BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT vs. SAN GABRIEL POMONA REGIONAL CENTER, Service Agency.	OAH No. 2016120804

DECISION

Ji-Lan Zang, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on March 10, and July 20, 2017, in Pomona, California.

Hortencia Tafoya, Fair Hearings Representative, and Daniela Santana, Fair Hearings Program Manager, represented San Gabriel/Pomona Regional Center (SGPRC or Service Agency).

Matthew M. Pope, Attorney at Law, represented claimant, who was present.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on July 20, 2017.

ISSUE

Whether claimant may change the basis for his eligibility under the Lanterman Developmental Disabilities Services Act (Lanterman Act) from a disabling condition closely related to intellectual disability or requiring treatment similar to that required for individuals with intellectual disability (commonly known as "the Fifth Category") to autism.

EVIDENCE RELIED UPON

Documents: Service Agency's exhibits 1-19; claimant's exhibits A and B.

Testimony: Hortencia Tafoya; Jose Aguirre; claimant; claimant's mother; Deborah Langenbacher, Ph.D.; Paul Mancillas, Ph.D.

FACTUAL FINDINGS

PARTIES AND JURISDICTION

1. Claimant is a 25 year-old male who lives at home with his parents and younger sibling. On March 17, 2016, Service Agency's interdisciplinary team determined that he met the eligibility criteria set forth in the Lanterman Act based on a condition under the Fifth Category. Claimant requested the Service Agency to change his eligibility category and deem him eligible based on a claim of autism.

2. By a Notice of Proposed Action (NOPA) and letter dated May 27, 2016, the Service Agency notified claimant that it denied his request. On December 19, 2016, claimant filed a fair hearing request to appeal the Service Agency's determination regarding his eligibility category. This hearing ensued.

CLAIMANT'S SCHOOL EVALUATIONS

3. A. In 2006, when claimant was 14 years old, his school psychologist conducted a triennial evaluation to determine his continued eligibility for special education services and his current levels of performance. Over the course of several days, the school psychologist reviewed claimant's medical and school records and administered a battery of tests, which focused on claimant's cognitive ability, verbal and visual processing, working memory, and academic achievement. She set forth her findings in a psycho-educational assessment report, dated January 26, 2006.

B. Claimant was initially referred for special education services in 1997. Since that

time, he underwent several previous psycho-educational assessments. In her review of claimant's previous test scores, the school psychologist found that claimant's results indicated "notable discrepancies between verbal and nonverbal/visual processing abilities." (Ex. 15, 2006 Psycho-Educational Assessment, p. 3.)

C. The school psychologist indicated that during the testing sessions, claimant was polite and mannerly. He often initiated conversation with the examiner on topics of personal interest. Claimant was also able to sustain focus of attention and persistence of effort without much evidence of frustration, fatigue, or resistance, although he worked at a slow pace.

D. On the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV), claimant's full scale intelligence quotient (IQ) was 73, indicating that he was functioning within the borderline range of intelligence. However, his score of 111 on the verbal processing subtest revealed average abilities, while his score of 63 on the visual processing subtest indicated significant deficits in visual-spatial awareness and perceptual reasoning. Similarly, claimant's performance on the working memory index of the WISC-IV revealed mild deficits in his ability to hold verbal material to process the information and plan a response, but he presented with severe deficits in visual working memory. The school psychologist concluded that these "diagnostic findings are highly indicative of a Nonverbal Learning Disability marked by deficits in visual-spatial awareness and visuoconstruction.[1]" (*Id.* at pp. 5-6.)

E. Based on the Woodcock-Johnson Tests of Achievement, Third Edition, claimant performed within the average range for his age in reading and within the low average range in math. His written expression skills were in the below average range.

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[1] Visuoconstruction is the ability to organize and manually manipulate spatial information to make a design.

F. With respect to adaptive and social emotional observations, the school psychologist noted, "[s]ocially, [claimant] is very respectful toward adults and he complies with classroom rules. He interacts appropriate [*sic*] among peers but he often makes comments that are not related to topic which may suggest misperception of social cues as consistent with a Nonverbal Learning Disability." (*Id.* at p. 9.)

G. The school psychologist did document any repetitive, stereotyped behavior exhibited by claimant, and she did not administer any tests to assess for the presence of autism.

H. Based on the information from her review of the documents as well as the testing data, the school psychologist found that claimant met the formal eligibility criteria for special education based on a Specific Learning Disability. In her opinion, claimant presented with a "Nonverbal Learning Disability marked by deficits in visual-spatial awareness, visuoconstruction, graphomotor planning, working memory, speed of symbolic processing, and fine motor control." (*Id.,* at p. 9.)

I. Following the school psychologist's evaluation, claimant's school district developed an Individualized Education Plan (IEP), dated January 31, 2006. The IEP identified "nonverbal learning disability" as the basis of claimant's eligibility for special education services. (Ex. 17, 2007 IEP, at p. 2A.)

4. A. In 2008, when claimant was 17 years old, another triennial evaluation was conducted to determine his continued eligibility for special education services and his current levels of performance. The school psychologist again reviewed claimant's medical and school records and administered a battery of tests, focusing on claimant's cognitive ability, verbal and visual processing, working memory, and academic achievement. She set forth her findings in a psycho-educational assessment report, dated November 7, 2008.

B. After reviewing claimant's scores from previous testing, the school psychologist again noted the significant discrepancies between claimant's verbal and nonverbal/visual

processing abilities. (Ex. 15, 2008 Psycho-Educational Assessment, p. 3.) She also found that a formal assessment of claimant's academic achievement over the last three years showed "evidence of a deficit skill acquisition in the area of written language." (*Id.*, at p. 5.)

C. The school psychologist indicated that during the testing sessions, claimant was very polite. He initiated conversation with the examiner and made jokes appropriate to the situation. He was also able to sustain focus of attention and work effort without evidence of frustration, fatigue, or resistance. Claimant expressed his ideas with clarity of thought, although his speech was sometimes difficult to understand.

D. To assess claimant's cognitive abilities, the school psychologist administered the Wechsler Intelligence Scale for Adults, Third Edition (WAIS-III). Claimant's full scale IQ was 77, indicating that he was functioning within the borderline range of intelligence. Consistent with the previous findings in 2006, claimant had a significantly higher verbal IQ of 92 than his performance IQ of 62. The school psychologist wrote, "analysis of the Perceptual Organization Index of the WAIS-Ill indicates deficits in visual-spatial reasoning and visuoconstruction." (*Id.* at p. 8.) Similarly, claimant's performance on the working memory index of the WAIS-III revealed mild deficits in his ability to retain, store, and retrieve perceptual information.

E. Based on the Woodcock-Johnson Tests of Achievement, Third Edition, claimant performed within the average range for his age on reading, and within the low average range for his age on math. Although he showed some improvement in written expression skills, claimant continued to function at the below average range in this area.

F. With respect to claimant's classroom functioning, the school psychologist wrote, "[b]ehaviorally, he is very respectful toward teachers, he complies with classroom rules, and he interacts appropriately among peers." (*Id.* at p. 11.)

G. The school psychologist did document any repetitive, stereotyped behavior exhibited by claimant, and she did not administer any tests to assess for the presence of

autism.

H. Based on the information from her review of the documents as well as the testing data, the school psychologist found that claimant again met the formal eligibility criteria for special education based on a "Nonverbal Learning Disability characterized by deficits in visual-spatial reasoning, visuoconstruction, graphomotor planning, working memory for recall of visual information, and speed of visual processing." (*Ibid.*)

I. Claimant's January 13, 2009 IEP identified "specific learning disability" as the basis of claimant's eligibility for special education services. (Ex. 17, 2009 IEP, at p. 13.)

5. On January 7, 2009, when claimant was 17 years old and in the twelfth grade, the school speech/language pathologist performed an assessment to determine his continued need for speech and language services. Regarding claimant's pragmatic language skills, the school speech/language pathologist wrote the following:

> **Pragmatics**
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> *Effective and appropriate communication of ideas and thoughts in social situations, including nonlinguistic behaviors (i.e. eye gaze, posture, facial expression and physical proximity) and linguistic skills, i.e., topic initiation and topic maintenance.*
>
> [Claimant] interacts successfully with adults and peers. Growth has been noted in this area and he has been observed to use appropriate verbal and nonverbal skills effectively with peers. No problem is noted in this area of language.
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> (Ex. 16, p. 3.) (Bold and italics in the original.)

6. Claimant graduated from high school in 2009. He subsequently enrolled in a local community college, where he took music and physical education classes. Although claimant is no longer enrolled in community college, he is currently employed part-time at Best Buy's, where he performs duties such as stocking and cleaning.

SERVICE AGENCY'S SOCIAL ASSESSMENT OF CLAIMANT

7. A. On November 9, 2015, claimant made a request for a determination of eligibility for regional center services. On December 7, 2015, the Service Agency's Intake Service Coordinator, Virginia Rodriguez-Wintz (Rodriguez-Wintz), conducted a social assessment of claimant. Portions of her report that are relevant to the issues at hand are summarized as follows:

B. Claimant was being referred to the Service Agency based on concerns that claimant is non-social, has poor eye contact, laughs inappropriately, has difficulty concentrating, and has low comprehension skills.

C. In the domain of mobility, claimant is able to walk, run, and jump. However, he has an awkward gait and often bumps into things. Claimant's right leg is reportedly longer than the left one, and he lacks strength in his hands and fingers due to a muscle disorder.

D. In the social domain, Rodriguez-Wintz found that "[claimant] initiates social contacts with familiar people. . . . He does not engage in disruptive or aggressive behavior. He is social and enjoys socializing with others but reportedly has to be comfortable with the individual. He readily engaged in conversation with this SC [Service Coordinator] and answered appropriately." (Ex. 12, at p. 5.)

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E. Regarding claimant's emotional functioning, Rodriguez-Wintz wrote:

> [Claimant] is not physically or verbally aggressive. He does not engage in self injurious behavior or intentional

destruction of property. He does not run or wander away. [Claimant] does not engage in emotional out bursts that require any intervention. [Claimant] often argues and yells loud [sic] at his parents when they ask him to do anything around the house or ask him to take care of his personal hygiene. [Claimant] argues and states he is an adult and they don't have to tell him to do anything. [Claimant] answered this SC's questions with no difficulties and provided appropriate detail. He gave good eye contact, smiled and responded to this SC. [Claimant] is bothered by loud noises such as fireworks, ambulances or loud action movies in theatres but states he can watch loud young children's movies without being bothered. [Claimant] prefers to follow structure or routines but is able to adjust if there is change. He is able to make transitions more readily than other times but it depends on the task that he is going to transition to. During the social assessment, [Claimant] engaged in back and forth conversation and laughed at appropriate times. Parent states [Claimant] tends to gravitate toward certain people such as maintenance or at custodians at school and he often developed a friendly relationship with them. [Claimant] does not rock his body nor does he engage in any repetitive body movements. However, he cracks his knuckles and moves his head around. According to parent, [claimant] often clears his throat.

(*Ibid.*)

F. In the area of communication, claimant spoke in complete sentences. Although he sometimes did not enunciate words clearly, his speech was readily understandable. Claimant was also able to carry on a basic back-and-forth conversation with Rodriguez-Wintz.

THE NEUROPSYCHOLOGICAL ASSESSMENT BY PAUL MANCILLAS, PH.D.

8. A. On August 23, 27, and September 1, 2015, when claimant was 24 years old, Paul Mancillas, Ph.D., conducted a neuropsychological assessment of claimant based on a referral from his health care provider. Dr. Mancillas reviewed claimant's prior records, interviewed claimant's parents, observed claimant at his home and at his work, and administered a battery of 24 tests to complete this evaluation. Dr. Mancillas detailed his findings in a neuropsychological assessment report dated September 10, 2015.

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B. Regarding claimant's behavior during the testing sessions, Dr. Mancillas observed the following:

> Upon initial contact, [claimant] appeared to be somewhat guarded and had a very nervous smile and demeanor. Some of the observations indicate that he was hard to understand because of his speech. He would grunt at times to say, "I don't know." He would often stare and would often observe what was going on around him. He seemed to be distracted easily when people walked by. He seemed to be very immature and socially awkward. Although at times he was friendly, he asked many questions about different testing

and procedures. He sometimes would randomly laugh at something, such as reading fluency.

(Ex. 11, p. 4.)

C. Dr. Mancillas administered the Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), to assess claimant's general intellectual functioning. Claimant's full scale IQ was 80, which ranked him in the borderline range. On the verbal comprehension index, he scored 83, which placed him below the average range, while his perceptual reasoning index score of 56 placed claimant in the impaired range. His working memory index yielded a score of 83, which was below average, and his processing speed index score of 84 was also considered as below average. The significant discrepancy between claimant's visual perceptual reasoning skills and his verbal comprehensions skills, according to Dr. Mancillas, "strongly indicate[s] a Non-Verbal Learning Disability." (*Id.* at p. 5 & 10.)

D. On the Woodcock-Johnson Tests of Achievement, Third Edition, claimant's overall academic skills measured in the average range. His basic reading skills were in the average to low average range, and his basic math skills were in the borderline range.

E. Dr. Mancillas evaluated claimant's adaptive skills by means of the Adaptive Behavior Assessment System-Ill. Claimant's overall general adaptive composite score of 51 measured at an impaired level. Although Dr. Mancillas did not report any other specific scores, he indicated that claimant also performed at the impaired level on the conceptual, social, and practical composite indices.

F. Dr. Mancillas assessed claimant's executive functioning by administrating the Color Word Interference Test and Barkely's Deficits in Executive Function Scale. Based on these test results, he concluded that claimant exhibited executive functioning deficits as he had difficulties with maintaining cognitive flexibility and engaging in abstract problem solving and reasoning.

G. Based on additional tests, Dr. Mancillas found strong evidence of auditory attention deficits and impairment in claimant, as well as visual inattentiveness and difficulty with visual mental concentration. He also found significant impairment in claimant's visual and auditory memory and language skills.

H. To evaluate for the presence of autism, Dr. Mancillas administered the Childhood Autism Ratings Scale-II (CARS-2) to claimant's mother. Her responses indicated that claimant exhibited severe symptoms of autism spectrum disorder due to poor social emotional understanding and difficulty with emotional expression and regulations of emotions. Claimant's mother also completed the Gilliam Autism Scale, the results of which indicated that claimant had poor social communication, abnormal emotional responses, and exhibited restricted and repetitive behaviors, along with poor social interaction. Additionally, claimant's responses on the Social Responsiveness Scale-II (SRS-2) indicated that he had moderate deficiencies in reciprocal social behavior. Claimant's mother's responses on the SRS-2 indicated that claimant showed unusual sensory interests, that he thought or talked about the same subject repeatedly, and that he engaged in repetitive and odd behaviors. Dr. Mancillas also administered the Autism Diagnostic Observation Scale, Second Edition (ADOS-2) to further assess for the presence of autism. Of the results of the ADOS-2, Dr. Mancillas did not report any scores but wrote:

> The Autism Diagnostic Observation Scale allowed for observations, as well as interview questions about work or school. These results of observations and conversation would generally support a diagnosis of an Autism Spectrum Disorder. [Claimant] states that he has trouble going to sleep and that he has trouble understanding the rules that are set in his household. He does not admit to feeling

> lonely, even when others are not around him. The overall score does indicate an Autism Spectrum Disorder.
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> (Ex. 11, p. 12.)

I. Based on his observations, the test data, and claimant's history, Dr. Mancillas diagnosed claimant with autism spectrum disorder, with a severity level of "requiring very substantial support" with accompanying intellectual impairment. (*Id.* at p. 13.) However, his report did not contain a discussion of the diagnostic criteria under which he reached his diagnosis. Dr. Mancillas also diagnosed claimant with attention deficit hyperactivity disorder (ADHD), combined presentation, and developmental coordination disorder, with evidence of poor fine motor coordination development and poor finger speed.[2] Dr. Mancillas also did not specify in his report which version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) he referenced in order to arrive at these conclusions. Nevertheless, it should be noted that he used a multi-axial classification system,[3] and placed all three diagnoses on Axis I.

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[2] Dr. Mancillas diagnosed claimant with developmental coordination disorder based on his performance on two tests of fine motor functioning. However, because claimant's fine motor functioning is not in contention in this case, a discussion of this issue is omitted.

[3] The DSM has undergone several revisions. The most recent edition, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) was released in May 2013. Prior versions of the DSM used a system that included five "axes" or dimensions for diagnostic and treatment purposes. Clinical syndromes and disorders were classified under Axis I. This multi-axial system was replaced with a simplified, non-axial documentation approach in the DSM-5.

THE PSYCHOLOGICAL EVALUATION BY JENNIE M. MATHESS, PSY.D.

9. A. On January 21 and February 18, 2016, when claimant was 24 years old, Jennie Mathess, Psy.D., conducted a psychological evaluation of claimant to determine claimant's eligibility for SPGRC's services. Dr. Mathess reviewed claimant's prior evaluations, interviewed claimant's mother and family friend, and administered four tests to complete the evaluation.

B. Dr. Mathess made the following behavioral observations of claimant during his testing sessions:

> [Claimant] was assessed over 2 sessions at San Gabriel/Pomona Regional Center. He arrive [sic] to both sessions dressed in a suit, but his hair appeared a bit unkempt. He presented with a typical gait and appropriate eye contact. He was cooperative throughout both sessions and demonstrated fair attention and concentration. He was particularly talkative at times and had to be redirected back to task on occasion. [Claimant] spoke loudly, using simple sentences to communicate. His speech was not always clear, but within context he was generally intelligible. He was easily engaged and was able to converse with the examiner. [Claimant] also displayed a sense of humor at both sessions and on one occasion made an appropriate joke about one of the presented activities. On another occasion [claimant] was able to laugh at himself and find humor in the fact that he wants some things perfectly organized, while he will happily throw other belongs [sic] into a pile in his closet. His overall demeanor did appear somewhat younger than his stated

> age. No echolalia or stereotyped and repetitive behaviors were observed at any time. Overall, results of the evaluation are considered a valid estimate of his current functioning.
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> (Ex. 8, p. 3.)

C. Dr. Mathess administered the WAIS-IV to measure claimant's cognitive functioning across verbal and nonverbal domains, including working memory and processing speed. Consistent with previous testing, claimant's verbal comprehension index score of 87 was significantly higher than his perceptual reasoning index score of 60. On the working memory index he ranked in the low average range with a score of 86, while his performance on the processing speed index was borderline with a score of 79.

D. With claimant's mother and family friend serving as informants, Dr. Mathess administered Vineland Adaptive Behavior Scales, Second Edition, to evaluate claimant's adaptive functioning. Claimant scored in the significantly low level in communication, low level in self-care and independent-living skills, and low level in socialization.

E. Using claimant's mother as the informant, Dr. Mathess completed the Autism Diagnostic Interview-Revised (ADI-R). In the areas of reciprocal social interaction, restricted, repetitive and stereotyped patterns of behavior, and abnormality of development prior to 36 months, claimant's mother's responses resulted in scores at or above the necessary cutoff scores for a diagnosis of autism spectrum disorder. Claimant's mother's responses in the area of communication, however, resulted in a score below the necessary cutoff score. Given these response patterns, Dr. Mathess concluded that a diagnosis of autism spectrum disorder is not likely.

F. Dr. Mathess administered the ADOS-2 for a further assessment of autism spectrum disorder. Claimant's overall total score on the ADOS-2 was in the non-spectrum range, below the cutoff scores for an autism spectrum disorder classification. Dr. Mathess

wrote:

> His eye contact was appropriate and [claimant] directed a range of appropriate facial expressions toward the examiner. He also communicated some understanding and labeling of emotions in other people and characters. During the ADOS-2 administration, [claimant] provided at least one clear indication of being responsible for his actions, but this was not consistent across contexts. His social overtures were generally related to his own interests, but with some attempt to involve the examiner in those interests. [Claimant's] social responses were awkward at times, but at other times they were appropriate to the immediate social situation. Additionally, he was able to engage in appropriate reciprocal social communication, using both verbal and nonverbal means. Conversation flowed and he was able to build on the examiner's dialogue. He spontaneously used several descriptive gestures and also used some emphatic or emotional gestures, though these were a bit limited. At no time did he use stereotyped or idiosyncratic speech or display any stereotyped behaviors and restricted interests.
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> (Id. at p. 4.)

G. Dr. Mathess used the DSM-5 to reach her diagnosis. Under the DSM-5, section 299.00, to diagnose autism spectrum disorder, it must be determined that an individual has persistent deficits in social communication and social interaction (Criterion A) across multiple contexts, as manifested by the following, currently or by history: (1) deficits in

social-emotional reciprocity, (2) deficits in nonverbal communication behaviors used for social interaction, and (3) deficits in developing, maintaining, and understanding relationships. The individual must also have restricted, repetitive patterns of behavior, interests, or activities (Criterion B), as manifested by at least two of the following, currently or by history: (1) stereotyped or repetitive motor movement, use of objects or speech, (2) insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior, (3) highly restricted, fixated interests that are abnormal in intensity or focus, and/or (4) hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment. In addition, symptoms must be present in the early developmental period and must cause clinically significant impairment in social, occupational, or other important areas of current functioning (Criteria C and D). Finally, these symptoms cannot be better explained by intellectual disability or global developmental delay (Criterion E).

H. Based upon claimant's mother and family friend's report, the test data and her own observations, Dr. Mathess opined that a diagnosis of autism spectrum disorder was not indicated. However, she diagnosed claimant with other specified neurodevelopmental disorder (significant visual/perceptual deficits); speech sound disorder (mild); and ADHD, combined presentation (by history).

SERVICE AGENCY'S DETERMINATION OF CLAIMANT'S ELIGIBILITY UNDER THE FIFTH CATEGORY

10. On March 4, 2016, Service Agency's interdisciplinary team held an initial meeting with claimant, claimant's mother, and family friend to review Dr. Mathess's psychological report.

11. On March 17, 2016, claimant's case was referred to the Service Agency's Fifth Category Consultation Committee. Later the same day at a follow-up meeting, the Service Agency's interdisciplinary team, based on the recommendations of the Fifth Category

Consultation Committee, determined that claimant met the eligibility criteria set forth in the Lanterman Act under the Fifth Category. The interdisciplinary team also determined that claimant had substantially handicapping deficits in the areas of communication skills, learning, self-care, and self-direction. (Ex. 17, p. 3.)

12. On April 5, 2016, during an in-person meeting among Service Agency's representatives, claimant, claimant's mother, and family friend, claimant's mother expressed her disagreement with the Service Agency's determination that claimant was eligible for regional center services under the Fifth Category. She believed that claimant should have been found eligible based on a diagnosis of autism.

13. On April 4, 2016, Dr. Mancillas wrote a letter challenging the validity of Dr. Mathess's findings. He contended that his neurophysiological assessment was more comprehensive than the evaluation performed by Dr. Mathess and that the conclusions he reached provide a more accurate diagnosis of claimant's condition. Specifically, Dr. Mancillas stated:

> In my opinion, this test report [Dr. Mathess's psychological evaluation] is very limited and the examiner decided to take an abbreviated approach to this assessment, with an over-reliance on a single instrument (i.e. ADOS-2) to yield a diagnostic conclusion that [claimant] does not have Autism. Dr. Mathess concludes other diagnoses, yet she did not do any testing in the specific areas that would allow for a diagnosis of ADHD, Speech Disorder, & other Specified Neurodevelopmental Disorder. She contradicts herself by indicating that the mother's responses to the ADI-R, "resulted in scores above the necessary cutoff scores in the areas of Reciprocal Social Interaction, Restricted Repetitive

> and Stereotyped Patterns of Behavior, and Abnormality of Development prior to 36 months." She dismisses these findings to focus on the area of Communication which she states is below the cutoff scores and thus suggests there is no evidence of Autism. . . . The reliance on a single instrument and her own subjective opinion about the nature of [claimant's] communication, raises questions about the validity of Dr. Mathess' psychological assessment.
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> (Ex. B.)

TESTIMONY OF JOSE AGUIRRE, CLAIMANT, AND CLAIMANT'S MOTHER

14. Jose Aguirre (Aguirre), claimant's family friend testified at the hearing on his behalf. Aguirre was claimant's teacher at his high school. After claimant had graduated from high school, Aguirre helped him to enroll in classes at his local community college. Aguirre testified that claimant makes attempts to socialize, but he is socially awkward and often speaks in a loud voice. He encouraged claimant's mother to take her son to Dr. Mancillas to test for the presence of autism. He was also present when Dr. Mathess performed her evaluation of claimant.

15. At the hearing, claimant testified that his typical day consists of waking up at late in the morning and watching videos or playing video games in his room until the night time. Sometimes he does not hear his mother calling him for meals because he is too focused on playing video games, but he generally stops playing at his mother's request. However, he does sometimes become angry when his mother interrupts his video games. Claimant also gets upset when his mother gives him a chore, although he usually does the chore eventually. He prefers to communicate with his mother through a teddy bear. When communicating with other people, claimant stated that they usually have a hard

time understanding his speech, and he sometimes must reword a sentence five or more times before being understood. Claimant has only one friend with whom he goes to a restaurant approximately three times a year. Claimant reported that loud noises bother and startle him, and that he cracks his knuckles approximately three times an hour. Claimant saw Dr. Mancillas for five to six times, with each session lasting approximately three to three and one half hours, in order to complete the neuro-psychological assessment. He saw Dr. Mathess for two 30- to 45- minute sessions in order to complete her evaluation.

16. Claimant's mother testified at the hearing regarding her observations and concerns of claimant's behavior. She stated that her son's school district failed to test him for autism spectrum disorder and diagnosed him instead with ADHD and a learning disability. According claimant's mother, her son spends all day in his room playing video games. He only comes out of his room for dinner, and he may stay up until 1 a.m. or 2 a.m. playing video games. Claimant's mother clarified that claimant only uses his teddy bear to communicate with her and his sister and not with strangers. She noted that her son reacts to loud noises, gets scared easily, and does not like changes. He also gets upset when asked to stop playing video games or do chores. She reports that he "gets into the face" of his family members and argues with them. Claimant's mother testified that she has tried to qualify her son for Supplemental Security Income (SSI), but he was denied. She believes that a diagnosis of autism from the Service Agency will help him qualify for SSI.

EXPERT WITNESS TESTIMONIES

17. A. Deborah Langenbacher, Ph.D., Service Agency's staff clinical psychologist testified at the hearing. Her testimony is summarized as follows:

B. When claimant's case was initially referred to the Service Agency's interdisciplinary eligibility team, Dr. Langenbacher reviewed all relevant documents,

including the reports of the school psychologist, Dr. Mancillas, and Dr. Mathess. In her review of the school psycho-educational assessment reports, Dr. Langenbacher noted that claimant's performance on tests of cognitive abilities revealed a significant discrepancy between his verbal and nonverbal abilities. For example, in 2000, claimant's verbal IQ on the WISC-III is 111, whereas his performance IQ was 65. Similarly, in 2008, claimant's verbal IQ on the WAIS-III was 92, whereas his performance IQ was 62. In Dr. Langenbacher's opinion, this discrepancy was indicative of a nonverbal learning disability.

C. Furthermore, in her review of claimant's IEP's, Dr. Langenbacher was struck by the fact that claimant was never found eligible based on a diagnosis of "autism" or "autistic-like behavior." She opined that, if claimant had exhibited symptoms of autism spectrum disorder, he would have been found eligible for special education services under that classification, given that eligibility based on autism in special education is more inclusive than eligibility for regional center services.

D. Regarding Dr. Mancillas's neuropsychological assessment, Dr. Langenbacher found that it "made a good case for [the diagnosis of] ADHD," because clinical observations and test data revealed both auditory and visual inattentiveness in claimant. Moreover, she believed that Dr. Mancillas's report provides further support for the diagnosis of a nonverbal learning disorder. For example, when claimant was asked to copy a complex figure, he performed at an impaired level on this task, which is indicative of a deficit in perceptual skills. (Ex. 11, p. 9.)

E. However, Dr. Langenbacher did not agree with Dr. Mancillas's diagnosis of autism spectrum disorder. She emphasized that, under the DSM-5, an individual can be diagnosed with autism spectrum disorder only if all three deficits under Criterion A (social communication and social interaction) and two of four behavior patterns under Criterion B (restricted, repetitive behavior, interests, or activities) must be present. In her opinion, Dr. Mancillas's findings did not demonstrate that claimant suffered the deficits described

under Criterion A or exhibited the behaviors described under Criterion B.

F. Additionally, Dr. Langenbacher opined that the ADOS-2 is the "gold standard" in diagnostic tests to assess for the presence of autism. The protocol consists of a series of tasks and activities, such as telling a story from a simple picture, that illicit traits of autism. The examiner observes and identifies the individual's behavior and produces a quantitative score. Observation and scoring of the ADOS-2 requires extensive training, and in fact, the examiner must be certified in order to administer the test. Dr. Langenbacher expressed surprise at the very short paragraph Dr. Mancillas wrote regarding the results of the ADOS-2 "generally support[ing]" the diagnosis of autism spectrum disorder. (See Factual Finding 8H.) In a report in which the diagnosis of autism spectrum disorder was made, she had expected a more thorough discussion of test results.

G. Dr. Langenbacher disagreed with Dr. Mancillas's criticism that Dr. Mathess had over-relied on the ADOS-2. Dr. Langenbacher pointed out that in addition to the ADOS-2, Dr. Mathess had also administered the ADR-I, which is another diagnostic tool to assess for autism spectrum disorder. However, claimant's test results from neither the ADR-I nor the ADOS-2 supported a diagnosis of autism spectrum disorder. Moreover, Dr. Mathess's observations of claimant's behavior during the test sessions, specifically that he made jokes, engaged in verbal and nonverbal social communication, and took responsibility for his own actions, also did not support a diagnosis of autism spectrum disorder.

H. Dr. Langenbacher made a distinction between the purpose of a neuropsychological evaluation, such as the one performed by Dr. Mancillas, and a psychological evaluation, such as the one performed by Dr. Mathess. While a neuropsychological evaluation maybe broader in scope and assesses for an individual's memory, attention, and cognition, the purpose of a regional center's psychological evaluation is narrower in scope and focuses on the individual's eligibility for regional center services.

I. Although Dr. Langenbacher did not personally perform an evaluation of claimant, she had the opportunity to meet claimant in person during the March 4, 2016 meeting described above in Factual Finding 10. Dr. Langenbacher observed that, at that meeting, claimant appeared younger than his age, but he had appropriate eye contact, participated in conversations, and made appropriate gestures.

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18. A. Paul Mancillas, Ph.D., testified at the hearing on behalf of claimant. His testimony is summarized as follows:

B. Referring to his neuropsychological evaluation report, Dr. Mancillas found indicators of autism spectrum disorder in claimant's performance on tests of adaptive behavior because he performed at the impaired levels in the areas of communication and social functioning. (Ex. 11, p. 5.) Additionally, claimant performed poorly on executive functioning, which involves problem solving, cognitive flexibility, and emotional regulation. (*Id.* at p. 6-7.) Dr. Mancillas testified that problems with executive functioning bear a strong relationship to autism spectrum disorder. Claimant was also diagnosed with ADHD, which according to Dr. Mancillas, is correlated with autism spectrum disorder in almost 90 percent of the cases.

C. Dr. Mancillas opined that claimant's condition fell within the diagnostic criteria for autism spectrum disorder. Dr. Mancialls testified that, under Criterion A, claimant exhibited deficits in (1) social-emotional reciprocity because he "can't put himself in the other person's shoes"; (2) nonverbal communications because he was diagnosed with a nonverbal learning disorder; and (3) developing, maintaining, and understanding relationships because his only relationship is with his caregiver. Under Criterion B, Dr. Mancillas contended that claimant exhibited (1) stereotyped or repetitive behavior because he cracks his knuckles; (2) inflexible adherence to routine because he constantly plays video games and has difficulty shifting away from this activity; and (3) highly restricted,

fixated interest because he plays video games; and (4) hyper- or hypo-reactivity because he demonstrated "the inability to engage in multi-sensory tasks on some tests." Under Criteria C and D, Dr. Mancillas asserted that claimant's symptoms manifested during the early development period, and that the symptoms have caused claimant impairment at his job and at home.

D. Regarding the lack of the discussion of the results of the ADOS-2 in his report, Dr. Mancillas characterized the ADOS-2 as a "very political instrument" that is "subjective because you have to use numbers." He believes that regional centers rely on this test excessively to cut off eligibility to consumers who have autism spectrum disorder. He further claimed that the ADOS-2 is a "publisher's ploy to sell a box of toys for $2000." According to Dr. Mancillas, although the ADOS-2 may be valuable for the novice, it has limited value for a professional such as himself who has been working with autism spectrum disorder for 33 years.

E. During further questioning, when asked about which version of the DSM he used for his diagnosis in the neuropsychological evaluation report, Dr. Mancillas initially stated that he used the DSM-5. When asked why he used the multi-axial classification system if he was using the DSM-5, he changed his answer to DSM-IV Text Revision (DSM-IV, TR).[4] When asked when about the release date of the DSM-5, Dr. Mancillas initially stated that the DSM-5 was released in 2015, but changed his answer to 2013 when he referred to his copy of the DSM-5. At that point, he claimed that he used the DSM-5 for his diagnosis but used the multi-axial classification system for "insurance purposes."

F. After being offered multiple opportunities to describe additional behaviors that he observed in claimant which may fall under Criterion B (restricted, repetitive patterns of

[4] The DSM-IV TR was prior version of the DSM before the release of DSM-5 in May 2013.

behavior, interests, or activities), Dr. Mancillas continued to cite to claimant's knuckle cracking and playing of video games as examples. When asked to describe in plain English what unusual sensory reactions he had observed in claimant, Dr. Mancillas maintained that claimant was unable to perform multi-sensory tasks on some tests without describing any specific behaviors. When asked about the "requiring very substantial support" severity level of autism spectrum disorder he had assigned to claimant and whether he found claimant to be "a person with few words of intelligible speech who rarely initiates interaction,"[5] Dr. Mancillas claimed that claimant is able to "mask" his symptoms in the presence of his mother. He speculated that claimant's mother acts as her son's "frontal lobe" and provides him with "very substantial support." Dr. Mancillas also contended that claimant's ability to joke and smile in response to social interactions is also a learned strategy designed to mask his symptoms.

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[5] The DSM-5 defines the "requiring very substantial support" severity level of autism spectrum disorder as follows:

> Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches.
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> (DSM-5, p. 52.)

CREDIBILITY FINDINGS REGARDING EXPERT OPINIONS

19. A. The neuropsychological evaluation report and the testimony of Dr. Mancilla's were problematic in several respects. The neuropsychological report contained few clinical observations regarding claimant's social communication and social interaction skills. Additionally, no clinical observations were documented of any repetitive or stereotyped behavior exhibited by claimant. In his analysis regarding the assessments for presence of autism spectrum disorder, Dr. Mancillas detailed the results of the CARS-2 and the SRS-2, which seems to rely on the reporting of claimant's mother. However, he does not discuss in detail the results of the ADOS-2, including any scores that he obtained. Instead, he wrote a single sentence stating that the results "generally support" the diagnosis of autism spectrum disorder. Another issue with the neuropsychological report is that it does not specify which version of the DSM was used to arrive at the diagnosis of autism spectrum disorder. This omission is troubling, given that the report was written approximately two years after the publication of DSM-5 but used an outdated multi-axial classification system. Even assuming that Dr. Mancillas used the DSM-5 to reach his diagnosis, his report does not include a discussion of how claimant's behavior and history fulfills the diagnostic criteria for autism spectrum disorder.

B. Dr. Mancillas's testimony, instead of clarifying these problems in his neuropsychological evaluation report, raises even more credibility issues. Dr. Mancillas's responses during both the direct examination and cross examination were often evasive, circuitous, and oblique. Particularly concerning are Dr. Mancillas's vacillation regarding which version of the DSM he used, his lack of knowledge regarding the release date of the DSM-5, and his equivocation when asked to provide specific examples of any unusual sensory reactions in claimant.

C. Although Dr. Mancillas cited claimant's cracking of his knuckles and constant playing of video games as behaviors that demonstrate restricted, repetitive patterns of

behavior, he could not explain how these behaviors are distinguishable from those of a neuro-typical individual. At the hearing, Dr. Mancillas stated that a neuro-typical individual may also be captivated by video games, but not to the same extent as claimant, and a neuro-typical individual would be able to shift to another activity easily. This explanation is vague and not supported by the evidence. Although claimant testified that he gets angry at his mother for interrupting him while he is playing video games, there is no evidence of any extreme distress which would make claimant's reaction distinguishable from that of a neuro-typical individual. By claimant's own admission, he generally complies with his mother's request to stop playing video games. (Factual Finding 15.) Additionally, while it was established that claimant has a habit of cracking his knuckles, little evidence was proffered to suggest that this is a ritualized behavior.

D. Dr. Mancillas also suggested, without citing to evidence, that claimant's ability to smile and joke in his social interactions with others is a strategy he has learned over time to mask the symptoms of autism spectrum disorder. However, claimant's documented history of engaging in appropriate social interactions with others tends to refute this theory. The school psychologist indicated that in 2009, when claimant was 17 years old, he made jokes appropriate to the situation during testing sessions. (Factual Finding 4C.) In 2006, when claimant was 14 years old, the school psychologist found that claimant was polite and mannerly and that he initiated conversations with her during the testing sessions. (Factual Finding 3C.) Although Dr. Mancillas claimed that claimant's mother acts as his "frontal lobe" in mitigating the effects of autism spectrum disorder, claimant's mother presumably was not present during these testing sessions.

E. The aforementioned problems in Dr. Mancillas's testimony and report significantly undermined his credibility.

20. A. Dr. Langenbacher presented as a very credible witness, as she testified in a clear, concise, and forthright manner. She disagreed with Dr. Mancillas's diagnosis and

concurred with Dr. Mathess's opinion that claimant does not suffer from autism spectrum disorder. Dr. Mathess's opinion is supported by her detailed clinical observations of claimant's behavior and thorough analysis of the test results of the ADR-I and ADOS-2. Furthermore, the opinions of Dr. Langenbacher and Dr. Mathess are consistent with the evidence in this case.

B. The evidence did not establish that claimant has deficits in social-emotional reciprocity (Criterion A, subsection (1)). The school psychologist's evaluations from 2006 and 2008 noted that, during test sessions, claimant initiated conversations with the examiner and made jokes appropriate to the situation. (Factual Findings 3C and 4C.) During the social assessment with Rodriguez-Wintz, claimant engaged in back-and-forth conversation with her. (Factual Finding 7E.) During his testing session with Dr. Mathess, claimant also easily engaged in conversations with his examiner and displayed a sense of humor by making an appropriate joke. (Factual Finding 9B.) Dr. Mancillas characterized deficits in social-emotional reciprocity as the inability to put oneself in another's shoes, but did not provide any specific examples of claimant's behavior that demonstrate this deficit. (Factual Finding 18C.)

C. The evidence did not establish that claimant has deficits in nonverbal communication. (Criterion A, subsection (2)). In 2009, claimant's school speech/language pathologist found that claimant did not exhibit any problems in pragmatic language and that he used both verbal and nonverbal skills effectively with his peers. (Factual Finding 5.) In November 2015, Rodriguez-Wintz observed in her social assessment with claimant that he had good eye contact and smiled at her. (Factual Finding 7E.) Dr. Mathess also commented on the fact that claimant made appropriate eye contact, directed facial expressions, and spontaneously used several gestures during her evaluation. (Factual Findings 9B, 9F.) Dr. Langenbacher, during her in-person meeting with claimant on March 4, 2016, found that claimant had good eye contact and made appropriate gestures.

(Factual Finding 17I.)

D. The evidence did not establish that claimant has deficits in developing, maintaining and understanding relationships. (Criterion A, subsection (3)). Although it appears that claimant has few friends, there was no evidence that he lacks an interest in his peers. According to the school psychologist's reports, he was respectful of his teachers at school and interacted well with his peers. (Factual Findings 3F and 4F.) Rodriguez-Wintz indicated in her social assessment that claimant was social and enjoys socializing with others. (Factual Finding 7D.) Claimant's mother also reported to Rodriguez-Wintz that claimant developed relationships with custodians and the maintenance staff at his school. (Factual Finding 7E.)

E. The evidence did not establish that claimant exhibits restricted, repetitive patterns of behavior, interests, or activities. (Criterion B.) The school psychologist did not document any such behavior in claimant in her psycho-educational assessments. (Factual Findings 3G and 4G.) Rodriguez-Wintz did not observe any repetitive body movements in claimant during her social assessment. (Factual Findings 7E.) Dr. Mathess also did not find that claimant engaged in repetitive behaviors or echolalia. (Factual Findings 9B.) Although Dr. Mancillas testified at the hearing that claimant's knuckle cracking and video game playing constituted restricted, repetitive patterns of behavior, his testimony in this respect was not credible. (Factual Finding 19C.)

F. In light of these factors, the opinions of Dr. Langenbacher and Dr. Mathess are deemed to be the more credible than those of Dr. Mancillas, and their opinions are afforded greater weight.

LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from autism spectrum disorder entitling him to change his eligibility category under the Lanterman Act, as set forth in Factual Findings 1 through 20, and Legal Conclusions 1 through 9.

2. Because claimant is the party asserting a claim, he bears the burden of proving, by a preponderance of the evidence, that he is eligible for regional center services based on a diagnosis of autism spectrum disorder. (See Evid. Code, §§ 115 and 500.) He has not met this burden.

3. The Lanterman Act governs this case. (Welf. & Inst. Code, § 4500 et seq.) Eligibility for regional center services is limited to those persons meeting the criteria for one of the five categories of developmental disabilities set forth in Welfare and Institutions Code, section 4512, subdivision (a), as follows:

> "Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual…. [T]his term shall include intellectual disability, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability [the "Fifth Category"], but shall not include other handicapping conditions that are solely physical in nature.

4. Welfare and Institutions Code section 4512, subdivision (*l*), provides:

> "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:

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

5. Here, the parties do not dispute that claimant has a developmental disability which qualifies him for services under the Lanterman Act. The question is whether that developmental disability is autism, or a disabling condition found to be closely related to intellectual disability or to require treatment similar to that required for individuals with intellectual disability, otherwise known as the Fifth Category.

6. While Dr. Mancillas diagnosed claimant with autism spectrum disorder, Dr. Mathess and Dr. Langenbacher concluded that claimant's condition did not meet the diagnostic criteria for autism spectrum disorder under the DSM-5. During closing argument, claimant contended that Dr. Mancillas's diagnosis should be given greater weight because his neuropsychological evaluation was more comprehensive and he spent more time with claimant. However, as Dr. Langenbacher pointed out during her testimony, while the purpose of a neuropsychological evaluation is broader in scope, it is not necessarily a more accurate assessment of claimant's condition. For the reasons set forth in Factual Findings 19 and 20, the opinions of Dr. Mancillas are deemed to be less credible than those of Dr. Langenbacher and Dr. Mathess and thus carried little weight. Consequently, when applying the DSM-5 diagnostic criteria to the instant case, the evidence did not support the conclusion that claimant suffers from autism spectrum disorder.

7. 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.)

8. In addressing eligibility under the Fifth Category, the Appellate Court in *Mason v. Office of* Administrative *Hearings* (2001) 89 Cal.App.4th 1119, 1129, stated in part:

> The fifth category condition must be very similar to mental retardation [now, intellectual disability[6]], with many of the same, or close to the same, factors required in classifying a

[6] The DSM-5 changed the diagnosis of mental retardation to intellectual disability.

person as mentally retarded. Furthermore, the various additional factors required in designating an individual developmentally disabled and substantially handicapped must apply as well.

9. All of the psychologists familiar with claimant's case, including the school psychologist, Dr. Mancillas, Dr. Mathess, and Dr. Langenbacher, agree that a significant discrepancy exists between his verbal and nonverbal cognitive abilities. This discrepancy is strongly indicative of a nonverbal *learning* disability, which has caused claimant to perform in the borderline range in overall intellectual functioning and in the low to impaired level in adaptive functioning. The parties also agreed that claimant suffers substantially handicapping deficits in the areas of receptive and expressive language, learning, self-care, and self-direction. Thus, the Service Agency properly determined that claimant is eligible for its services under the Fifth Category.

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ORDER

Claimant's appeal is DENIED. Claimant may not change the basis for his eligibility under the Lanterman Act from the Fifth Category to autism.

DATE:

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JI-LAN ZANG

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.