BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, and INLAND REGIONAL CENTER, Service Agency.	OAH No. 2015030935

DECISION

Kimberly J. Belvedere, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California, on February 22, 2016.

Lee-Ann Pierce, Consumer Services Representative, Fair Hearings and Legal Affairs, represented Inland Regional Center (IRC).

Claimant's mother appeared on behalf of claimant who was not present.

The matter was submitted on February 22, 2016.

ISSUE

Is the previous determination, which found claimant eligible for regional center services under the Lanterman Act based on a diagnosis of Autism Spectrum Disorder, clearly erroneous in light of the comprehensive re-assessment conducted by IRC?

FACTUAL FINDINGS

JURISDICTIONAL MATTERS

1. Claimant was first diagnosed with autism in 2009 when she was approximately 18 months old, and she began receiving services from the North Los Angeles Regional Center. Claimant is now nine years old.

2. Claimant moved to the jurisdiction of IRC in 2014. IRC held a planning meeting to develop claimant's new Individual Program Plan (IPP). At the time of her transfer, claimant was receiving respite services and applied behavioral analysis services (ABA). IRC continued these services pending a comprehensive re-assessment.

3. On June 24, 2014, IRC Staff Psychologist Paul Greenwald, Ph. D., conducted a psychological reassessment of claimant in a clinical setting. On January 15, 2015, Dr. Greenwald conducted an assessment of claimant in a school setting. Based on the overall comprehensive reassessment, Dr. Greenwald concluded that claimant no longer met the diagnostic criteria for Autism Spectrum Disorder (autism) as specified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

4. On March 2, 2015, IRC notified claimant that she was no longer eligible for regional center services.

5. On March 15, 2015, claimant filed a Fair Hearing Request appealing IRC's determination. A hearing was held on October 8, 2015. Nobody appeared on behalf of claimant. A final decision denying claimant's appeal was subsequently issued.

6. Claimant timely sought and received relief from the decision, which was set aside. This hearing ensued.

DIAGNOSTIC CRITERIA FOR AUTISM UNDER THE DSM-5

7. The DSM-5 identifies the following five criteria for the diagnosis of autism: persistent deficits in social communication and social interaction across multiple

contexts that are pervasive and sustained; restricted, repetitive patterns of behavior, interests, or activities; symptoms that are present in the early developmental period; symptoms that cause clinically significant impairment in social, occupational, or other important areas of function; and disturbances are not better explained by intellectual disability or global developmental delay.

The severity of symptoms may vary and fluctuate over time. Core diagnostic features are evident in the developmental period; however, intervention, compensation, and current supports may mask the difficulties in some contexts. Deficits in developing, maintaining and understanding relationships must be judged accounting for age, gender, and culture. Stereotyped or repetitive behaviors include, but are not limited to, repeated simple motor movements (hand flapping, pointing, finger flicking), and repetitive use of objects (spinning coins, lining up toys), repetitive speech (echolalia). A person may also exhibit excessive adherence to routines, restricted patterns of behavior, and hyper- or hypo-reactivity to sensory input.

Autism is frequently associated with intellectual impairment; structural language disorder, coordination disorders, anxiety disorders, depressive disorders, and Attention Deficit Hyperactivity Disorder.

CLAIMANT'S ORIGINAL 2009 PSYCHOLOGICAL ASSESSMENT

8. Kathy Khoie, Ph.D., conducted a psychological assessment of claimant on December 7, 2009, to determine eligibility for regional center services on the basis of a diagnosis of autism under the DSM-4 TR. At the time of Dr. Khoie's assessment, claimant was almost three years old.

Dr. Khoie used the following tests to evaluate claimant: Wechsler Preschool & Primary Scale of Intelligence, Third Edition (WISC-III); Autism Diagnostic Observation Schedule, Module 1 (ADOS-I); Autism Diagnostic Interview-Revised (diagnostic interview); and the Adaptive Behavior Assessment System, Second Edition (ABAS-II). Dr.

Khoie also reviewed three prior reports regarding claimant's development. Dr. Khoie noted in her written report that, a 2009 Outpatient Child Development Report authored by Alice Lim, M.D., reflected an impression of "mild autism."

Dr. Khoie found that, on the WISC-III, claimant scored an intelligence rating in the high end of the average range but had a 20-point discrepancy between verbal and performance IQ scores. On the subtests, claimant's scores ranged from average to the "superior range on receptive vocabulary." On the ABAS-II, designed to assess communication and adaptive functioning, claimant's receptive and expressive language development fell "within normal limits." However, her academic score was in the low range; her leisure score was in the deficit range; and her health and safety and self-care scores were in the borderline range. Overall, claimant's scores on the ABAS-II placed her "in the deficit range of functioning."

Dr. Khoie interviewed claimant's mother to obtain the necessary information to complete the ADOS-I and diagnostic interview. Claimant scored "at or above the cutoff scores for autism in the areas of communication and reciprocal social interaction" on the ADOS-I. The responses on the diagnostic interview yielded scores below the cutoff for autism in the areas of reciprocal social interaction, communication, and restricted repetitive and stereotypic patterns of behavior. Dr. Khoie personally observed claimant to have poor social eye contact and lack of interest in socialization. Claimant was inconsistent in her emotional reciprocity when interacting with others. Claimant also engaged in repetitive and restricted speech on occasion.

Thus, while claimant's overall cognitive functioning was in the average range, her adaptive functioning placed her in the deficit range and "warranted" a diagnosis of autism.

DR. GREENWALD'S COMPREHENSIVE PSYCHOLOGICAL RE-ASSESSMENT IN 2014 AND 2015

9. Dr. Greenwald performed psychological assessments of claimant on June 24, 2014, and January 15, 2015, when claimant was seven years old. Dr. Greenwald used the following tests to evaluate claimant: the Wechsler Intelligence Scale for Children, 4th Edition (WISC-IV); Autism Diagnostic Interview (ADI-R); Childhood Autism Rating Scale – 2nd Edition (CARS2-ST); and the Vineland-II Adaptive Behavior Scales. Dr. Greenwald also reviewed claimant's clinical records on file with IRC, including psychological assessments that determined she met the criteria for autism. Dr. Greenwald testified in this proceeding consistent with his report.

According to Dr. Greenwald, claimant scored a 90 on the WISC-IV, which is not consistent with a diagnosis of autism. On the CARS2-ST administered first on June 24, 2014, and again on January 15, 2015, claimant's scores of 25.5 and 18, respectively, placed her well below the cutoff for "minimal to moderate" autism spectrum symptoms.

Dr. Greenwald noted that the results on the Vineland-II scales, based on reporting by claimant's mother, indicated that claimant had moderate deficits in communication, daily living and in social domains, consistent with a diagnosis of autism spectrum disorder. Similarly, Dr. Greenwald noted that the reporting by claimant's mother on the ADI-R inquiry generated a result that placed claimant within a diagnostic range of autism spectrum disorder in all four categories for that assessment. Dr. Greenwald explained that the results of the Vineland-II scales and ADI-R were "unusual" given claimant's high score on the WISC-IV. Dr. Greenwald attributed the discrepancy to inaccurate reporting on the Vineland-II scale and ADI-R by claimant's mother.

Dr. Greenwald observed claimant on June 24, 2014. Dr. Greenwald noted that claimant was very guarded in communicating with him, yet she did not restrict her verbal communications with her mother. Further, Dr. Greenwald observed claimant

disagree with her mother multiple times during her mother's verbal reporting to Dr. Greenwald on the ADI-R. Dr. Greenwald said that claimant's verbal disagreements suggested claimant had sufficient verbal comprehension. Claimant did not display any motor stereotypes or sensory anomalies, and no vulnerability to visual, auditory, kinesthetic-vestibular, or tactile distractions.

When Dr. Greenwald assessed claimant at her school on January 15, 2015, he did not find claimant to have persistent impairment in reciprocal social communication and interaction or restricted and repetitive patterns of behavior, all of which are essential features of autism spectrum disorder according to the DSM-5. Claimant demonstrated sustained attention to her assignments and appeared alert and attentive to the teacher's instructions. Claimant was very aware of Dr. Greenwald's presence and constantly looked in his direction. Claimant's teacher told Dr. Greenwald that they had visitors in the classroom before, but claimant had never reacted in that manner. Dr. Greenwald concluded that claimant was "very aware" that he was there to observe her, and she changed her behaviors consistent with that perception.

During the lunch period, claimant calmly lined up with the other children; inserted herself on an already crowded bench in between other children after getting her lunch tray; and had a striking change in her demeanor. Claimant's face "lit up" and she "cheerfully initiated greeting her tablemates." Claimant directed words, gestures, and smiles at the other children. Claimant compared, swapped, and ate items from her lunch box with the other children. Claimant rose from the table and engaged a boy in dialogue and "horseplay."

Dr. Greenwald concluded that claimant's "uninhibited and mildly boisterous social communications and interaction with schoolmates in the lunch setting are not consistent with an [sic] non-selective autistic process."

Dr. Greenwald noted that autism spectrum disorder is not a "static" disorder. He

explained that, in his experience, almost 40 percent of individuals diagnosed with autism at an early age will no longer demonstrate symptoms consistent with autism spectrum disorder as they age. He has found this to be true based on his review of research in the field, as well as in his own personal observations and assessments of patients. The change in symptomology very likely is a result, at least in part, of early interventions, regional center services, and other school-based or social interactions.

After reviewing claimant's records, her scores on the various assessments, and in consideration of his overall comprehensive assessment of claimant, Dr. Greenwald's diagnostic impression was that claimant did not meet the diagnostic criteria for Autism Spectrum Disorder under the DSM-5. As a result, claimant was no longer eligible for regional center services.

10. Dr. Greenwald testified that one of the paramount features of autism is deficits in communication that are persistent, not selective. In his observations of claimant, her deficits in communication were selective in there was not a "uniform" failure to communicate. In other words, she adapted her choice to communicate with others based on the setting. Dr. Greenwald testified that he has assessed many children with autism in a school setting. They typically will sit alone, or if they have to sit with other children, they will do so but limit their communication and interaction to only that which is absolutely necessary (i.e. pass the salt or to request a condiment.) Typically, a child with autism will also do the same thing on the playground.

Dr. Greenwald's conclusion was that claimant should be evaluated for Attention Deficit Hyperactivity Disorder, Selective Mutism, and Social Anxiety Disorder, because her behaviors conform to those disorders. Moreover, based on his review of prior medical records, claimant had a diagnostic history of ADHD, sensory processing difficulties and selective mutism. He testified that, while ADHD and anxiety disorders may be comorbid with autism, they can also stand alone as a diagnosis.

2015 PSYCHOLOGICAL ASSESSMENT BY ALAN LINCOLN, PH.D.

11. Following Dr. Greenwald's assessment, claimant's mother requested an independent psychological assessment be completed by Dr. Lincoln, who did so on May 18, 2015, and June 2, 2015. The report submitted reflected that a psychological assistant, Shemayne Brown, M.A., also conducted the assessment. The report did not contain any information regarding whether Dr. Lincoln conducted the testing with Ms. Brown observing; whether Ms. Brown conducted the testing with Dr. Lincoln observing; or whether Dr. Lincoln was present throughout the testing. There was also no signature page attached to indicate whether, if Ms. Brown conducted the assessment, Dr. Lincoln concurred in the conclusions. Neither Dr. Lincoln nor Ms. Brown testified at the hearing. Claimant's mother testified that Dr. Lincoln was present throughout the entire assessment. For purposes of this decision, the report will be referred to as being completed by Dr. Lincoln.

Dr. Lincoln used the following tests to evaluate claimant: the Wechsler Abbreviated Scale, Second Edition (WASI-II); Wechsler Individual Achievement Test, Third Edition (WIAT-III); Peabody Picture Vocabulary Test, Fourth Edition (PPVT-4); Expressive Vocabulary Test, Second Edition (EVT-2); Beery-Buktencia Developmental Test of Visual Motor Integration (VMI); Human Figure Drawing; Vineland II- Parent Caregiver Form; a parent and teacher Behavior Rating Inventory of Executive Function; Child Behavior Checklist (CBCL); a parent and teacher Conner's 3 Short Form; a parent and self-report Child Depression Inventory (CDI-2); Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2); and the Autism Diagnostic Observation Scale, Second Edition (ADOS-2, Module 3). Dr. Lincoln also reviewed prior medical records and interviewed claimant's mother.

12. Dr. Lincoln's report contained a section indicating that on June 4, 2015, claimant was observed by Kris Thomasian, M.A., a supervisor of claimant's Novata CARES

Homes Program. The observation was conducted at claimant's elementary school, where claimant attends a special day program for children with "high functioning autism." The observations were as follows:

> The classroom observation included the language arts and rotation of activities. The six students were divided into three groups of two, and rotated through each of the stations. Initially, claimant and another child participated in a computer reading game moderated by the teacher. Claimant was appropriately engaged in the activity, answered questions, and initiated asking the teacher several questions during this highly structured teacher-guided lesson.
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> The next station was an independent computer activity. Claimant followed the teacher's direction to go to the next station, however, she sat, staring off, unengaged in the activity for nearly 2 minutes. . . . At one point, she asked the teacher, in an appropriate volume . . . "Has it been 10 minutes?", a reference to the required 10 minutes of work necessary for this particular reading activity. . . .
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> [¶] . . . [¶]
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> Lunch was next on the schedule, and claimant followed directions, lined up with the other students and proceeded to the cafeteria, where she purchased her lunch. She . . . independently carried her tray to the table with her classmates

> . . . . After several minutes, several students who had eaten very fast, got up to go to the playground, and claimant started to get up too. The aide asked her to finish her lunch before playing, and claimant continued to slowly eat. While at the lunch table, claimant did not initiate conversation with other students, however, she did respond to questions from several students. She did initiate a brief conversation with her aide, and told her that she had moved and that her new bedroom was purple. The conversation included several appropriate exchanges . . . .

13. Under the portion of Dr. Lincoln's report entitled, "Behavioral Observations and Mental Status Evaluations," there was no information regarding who observed claimant or if Dr. Lincoln was present, but later in the report it indicated that it was Ms. Brown who assessed claimant on two separate occasions. Ms. Brown observed the following:

> Claimant presented and was seen on two occasions and presented appropriately dressed and groomed. She appeared oriented to person, place, and time. She made eye contact with the examiner but would not speak to her in the lobby. She was cooperative in walking with the examiner to the testing room. Much effort was made to interact and make her feel comfortable throughout both testing sessions. Claimant did speak after about 30 minutes into the first session, but would often revert back into minimal or no speech. During the second session, she spoke to the

> examiner within the first 10 minutes of testing, but again, the examiner had to put forth great effort to build rapport. . . .
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> Her mood ranged from euthymic to anxious with congruent affect. For example, while she was often mute she would smile when a joke was made. Claimant was alert and appeared to put forth a fair effort throughout the assessment. During the assessment, claimant appeared to give up on difficult items without trying. She stated "that's too hard" during several items on the block design subtest. During other subtests, she would reply, "I don't know" in a somewhat scripted, staccato manner. She never refused to attempt a task, although she said she was "bored" and wanted to know "how much more" during the assessment. She was extremely fidgety in her seat and needed constant reminders to sit up and bring the chair back to the table. Her constant movements resulted in the chair moving back from the table by approximately a foot. She was observed to bite her nails, chew on her hair, and suck on multiple fingers at a time. These behaviors did not appear to be in combination with any stress or increased concentration. She was observed to make an odd, grimacing face while concentrating, specifically during the block design subtest. Additionally, claimant yawned frequently and indicated that she feels tired most of the time.

Claimant's results on the WASC-II, which tests cognitive functioning, were

average generally with low average results in one area. Claimant's results on the WASI-II and WISC-V, which measure comprehension and perceptual reasoning, placed her in the average range. Claimant's results on the WIAT-III, which measures her level of academic achievement, placed her in the average range in all subtests. Claimant's results on the PPVT-4, which measures receptive hearing and language ability, placed her in the average range. Claimant's test results on the EVT-2, which measures expressive language and word retrieval skills, placed claimant in the average range.

Claimant's results on the VMI and Human Figure Drawing placed her in low range. These tests both require the use of fine motor skills to copy and draw figures with varying degrees of difficulty. Claimant exhibited difficulty copying the required figure and did not follow instructions when told to draw a whole person. Instead, she drew a stick figure.

Claimant's results on the Vineland-II, which is a form that involves reporting by the caregiver, placed her in the low range. Claimant's results on the CBCL, which is also based on reporting from the parent, placed claimant overall within the clinical range across all indexes and scales.

On the ADOS-II, the report concluded that claimant exhibited signs and symptoms of autism in the "moderate range."

14. Dr. Greenwald reviewed Dr. Lincoln's report. He noted that the report does not suggest moderate autism; rather, it suggests, at a maximum, that claimant has mild symptoms. Dr. Greenwald pointed out on the ADOS-II, claimant's social affect score was nine and her restrictive and repetitive behavior score was two, yielding a comparison score of 7 – yet the narrative of the report indicated that claimant's social affect score was 13. Thus, when adjusted for the correct numbers, claimant's overall ADOS-II behavior score should be below 7 – placing her in the low/mild category for autism and not the moderate category.

TESTIMONY OF CLAIMANT'S MOTHER

15. Claimant's mother testified at the hearing. Her love for her daughter was evident. She zealously advocated for her daughter and stated that her goal is to obtain the best treatment possible for her daughter's autism so that claimant can have a "fighting chance."

16. Claimant's mother did not dispute that claimant may have ADHD, anxiety disorders, sensory processing disorders, or selective mutism. However, claimant's mother believed that if claimant suffers from any other disorder that it is comorbid with the autism diagnosis.

17. Claimant's mother presented numerous medical records, school records, Individualized Education Plan Meeting records, IHSS records, and occupational progress reports. All of the records provided pre-dated the comprehensive psychological assessments completed by Dr. Greenwald and Dr. Lincoln. The records from the school all stated that claimant had a diagnosis of autistic-like behavior. Claimant's records from Children's Primary Care Medical Group stated that claimant previously had a diagnosis of autism, sensory processing difficulty, hearing problem, and selective mutism. Other records reflect claimant has been diagnosed with ADHD. Claimant's mother, however, stated that claimant was never diagnosed with those afflictions.

18. Claimant's mother testified that she believes claimant meets the criteria for autism under the DSM-5. According to claimant's mother, claimant does not have daily living skills. For example, she does not dress appropriately for the seasons, does not put her clothes on properly, and has a "meltdown" over brushing her teeth. Claimant receives protective supervision because she tends to run into the street, climbs things, hide, and fails to take appropriate safety precautions.

19. Claimant does not exhibit reciprocal social interaction. She doesn't show an interest in many activities and lacks emotion. Claimant experiences deficits in

understanding how to maintain relationships; she is able to interact and play with a best friend but eventually sits down because the friend will stop talking to her.

20. Claimant does not know how to act in social settings. She will crawl on booths at restaurants and will not sit still.

21. Claimant spins, exhibits echolalia, lines up objects, and speaks in her own language. She is fascinated by certain movies or themes and does not like to speak unless you are speaking about her topic of choice. Claimant is similarly rigid in her eating habits. She always has pancakes for breakfast and peanut butter and jelly sandwiches for lunch.

22. Claimant smells everything and has an intense sensory reaction. She will only wear leggings because of the texture. When claimant's mother cleans things in the house claimant will lick the cleaned surface. For that reason, claimant's mother has switched exclusively to cleaning with vinegar.

23. Claimant's mother submitted a statement at the hearing in support of claimant. Her statements in the document were consistent with the testimony at the hearing.

24. Claimant's mother believed that claimant benefits from the ABA treatment she receives because she noticed that when services were discontinued for a brief period when claimant visited her father, claimant appeared to regress.

LEGAL CONCLUSIONS

1. The Lanterman Act is set forth at Welfare and Institutions Code section 4500 et seq.

2. Welfare and Institutions Code section 4643.5, subdivision (b), provides:

> An individual who is determined by any regional center to have a developmental disability shall remain eligible for services from regional centers unless a regional center, following a comprehensive reassessment, concludes that the original determination that the individual has a developmental disability is clearly erroneous.

3. In a proceeding to determine whether a previous eligibility determination "is clearly erroneous," the burden of proof is on the regional center to establish that the individual is no longer eligible for services. The standard is a preponderance of the evidence. (Evid. Code, § 115.) Thus, IRC has the burden to establish by a preponderance of the evidence that its previous eligibility determination "is clearly erroneous."

4 Welfare and Institutions Code section 4512, subdivision (a), defines developmental disability as a disability that originates before an individual attains 18 years of age; continues, or can be expected to continue, indefinitely; and constitutes a substantial disability for that individual. A developmental disability also includes "disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with an intellectual disability." (*Ibid.*) Handicapping conditions that are "solely physical in nature" do not qualify as developmental disabilities under the Lanterman Act. (*Ibid.*)

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5 California Code of Regulations, title 17, section 54000 provides:

(a) 'Developmental Disability' means a disability that is attributable to mental retardation[1], cerebral palsy, epilepsy, autism, or disabling conditions found to

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[1] Although the Lanterman Act has been amended to eliminate the term "mental retardation" and replace it with "intellectual disability," the California Code of

be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.

(b) The Developmental Disability shall:

(1) Originate before age eighteen;

(2) Be likely to continue indefinitely;

(3) Constitute a substantial disability for the individual as defined in the article.

(c) Developmental Disability shall not include handicapping conditions that are:

(1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.

(2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.

(3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

4 California Code of Regulations, title 17, section 54001 provides:

(a) 'Substantial disability' means:

Regulations has not been amended to reflect the currently used terms.

(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.

(b) The assessment of substantial disability shall be made by a group of Regional Center professionals of differing disciplines and shall include consideration of similar qualification appraisals performed by other interdisciplinary bodies of the Department serving the potential client. The group shall include as a minimum a program coordinator, a physician, and a psychologist.

(c) The Regional Center professional group shall consult the potential client, parents, guardians/conservators, educators, advocates, and other client representatives to the extent that they are willing and available to participate in its deliberations and to the extent that the appropriate consent is obtained.

(d) Any reassessment of substantial disability for purposes of continuing eligibility shall utilize the same criteria under which the individual was originally made eligible.

4. Children who meet the criteria for an autistic-like disorder for purposes of obtaining special education services are evaluated pursuant to California Code of Regulations, title 5, section 3030, subdivision (g). The Lanterman Act is more restrictive than the eligibility criteria for special education, and adheres to the diagnostic features contained in the DSM-5. Thus, a child may qualify for special education services under the eligibility criteria specified in Title 5, but not qualify for regional center services under the Lanterman Act.

EVALUATION

5. The Lanterman Act and the applicable regulations set forth criteria that a claimant must meet in order to be eligible for regional center services. Dr. Greenwald completed a comprehensive assessment of claimant that began in 2014 and ended in 2015. He observed her in a clinical setting as well as a school setting. He noted that she did not display the typical behaviors of someone with autism. Many of her scores on the various assessments placed her well-below the minimal cutoff for autism. Although the Vineland-II scales and ADI-R test yielded scores that placed claimant within the cutoff for autism, it appeared that those scores were achieved due to the inaccurate reporting of claimant's mother, given that the scores on those subjective tests were inconsistent with the scores achieved by claimant on the objective WISC-IV test.

Dr. Greenwald did not dispute Dr. Khoie's 2009 diagnosis of autism. However, Dr. Greenwald's comprehensive assessment established that, after almost seven years of ongoing regional center services and school-based interventions, claimant no longer meets the DSM-5 diagnostic criteria for autism spectrum disorder.

Dr. Lincoln's report, which did not contain a signature page identifying what portions of the psychological assessment he conducted, concluded that claimant had moderate autism. However, Dr. Greenwald pointed out that the numbers on the ADOS-II were erroneous and inconsistent with a diagnosis of moderate autism. At best, claimant

may, based on Dr. Lincoln's ADOS-II assessment, warrant a diagnosis of mild autism. Nonetheless, after a careful review of Dr. Lincoln's report, which contained clinical observations that appeared to have been made by two separate psychological assistants, claimant's behaviors did not exhibit the stereotypical behaviors consistent of a person with autism. Indeed, most of claimant's scores on the various testing measures placed her within the average or clinical range across most subsets.

Claimant's mother's testimony was heartfelt and sincere. She clearly wants the best for her daughter and does not doubt that the ABA treatment claimant has been receiving has helped claimant. However, the noted behaviors of claimant as reported by claimant's mother were not observed or detailed in the psychological assessments. It is as if claimant acts markedly different at home than she does in a school setting. While claimant's mother reported repetitive behaviors, none of the psychological assessments indicated persistent repetitive behaviors, which is a main diagnostic feature of autism. While claimant's mother reported claimant's problems with social interaction and communication, claimant was observed by Dr. Greenwald and Dr. Lincoln's psychological assistant to interact in a generally appropriate fashion with other students and engage the teacher appropriately. Although claimant expressed frustration or difficulty when moving to a project she did not prefer, in general, claimant's behavior was not consistent with a person who has autism.

Claimant's behaviors are consistent with ADHD, anxiety disorders, sensory disorders, and selective mutism under the DSM-5. Although it is true that these disorders can be comorbid with autism, they can also stand alone. Based on the overall record, claimant may suffer from mild autism. However, it is equally as plausible that she may suffer from the other noted disorders. None of the medical or school evaluations reflected that claimant has the main diagnostic features of autism.

Moreover, even if claimant does suffer from autism, the evidence did not support

a finding that claimant has a substantial disability as a result of autism, which is required to be found eligible for regional center services under the Lanterman Act

Accordingly, a preponderance of the evidence established that claimant's prior eligibility determination under a diagnosis of autism is clearly erroneous in light of the record as a whole. As a result, claimant is no longer eligible for regional center services under the Lanterman Act.

ORDER

Claimant's appeal from the Inland Regional Center's determination that she is no longer eligible for regional center services is denied.

DATED: March 4, 2016

_____/s/_____

KIMBERLY J. BELVEDERE

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 ninety days.