

BEFORE THE  
OFFICE OF ADMINISTRATIVE HEARINGS  
STATE OF CALIFORNIA

In the Matter of the Fair Hearing Request of:

OAH No. 2014050356

CLAIMANT

vs.

EASTERN 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 June 10, 2014, in Alhambra, California. Claimant was represented by her parents and authorized representatives.<sup>1</sup> Eastern Los Angeles County Regional Center (ELARC or Service Agency) was represented by Edith Hernandez.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on June 10, 2014.

ISSUE

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

FACTUAL FINDINGS

1. Claimant is a four-year-old girl. She seeks eligibility for regional center services based on the eligible conditions of Autism Spectrum Disorder, Intellectual Disability or fifth category (See also Legal Conclusion 5).

2. On March 6, 2014, ELARC sent a letter to Claimant's parents, informing them that ELARC had determined that Claimant is not eligible for regional center services. Claimant's parents requested a fair hearing. (Exhibits 1 and 2.)

---

<sup>1</sup> Claimant's and her parents' names are omitted to protect their privacy.

3. Claimant lives with her parents and five siblings. She is not toilet trained and has not been enrolled in school. Her parents have met with the school district to create an Individualized Education Plan and are awaiting assessment results. (Testimony of Claimant's parents.)

4(a). On November 19, 2013, licensed psychologist Heike Ballmaier, Psy.D., conducted a psychological evaluation of Claimant to determine her cognitive and adaptive functioning levels and to assess for possible Autism Spectrum Disorder. The evaluation included an interview with Claimant's parents, observations of Claimant, and administration of diagnostic tools for measuring cognitive functioning and adaptive skills and for ascertaining characteristics of autism. At the time of the evaluation, no prior records or testing were available for review. (Exhibit 3.)

4(b). Claimant's parents reported that she is a slow learner, that her expressive language skills are delayed, that she is hyperactive, eats dirt and does not know how to play with other children. They also reported that she lines up rocks and other objects at home. She is a picky eater and will turn her whole plate upside down if she does not like what is being served or if a parent watches her while she is eating. She also tantrums when she cannot have what she wants. Claimant has a family history of intellectual disability and mental health diagnoses. Her mother has Mild Intellectual Disability and is a regional center consumer; her father has been diagnosed with Schizophrenia; and her brother has been diagnosed with Attention Deficit Hyperactivity Disorder and Bipolar Disorder. (Exhibit 3.)

4(c). Dr. Ballmaier made the following observations of Claimant:

[U]pon being greeted, she smiled and exhibited good eye contact. . . . During testing, she was cooperative and completed all tasks presented to her. She was not withdrawn or aloof and did not appear to be easily distracted or confused. [Claimant] presented as a socially responsive child[,] however her verbalizations were limited to occasional one- and two-word word phrases. [Claimant] continued to demonstrate good eye contact, varied facial expressions, and was able to point to pictures when requested. She did not spontaneously initiate conversation with the examiner and her verbalizations were difficult to understand. Moreover, [Claimant] was able to engage in shared enjoyment with the examiner and followed the examiner's gaze when applicable. Overall, [Claimant] appeared to exhibit excellent effort, motivation, and perseverance. It is the examiner's impression that the conditions for testing were satisfactory and that the obtained results represent a valid indication of her current level of functioning.

(Exhibit 3.)

4(d). To assess Claimant's cognitive functioning, Dr. Ballmaier administered the

Wechsler Preschool and Primary Scale of Intelligence – Fourth Edition (WPPSI-IV). The measure of Claimant’s overall intellectual abilities was in the borderline range (Full Scale IQ of 76). Her Verbal Comprehension Index score was in the low average range (Standard score 82), and her Visual Spatial Index and Working Memory Index scores were in the borderline range (Standard scores of 78 and 76, respectively). Dr. Ballmaier noted that there were no significant discrepancies across indices. Dr. Ballmaier further noted:

[Claimant] obtained average scores on tasks that required her to identify a select picture amongst a group of four pictures presented to her, requiring her to demonstrate her knowledge of receptive vocabulary skills, and to assemble pieces of a puzzle requiring the recognition of part- whole relationships. Her scores dropped to the borderline range when she was asked to provide verbal responses to basic information questions and when she was asked to work with more abstract visual spatial tasks. [Claimant] further demonstrated low average skills in areas that measured her immediate and short term visual memory skills. Overall, she is currently estimated to demonstrate cognitive functioning in the borderline range.

Regarding her pre-academic skills, [Claimant reportedly] always points to pictures in books when asked, sometimes attempts to imitate simple drawings, sometimes counts three or more objects, and sometimes draws a face when asked. She never holds a crayon or pencil with point down when using paper, never states her age, never names colors, and never identifies shapes. Her current pre-academic functioning reflected borderline abilities. She is also unable to recite nursery rhymes or sing the alphabet song. *It should be emphasized that [Claimant] has not experienced the opportunity to engage in more structured learning opportunities within a preschool setting and it is estimated that she would progress in her current skill level if she was exposed to such opportunities.* (Emphasis added.)

(Exhibit 3.)

4(e). In the area of adaptive functioning, Dr. Ballmaier administered the Adaptive Behavior Assessment System (ABAS-II); Claimant’s father provided the responses necessary for the completion of this test. Her overall measure of adaptive functioning was in the “extremely low” range (standard score 56). Dr. Ballmaier noted:

On the Social Composite of the ABAS-II [Claimant] obtained a score in the borderline range (SS=74). According to her father, she always shows a sense of humor, always displays a special closeness to family members, and always shows affection towards family members, always seeks friendships with others in her age group (this is in contrast to what her father was reporting to this examiner and what was reported

on an Autism questionnaire). In addition she is able to s[t]ate how she and others might be feeling. [Claimant] sometimes imitates adult actions, sometimes greets other children, and sometimes shows sympathy for others when they are upset. She never shares toys and never moves out of another person's way without being asked. Moreover, in the leisure domain she reportedly always plays alone with toys and games, always looks at pictures in books, always plays simple games with others, always plays on playground equipment with an adult and always invites others to join her in playing games. She sometimes plays with toys and games with other people, sometimes plays with other children when asked, and sometimes attend[s] fun activities at another person's home[.] [Claimant] never asks to be read to from a favorite book and never waits for her turn in games. It should be noted that the social subtest alone reflected a relative strength when compared to scores obtained for other subtests of adaptive functioning.

In the area of self-direction [Claimant] also obtained a score in the extremely low range[.] . . . Overall, [Claimant] is described as a child who is interested in peers but highly active and not understanding or wanting to follow basic social rules for sharing and interacting with others in positive ways. *Overcrowding and lack of resources may also play a factor in her current level of achievement (or perceived difficulties).*

[Claimant's] communication skills . . . were in the borderline range. [Claimant] raises her voice to get attention and always repeats words other say. She sometimes looks at others' faces when they are talking, sometimes greets others by their names, sometimes shakes her head "yes" and "no" in response to a simple question, sometimes speaks clearly, and sometimes asks questions. She never listens closely for one minute when other people are talking, never follows simple commands, and never refrains from interrupting others. During this assessment [Claimant] offered a limited number of verbalizations but appeared to have a more highly developed receptive understanding as she was able to follow most instructions given to her on assessment instruments.

[¶] . . . [¶]

[T]he Practical Skills domain consisting of community, home living, health and safety and self-care skills fell in the extremely low range (SS=49). . . . [Claimant] never recognizes her own home in her immediate neighborhood and never recognizes and names buildings. She is unable to refrain from talking loudly in a public place, remain seated during a movie, or refrain from touching items at a store. . . .

She is unable to assist others with putting away toys and games, never throws away her [t]rash, and never wipes up spills. . . . [Claimant] never avoids getting too near a fire or hot stove and never avoids touching or playing with dangerous items. She is further unable to follow an adult's direction to stop when in danger, . . . or refrain from putting toys in her mouth. . . . She is not yet toilet trained. She needs full assistance with brushing her teeth and taking a shower or bath. Overall, significant deficits are evident in the area of daily living skills. (Emphasis added.)

(Exhibit 3.)

4(f). To address autism concerns, Dr. Ballmaier administered the Autism Diagnostic Observation Schedule – 2, Module 1 (ADOS-2), an observational assessment of Autism Spectrum Disorders, and the Gilliam Autism Rating Scale Third Edition (GARS-3), with Claimant's father providing the necessary responses. On the ADOS-2, the overall score fell below the autism spectrum cutoff scores (i.e. not indicative of autism spectrum disorder). Dr. Ballmaier noted:

[In the] area of Social Affect, [Claimant] offered occasional and somewhat limited verbalizations to the examiner or a parent due to generally delayed expressive language skills. Her use of gestures was also somewhat limited. [Claimant] demonstrated excellent eye contact however, smiled frequently or demonstrated a more serious facial expression as appropriate, and was able to integrate gaze with the use of gestures or pointing. She further shared enjoyment with the examiner . . . [although she] showed toys to the examiner to a lesser extent than what might be expected given her age. She also seemed somewhat passive and did not regularly initiate joint attention with the examiner. On the other hand, she was able to respond to joint attention efforts by the examiner. . . . Additionally, [Claimant] consistently responded to her name and smiled and looked at the toy and back at the examiner when the pop up clown was activated. No repetitive or stereotyped behaviors were observed during the ADOS-2 administration.

In contrast [Claimant's father] noted a number of Autistic-like characteristics when he completed the [GARS-3]. In the area of Restricted Repetitive Behaviors she reportedly frequently stares at her hands or other objects in the environment and her mother might have to touch her to get her attention. She also frequently screams for no reason and frequently uses toys or objects inappropriately by taking them apart and breaking them. [Claimant] likes to watch the same movie repeatedly. Moreover, she engages in repetitive play with toys at home. In the area of Social Interactions, [Claimant] does not like to

share her toys and displays little excitement when asked to show her toys to others. She further does not engage in reciprocal communication and does not have sufficient verbal language skills to engage in a back-and-forth conversation. In addition, [Claimant] does not have sufficient understanding to realize that other people have thoughts different from hers and fails to predict probable consequences in social events. Moreover, [Claimant] becomes extremely upset when her parents change their scheduled plans or when her daily routine is changed. . . . [Claimant] reportedly gets stuck on certain topics . . . .

In conclusion, some Autistic-like characteristics appear to be present [but] they do not appear to be sufficient in frequency and severity to qualify for a full diagnosis. Specifically, in the area of Social Communication and Social Interaction deficits [Claimant] has great difficulty with engaging in back-and-forth conversation however the current level of her conversation skills is heavily influenced by her current lack of age-appropriate expressive language skills. In addition, she did not use gestures frequently but displayed excellent eye contact and was able to demonstrate a pointing response. Finally, significant difficulties are reported with [Claimant's] inability to show or share her belongings with others[,] *however this may be also influenced by other factors such as possible crowding and lack of structure in her home, the absence of a school experience and lack of opportunity to be socialized away from home thus far, and possible other diagnostic issues that may be influencing her behavior, particularly as she gets older, such as her [family] history of mental illness.* Moreover, regarding Restricted Repetitive Behaviors [Claimant] reportedly demonstrates some inflexible adherence to routines, . . . lines up rocks and toys, and appears to have rigid food expectations. . . . It is estimated that a language disorder and possible emotional disturbances better account for her current symptom presentation at home. (Emphasis added.)

(Exhibit 3.)

4(g). Dr. Ballmaier provided the following DSM-5 diagnoses <sup>2</sup>: Language Disorder; Rule Out (R/O) Unspecified Disruptive, Impulse Control and Conduct Disorder; R/O Attention Deficit Hyperactivity Disorder; Borderline Intellectual Functioning.

---

<sup>2</sup> The Administrative Law Judge takes official notice of the Diagnostic and Statistical Manual of Mental Disorders as a generally accepted tool for diagnosing mental and developmental disorders.

5(a). On April 16, 2014, licensed psychologist Harrell Reznick, Ph.D., conducted a psychological evaluation of Claimant at the request of the Department of Social Services, Disability and Adult Programs, to determine Claimant's eligibility for Social Security income.

5(b). Dr. Reznick listed "Tests Administered" as a mental status examination and the WPPSI-IV. No other testing instruments were listed.

5(c). Under the Presenting Illness, Dr. Reznick noted what Claimant's mother reported as follows:

When asked the nature of claimant's primary problem or disability, his [*sic*] mother replied that the claimant is autistic and was initially diagnosed with autism (as well as Attention Deficit Hyperactivity Disorder) in a psychological evaluation conducted through the Regional Center in December 2013.<sup>[3]</sup> The claimant was subsequently diagnosed with a pervasive developmental disorder as well as mental retardation by an unspecified mental health practitioner at Pacific Clinics, in January of this year.<sup>[4]</sup>

The claimant was characterized as exhibiting repetitive motor movements indicative of an autistic spectrum disorder. The claimant paces back and forth in circles in an agitated manner at home. She fidgets repetitively with her fingers, including engaging in repetitive hair-smoothing gestures. The claimant also picks scabs until they bleed. She sways while standing and in addition, rocks repetitively while seated, during which she engages in repetitive foot-tapping and leg-shaking gestures. In addition, the claimant jumps up and down while engaging in arm-flapping motions. The claimant also talks, laughs and makes noises to herself, but when she is not being hyperactive and engaging in repetitive motor movements, she periodically stares out into space for prolonged periods of time, as if she were lost in her own world. The claimant also often does not respond when her name is being called.

The claimant's preferred activities at home suggest autism in their repetitiveness. The claimant watches the same DVD's over and over again. . . . The claimant likes to line up her toys . . . . [T]he claimant has daily temper outbursts and has marked social skills deficits.

---

<sup>3</sup> Claimant's mother's reported information about the regional center diagnosis was incorrect.

<sup>4</sup> No Pacific Clinics records were submitted to substantiate this reported diagnosis.

Consequently, the claimant does not readily interact with other children outside of the home.

The mother described sensory defensiveness suggestive of autism. She indicated that the claimant is a picky eater . . . . The claimant was described as oversensitive to any sudden or loud noises, to which the claimant responds fearfully by covering her ears with her hands. Moreover, the mother stated that the claimant displays an autistic-like insistence on wearing the same clothes over and over again. . . . She insists on having tags removed from her clothes because they rub against her skin, and in addition, whenever she comes home from outside, she immediately takes off her clothes and runs around in her diaper. . . .

(Exhibit 5.)

5(d). Dr. Reznick further noted that Claimant had participated in outpatient mental health interventions at Pacific Clinics for six to seven months. He reviewed a Child Initial Assessment from Pacific Clinics, dated November 13, 2013, which purportedly indicated that Claimant had been “diagnosed with a pervasive developmental disorder, not otherwise specified.”<sup>5</sup> At the time of Dr. Reznick’s evaluation, Claimant was receiving speech and language therapy and physical therapy from unspecified providers.

5(e). Following a mental status examination, Dr. Reznick observed:

The claimant presented as hyperactive and distractible throughout this evaluation, requiring multiple re-directions to the test tasks. She spoke with a speech impediment, but her speech was generally intelligible, with intact receptive and expressive language abilities at least during this evaluation. . . . Mood and affect were constricted and the claimant tended to avoid eye contact with this examiner. The claimant knew her first name but not her last name. She did not know her age. . . . She only knew letters of the alphabet in correct sequence from A through G.

(Exhibit 5.)

5(f). On administration of the WPPSI-IV, Claimant obtained a Full Scale IQ of 82. Her Verbal Comprehension Index score was 96, and her Visual Spatial Index and Working Memory Index scores were 70 and 116, respectively.

5(g). Dr. Reznick documented the following diagnostic impression:

---

<sup>5</sup> The November 2013 Child Initial Assessment from Pacific Clinics was not submitted as evidence, so the bases for this purported diagnosis were not ascertainable.

Given the above test results and clinical data, the claimant is diagnosed as having the following DSM-IV classification<sup>6</sup>:

AXIS I:           Autistic Disorder  
                    Attention Deficit Hyperactivity Disorder, combined type

(Exhibit 5.)

6(a). At the fair hearing, Randi Bienstock, Psy.D., testified credibly on behalf of the Service Agency. Dr. Bienstock is a licensed clinical psychologist who provides consultation services to determine claimants' eligibility for regional center services. Dr. Bienstock reviewed Dr. Ballmaier's and Dr. Resznick's reports and had a discussion with Dr. Ballmaier on May 22, 2014.

6(b). Regarding the assessment for Autism Spectrum Disorder:

(1). Dr. Bienstock noted that Dr. Ballmaier appropriately took into account Claimant's lack of attendance at preschool or any educational program. An evaluator should consider the potential impact of exposure, or lack thereof, to therapeutic interventions or educational opportunities on a child's delays. Dr. Bienstock also pointed out that Dr. Ballmaier did not observe any of the restricted and repetitive patterns reported by Claimant's parents. Dr. Bienstock agreed with Dr. Ballmaier's conclusion that the overall clinical information/observations did not meet criteria for a DSM-5 diagnosis of Autism Spectrum Disorder (ASD).

(2). Dr. Bienstock noted several problems with Dr. Resznick's report and conclusions. She had significant concerns about his diagnostic impressions because they were not consistent with the DSM-5 criteria. Additionally, Dr. Resznick did not utilize any standardized or direct measures consistent with best practice guidelines which clinicians should follow to make an accurate diagnosis of ASD. Dr. Resznick documented Claimant's mother's report but virtually no other information. A clinician must document clinical observations which support or rule out a diagnosis, and Dr. Resznick did not do so, providing no substantiation for any diagnosis. Furthermore, he diagnosed Claimant with Autistic Disorder, a DSM-IV diagnosis which was no longer utilized with the revised DSM-5. Although clinicians should have time to adapt to the changes in the DSM-5, this should take no longer than six months, and Dr. Resznick was employing the outdated diagnosis almost a year later. This raises concerns about his knowledge of the current diagnostic criteria. Consequently, Dr. Resznick's report and his conclusions, including the diagnosis of Autistic Disorder, were not clinically substantiated.

---

<sup>6</sup> At the time of Dr. Resznick's report, the DSM-IV was no longer being utilized. An updated edition, the DSM-5, was published in May 2013, and was subsequently utilized as the current tool for diagnosing mental and developmental disorders. Dr. Resznick did not provide any DSM-5 diagnosis.

6(c). With regard to testing and assessment for Intellectual Disability or Fifth Category eligibility: Dr. Bienstock noted that Claimant’s cognitive and adaptive scores, although not at the level to diagnosis her with Intellectual Disability, were sufficiently delayed to produce a diagnosis of Borderline Intellectual Functioning. Given Claimant’s cognitive and adaptive functioning delays, this raised questions regarding her eligibility for regional center services under the Fifth Category. In order to address this question, Dr. Bienstock called Dr. Ballmaier to discuss whether she considered Claimant eligible under the Fifth Category. Dr. Ballmaier pointed out, and Dr. Bienstock agreed, that when looking at the WPPSI-IV subtests, several were in the average range, which could suggest difficulties in particular areas and would weigh against a determination of Fifth Category eligibility. Dr. Bienstock also noted that, if a child suffers from expressive language difficulties and behavioral difficulties, these problems could affect her adaptive functioning. She cautioned against prematurely diagnosing or labeling a child without “considering everything.” Dr. Bienstock agreed with Dr. Ballmaier’s analysis and did not believe that Fifth Category eligibility was warranted.

6(d). Dr. Ballmaier opined, and Dr. Bienstock agreed, that Claimant could benefit from one year of educational instruction, including more opportunities for peer social interaction, speech therapy and behavioral intervention. If concerns related to possible ASD or Fifth Category eligibility persist, Claimant should undergo an updated evaluation after one year.

6(e). Dr. Bienstock’s testimony and Dr. Ballmaier’s report were given more weight than Dr. Reznick’s report, which contained several problems as outlined in Finding 6(b)(2) above.

7. At the fair hearing, Claimant’s mother noted Claimant’s difficulty with toilet training and behavior issues, maintaining that she needs “to find a place to get help.” Claimant is receiving services from Pacific Clinics to address her behavior. Claimant’s father testified that he agreed with Dr. Bienstock’s testimony and would bring Claimant back to ELARC in a year for re-assessment.

8. The totality of the evidence did not establish that Claimant suffers from Autism Spectrum Disorder, Intellectual Disability or a condition similar to Mental Retardation or requiring treatment similar to that of people with Mental Retardation.

## **LEGAL CONCLUSIONS**

1. Claimant did not establish that she suffers from a developmental disability (Autism Spectrum Disorder; Intellectual Disability; or a Fifth Category condition) which would entitle her to regional center services under the Lanterman Developmental Disability Services Act (Lanterman Act).<sup>7</sup> (Factual Findings 1 through 8.)

---

<sup>7</sup> Welfare and Institutions Code section 4500 et seq.

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 her 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 not met her 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.

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 her 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 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-5, the term mental retardation has been replaced with the diagnostic term "Intellectual Disability."

8. The DSM-5 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-5, p. 33.)

9. The DSM-5 notes that the most significant change in diagnostic categorization accompanying the change from the DSM-IV-TR diagnosis of Mental Retardation to the DSM-5 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-5 notes no other significant changes. Furthermore, the DSM-5 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 Intellectual Disability or requiring treatment similar to the treatment provided to individuals with Intellectual Disability.

10(a). The evidence did not establish that Claimant suffers from Intellectual Disability. Although she has a Full Scale IQ of 76 (in the Borderline range) and significant adaptive deficits, Dr. Ballmaier did not find that Claimant met the criteria under the DSM-5 for a diagnosis of Intellectual Disability. She therefore does not qualify for regional center services under the category of mental retardation.

10(b). Additionally, the evidence did not demonstrate that Claimant suffers from deficits in cognitive and adaptive functioning such that she presents as a person suffering from a condition similar to Mental Retardation/Intellectual Disability or that she requires treatment similar to that required for individuals with Mental Retardation/Intellectual Disability. Based on the foregoing, the evidence did not establish that Claimant falls 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-5, the qualifying disability of "autism" is defined as congruent to the DSM-5 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-5 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-5, 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-5 at pp. 50-51.)

13(a). Although Claimant maintains that she is eligible for regional center services under a diagnosis of Autism Spectrum Disorder, this diagnosis was not established by the totality of the evidence.

13(b). After conducting psychological testing, Dr. Ballmaier found, and Dr. Bienstock agreed, that Claimant did not meet the criteria for a DSM-5 diagnosis of Autism Spectrum Disorder. Although Dr. Reznick provided Claimant with a diagnosis of Autistic Disorder, as set forth in Findings 6(b)(2) and 6(e), his report was faulty and was given less weight than Dr. Ballmaier's. Consequently, the evidence did not establish that Claimant has ever been diagnosed with Autism Spectrum Disorder by a qualified psychologist utilizing appropriate testing, best practices guidelines and DSM-5 criteria.

13(c). Based on the psychological testing and application of the DSM-5 criteria, Claimant does not meet the requisite clinical criteria to diagnose her with Autism Spectrum Disorder. While Claimant may manifest some deficits in her communication and social skills, her symptoms do not cause clinically significant impairment which would satisfy the required DSM-5 criteria for a diagnosis of Autism Spectrum Disorder. Consequently, Claimant has not established that she is eligible for regional center services under the eligibility category of autism.

14. The preponderance of the evidence does not support a finding that Claimant is eligible to receive regional center services at this time.

### **ORDER**

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant's appeal is denied. The Service Agency's determination that Claimant is not eligible for regional center services is upheld.

DATED: June 18, 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.