helping a patient to function better notwithstanding existing and identifiable vision deficits. Consequently, anyone doing good therapy is actually doing some form of functional therapy.

12. Dr. Suter opined that vision therapy is not experimental “because there is literature from multiple fields, both scientific and clinical, from decades of research, which are summarized in a number of chapters and books.” “At this point, it is a bit absurd to think that in the most researched sensory and perceptual system in humans and primates that we are unable to do any sort of therapy that is established by now where we assume that speech and language therapy is reasonable therapy, we assume that occupational therapy is reasonable therapy, we assume that cognitive rehabilitation is reasonable therapy, we assume that psychotherapy is reasonable therapy. But in the most researched sensory and perceptual system with a dozen professions contributing and several professions treating in the area, to say that is experimental is impossible. It is just not reasonable.” According to Dr. Suter’s testimony, speech and language therapy and occupational therapy “are example of therapies on systems that have inputs and have outputs that have clinical and scientific literature bases which are smaller than that for vision and which are well-accepted therapies. They are not considered experimental. There is a great more evidence for vision therapy—vision rehabilitation therapy, orthoptic therapy—than there is for pretty much any other therapy.”

13. Dr. Suter expressed that “it is almost silly providing research articles saying the vision therapy works because there are so many articles to that effect.” By way of example Dr. Suter provided *Effect of Oculomotor Rehabilitation on Accommodative Responsivity in Mild Traumatic Brain Injury*, published in the Journal of Rehabilitation Research and Development, the official journal of the Veterans Administration’s Office of Research and Development. (Ex. 7.) According to Dr. Suter, “If there were any organization that required evidence-based medicine, that would be the organization.” Dr. Suter also offered an abstract titled *Versional Eye Tracking in Mild Traumatic Brain Injury (mTBI): Effects of Oculomotor training (OMT)* (Ex. 8.) and her own article in chapter nine of

not as well documented in terms of clinical guidelines and practices. It is more about a clinician developing things and then passing them on to the profession.

Thematic Brain Injury (see Factual Finding 9; Ex. 11.) in further support of the efficacy of vision therapy.⁵

14. According to Dr. Suter, Claimant’s difficulty fixating (looking at objects with his eyes), difficulty pursuing (following objects without using his vestibular muscles to move his head), poor visual processing skills (seeking information from tactile system rather than visual system) and accommodative insufficiency (inability to focus) are symptomatic of neurologic deficiencies associated with ASD. In general, individuals with ASD experience difficulty receiving and processing visual stimuli which travel along a complex series of pathways from the eyes to areas of the brain controlling sensory motor functions. As a consequence, individuals with ASD, including Claimant, manifest atypical behaviors in reaction to what they see, which in turn affect their quality of life. According to Dr. Suter, it is a “huge problem” for Claimant “to not be able to look at something and process it and to attend to it visually, to have to investigate tactilely, rather than with his eyes. That is a significant problem both for academic learning and social interactions, [and for] learning from what other people are doing through joint attention.” Dr. Suter’s opinion is formed through her professional knowledge and clinical experience, and is informed by several publications addressing a complicated nexus among ASD, brain functions, the visual system, and perceptual processing including *Temporal Dynamics of Coherent Motion Processing in Autism Spectrum Disorder: Evidence for a Deficit in the Dorsal Pathway* (Ex. 2), *Vision in Children and Adolescents with Autistic Spectrum Disorder: Evidence for Reduced Convergence* (Ex. 3.), *Dyspraxia, Motor Function and Visual-Motor Integration in Autism* (Ex.4.), *Marked Selective Impairment in Autism on an Index of Magnocellular Function* (Ex. 5.), *Oculomotor Performance in Children with High Functioning Autism Spectrum Disorders* (Ex. 6.), *Vision in Autism Spectrum Disorders* (Ex. 9.), *Vision and Autism* (Ex. 12), *Brain Anatomy, Electrophysiology and Visual Function/Perception in Children within Autism Spectrum Disorder* (Ex. 13.), *Understanding the Visual Symptoms of Individuals with Autism Spectrum Disorder (ASD)* (Ex. 14.), and *Insights into the Diagnosis and Treatment of Patients within the Autism Spectrum: A Patient’s Story* (Ex. 15.)

15. The vision therapies Dr. Suter provides to individuals with ASD are intended to strengthen the brain’s pathways and to guide visual stimuli along the appropriate and correct brain pathways. Dr. Suter indicated that, as a result of her treating Claimant with the three forms vision therapies set forth in Factual Finding 11, Claimant has shown “a number of significant improvements.” Dr. Suter reported improvements in Claimant’s focusing disorder, head-eye dissociation—his ability to move his eyes to look at objects without also moving his head, and visual attention skills—his ability to compete a complex task requiring him to focus on an object while using his peripheral vision. Dr. Suter cautions that notwithstanding these improvements, Claimant has “a long way to go.” Dr. Suter opined that

⁵ Dr. Suter acknowledged situations, not presented in this case, where vision therapy would not be suitable. According to Dr. Suter, there are patients with ASD whose quality of life would not improve with vision treatment therapy. According to Dr. Suter, it is about testing, identifying a vision deficit and its effect on the patient’s quality of life, and determining whether treatment would improve the patient’s quality of life.

continuing vision therapy is beneficial for Claimant. Dr. Suter noted that the complexity of Claimant's deficits cannot be adequately addressed with occupational therapy.

16. Dr. Suter reviewed Aetna's policy bulletin set forth in Factual Finding 5, and KRC's Exhibit H (the American Association for Pediatric Ophthalmology and Strabismus statement regarding Vision Therapy) and Exhibit I (Vision Impairment). Dr. Suter dismissed Aetna's policy bulletin, noting that it contains a problematic review of scientific research in vision therapy that privileges randomized, controlled trials, and that in doing so incorrectly implies an absence of reliable data, evidence, or studies supporting the efficacy of vision therapy. Dr. Suter noted that scientific progress in vision therapy does not occur on the basis of randomized, controlled trials alone because there are subject areas in vision therapy that are unsusceptible to such trials.⁶ According to Dr. Suter, good scientific research is not limited to randomized, controlled trials. Good scientific research includes research identifying what has been done in the field, remaining areas of concerns, and proposals for further exploration and studies. Dr. Suter noted that Exhibit H did not change her opinions set forth above in Factual Findings 13 and 14 regarding the non-experimental status and efficacy of vision therapy because it contains statements conceding that orthoptic therapy is beneficial. Dr. Suter regarded Exhibit I as "a rudimentary document" only discussing visual impairment in terms of visual acuity, meaning the presence of 20/20 vision, size of peripheral field of vision, and the detail with which objects are perceived, all of which constitute a very limited sub-set of visual impairment. Dr. Suter noted that the content of Exhibit I is analogous to incorrectly positing that speech and language impairment can be reduced to a hearing deficit—the loudness and frequency of sound. As such, Exhibit I fails to look at the broad, complex scope of visual impairment. Dr. Suter additionally noted that the source or origin of Exhibit I is unclear and that its cited references are very old.

17. Significant weight is accorded Dr. Suter's expert opinion testimony in light of her education, training, expertise derived from clinical practice, scholarship in vision therapy, and clinical evaluation and treatment of Claimant.

18. Dr. Fidel Huerta earned his medical degree from the University of California Los Angeles School of Medicine. Dr. Huerta completed residency training in family practice at Kern Medical Center. He has completed a fellowship in infectious diseases. He holds no certifications. Dr. Huerta has no training in and has conducted no research in ophthalmology, optometry, or vision therapy. Dr. Huerta has not participated in or presented at any conferences in ophthalmology, optometry, or vision therapy. Dr. Huerta's role as KRC's medical director involves conducting assessments of individuals with cerebral palsy and epilepsy, and reviewing medical services. He has no responsibilities for assessing individuals with ASD. He engages in no clinical practice. He has never evaluated or treated Claimant.

⁶ One such example is eye turn surgery. Dr. Suter testified that there are zero random, controlled studies in the literature regarding the success of eye turn surgery. Dr. Suter noted that the success rates for eye turn surgery and vision therapy are the same, but the critics continue to question the absence of random, controlled trials in vision therapy research.

19. At the administrative hearing, Dr. Huerta testified on behalf of KRC that “vision is not part of the diagnosis of autism” and that “vision therapy is considered by the Academy of Ophthalmology and the Academy of Pediatrics to be experimental therapy.” “The final verdict so far is that [vision therapy] is inconclusive.” Dr. Huerta opined that Claimant “needs to be seen by an ophthalmologist to be tested and evaluated to see specifically what needs to be done. You have an optometrist practicing vision therapy, which is said to be experimental, and the results are yet to be proven. It is not a cure for problems that a child like this may have. The standard of care is for an ophthalmologist to see this child and evaluate him and see what is going on.” Dr. Huerta testified that he reviewed Aetna’s February 17, 2015 letter denying benefits for vision therapy for Claimant and accompanying policy bulletin regarding vision therapy (Ex. E.), and he opined, “My take is that they are basically supporting what we are supporting, which is that it is an experimental program and the outcomes are yet to be proven that it really works.” Dr. Huerta indicated that he understands Exhibit H as stating that “vision therapy is not a treatment option for an eye muscle movement disorder. That is a condition that should be assessed by an ophthalmologist and treated according to their standard of care.” Dr. Huerta concluded his testimony stating, “Because it is not an established treatment therapy, we as an agency cannot fund it. The state does not allow us to fund it. If it was an established treatment program for autism or cerebral palsy or mental retardation we would look into it and fund.”

20. Slight weight is accorded Dr. Huerta’s opinion testimony in light of the fact that he has no demonstrated training, experience, or scholarship in ophthalmology, optometry, or vision therapy, he has never evaluated or treated Claimant, and he is not a practicing clinician.

LEGAL CONCLUSIONS

1. Under the Lanterman Act, developmentally disabled persons in California have a statutory right to treatment and habilitation services and supports. (§§ 4502, 4620, 4646-4648; *Association for Retarded Citizens—California v. Department of Developmental Services* (1985) 38 Cal.3d 384, 389.) The Lanterman Act mandates that an “array of services and supports should be established . . . to meet the needs and choices of each person with developmental disabilities . . . and to support their integration into the mainstream of life in the community.” (Welf. & Inst. Code, § 4501.)

2. Services and supports for persons with developmental disabilities are defined as “specialized services and supports or special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of independent, productive, normal lives. The 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. Services and supports listed in the individual program plan may include, but are not limited to, . . . specialized medical . . . care [.]” (Welf. & Inst. Code, § 4512, subd. (b).)

3. Regional centers play a critical role in the coordination and delivery of treatment and habilitation services and supports for persons with disabilities. (Welf. & Inst. Code, § 4620 et seq.) Regional centers are responsible for developing and implementing individual program plans (IPP) for the individual with developmental disabilities, for taking into account the needs and preferences of the individual and the family, and for promoting community integration, independent, productive, and normal lives, and stable and healthy environments. Regional centers are additionally responsible for ensuring that the provision of treatment and habilitation services and supports to individuals with disabilities and their families are effective meeting the goals stated in the IPP, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources. (Welf. & Inst. Code, §§ 4646, 4646.5, 4647, and 4648.)

4. Regional centers are mandated to secure needed services and supports to achieve the stated objectives of an individual's IPP. (Welf. & Inst. Code, § 4648, subd. (a).) Consequently, regional centers are authorized to purchase treatments, therapeutic services, or devices for individuals with developmental disabilities, unless the treatment, service or device is “experimental” or “have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown.” (Welf. & Inst. Code, § 4648, subd. (a)(16).)

5. As the party asserting a claim for services and supports under the Lanterman Act, Claimant bears the burden of proving by a preponderance of evidence his entitlement to the services and supports. (Evid. Code, §§ 115 and 500.) Claimant has met his burden.

6. Dr. Suter's thoughtful and thorough explanation of vision therapy, its history, development, processes and modalities, and why vision therapy should not be regarded as experimental, is more credible than Dr. Huerta's reiteration, without any in-depth interrogation, of an insurer's policy conclusion to the contrary. (Compare Factual Findings 9 through 13 and 16 with Factual Finding 19.) Dr. Suter's testimony establishes that vision therapy has existed for at least three centuries and that its efficacy is well documented in both the scientific and clinical literature. Dr. Huerta's testimony ignores the evidence establishing that Claimant's deficits amount to more than mere “eye muscle disorder.” Claimant presents with difficulty integrating and processing complex perceptual information. These difficulties are alleviated when Claimant is treated with the forms of vision therapy set forth in Factual Finding 11. The preponderance of the credible evidence establishes that vision therapy has been beneficial for Claimant. (Factual Finding 16.) Dr. Huerta offered no support for his statement that the standard of care requires exclusive diagnosis and treatment from an ophthalmologist to achieve such improvements.

7. Cause exits for KRC to fund vision therapy services for Claimant by reason of Factual Findings 1, 2, and 8 through 17 and Legal Conclusions 1 through 6.

ORDER

1. Claimant's appeal is granted.
2. Kern Regional Center shall fund vision therapy for Claimant three times per week for at least six weeks.

Dated: August 3, 2015



JENNIFER M. RUSSELL
Administrative Law Judge
Office of Administrative Hearings

NOTICE

This is a final administrative decision. This decision binds both parties. Either party may appeal this decision to a court of competent jurisdiction within 90 days.