BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: CLAIMANT, and INLAND REGIONAL CENTER, Service Agency.	OAH No. 2017010431

DECISION

Administrative Law Judge Vallera J. Johnson, State of California, Office of Administrative Hearings, heard this matter in San Bernardino, California on March 1, 2017.

Claimant's mother and father represented claimant.

Stephanie Zermeño, Consumer Services Representative, Fair Hearings and Appeals, Inland Regional Center, represented Inland Regional Center.

The matter was submitted on April 24, 2017.[1]

---

[1] The hearing in this matter occurred on March 1, 2017.After the hearing, claimant requested that the record remain open because there was an IEP meeting scheduled for March 10, 2017, and he wanted the service agency to consider the information from the IEP meeting.Without objection by the service agency, the record remained open until April 5, 2017, to allow the service agency to respond to the report from the IEP meeting.Claimant notified the service agency and the administrative law judge that the IEP meeting had been rescheduled to March 24, 2017.Without objection

ISSUE

Whether claimant is eligible to receive services from the Inland Regional Center based on the qualifying condition of Epilepsy or Autism Spectrum Disorder?

FACTUAL FINDINGS

JURISDICTION

1. Claimant is a five-year-old boy who lives with his adoptive parents, his biological grandfather, and his biological grandfather's wife.

2. Claimant applied for regional center services from Inland Regional Center. As a result, service agency staff evaluated documents provided by claimant to the service agency.

The service agency conducted a clinical team meeting and determined that claimant is not eligible to receive regional center services.

On December 12, 2016, the service agency provided claimant with a Notice of Proposed Action, notifying him that he was not eligible to receive regional center services because he does not have a developmental disability. As stated in this letter, "the records indicate that he does not currently have a 'substantial disability' as a result of Intellectual Disability, Autism, Cerebral Palsy, Epilepsy and [Claimant], also does not

---

by the service agency, the record remained open to April 24, 2017, to give the service agency an opportunity to respond to the March 24, 2017, IEP report and to give claimant an opportunity to reply to the service agency's response.On April 19, 2017, the service agency filed a response to the IEP meeting report, marked Exhibit 11.The IEP report was marked Exhibit F.Claimant did not file a reply to the service agency's response.

On April 24, 2017, the record was closed, and the matter was submitted.

appear to have a disabling condition related to intellectual disability, or to need treatment similar to what individuals with an intellectual disability need."

Claimant filed a Fair Hearing Request, dated January 10, 2017.

3. On January 18, 2017, the service agency conducted an informal meeting. Claimant's mother was present at the meeting. During the meeting, his mother described the medications that claimant was taking and his history of seizures; further she explained that she had Individualized Education Program meetings scheduled, seeking a 1:1 educational aide to help him focus in school.

During the meeting, the service agency affirmed its decision that claimant is not eligible to receive regional center services and explained. Thereafter, the service agency issued a letter, dated January 24, 2017, that summarized the discussion at the meeting.

4. On March 1, 2017, this hearing ensued.

MEDICAL RECORDS

5. On August 10, 2016, Bhagwan Moorjani M.D., of the Hope Neurologic Center, evaluated claimant. Previously, claimant had been evaluated on May 25, 2016, at the Hope Neurologic Center. Dr. Moorjani prepared a report that included the following relevant information:

- Physical and neurological skills – poor hopping skills.
- Interval History

> Since last seen [claimant] has not had any seizures despite an abnormal ambulatory EEG. His behavior has improved with clonidine but could be better.
>
> The semiology of the symptom: behavioral issues, is as follows, Location: brain. Quality or characteristic: aggressive behavior. Associated symptoms: violent behavior. speech

and language difficulty, Severity: moderate. Precipitating factors: drug and alcohol exposure in utero. Alleviating factors: improved with clonidine. Symptoms occurs in terms of timing: daily. Side effect or unwanted effects from the medication: deep sleep at night.

- Medications – Multivitamin, Nystatin (a topical cream and a topical lotion)[as needed], and Clonidine [morning and bedtime].
- Family History - Autism, pervasive developmental delay or autism spectrum disorder, bipolar disorder, depression, anxiety and dementia.
- Past medical and surgical history
    - Behavior problems
    - Ear tubes
    - Eczema
- Developmental History – Claimant's motor skills were delayed; gross motor skills were clumsy; his speech and language were delayed.
- Diagnostic Studies Perform – MRI brain – wni;[2] Ambulatory EEG – propensity for focal seizures

Except for the foregoing, on review of systems, physical examination and neurological examination, Dr. Moorjani noted no other complaints, symptoms or abnormalities. This report contained Dr. Moorjani's impressions and diagnoses.

- Impressions
    - Autism
    - Behavioral Disorder

[2] No evidence was offered to establish what the abbreviation "wni" stands for.

- Abnormal EEG suggesting propensity to a focal onset seizure, at present clinically no seizures

- Diagnosis
  - Child and adolescent antisocial behavior
  - Other convulsions
  - Behavior problem of child and adolescence

6. On December 12, 2016, Dr. Moorjani assessed claimant's condition and thereafter issued a report.

As summarized in his report, claimant's mother reported that he had episodes of talking; then he would babble and seem to be unaware of his surroundings; and this lasted about a minute; this behavior happened in school; he had had two such episodes since he was last seen; the behavior stops spontaneously.

Under neurologic examination, Dr. Moorjani described claimant's (1) "mental status: active, alert and playful and cooperative; (2) speech as intact for age."

Dr. Moorjani assessed claimant with possible complex seizures. As treatment, Dr. Moorjani increased claimant's dosage of Clonidine from one-half table to one tablet at bedtime; in addition, she prescribed Oxcarbazepine (Trileptal) twice a day.

IEP AND AMENDMENTS

7. In fall 2016, claimant began kindergarten at Abraham Lincoln Elementary School, a school in the Desert Sands Unified School District, in the Riverside County Special Education Local Plan Area.

8. In May 2016, claimant was assessed for eligibility to receive special education services. The initial meeting to determine eligibility occurred on August 26, 2016, and thereafter a report was issued. Claimant qualified to receive special education services under the emotionally disturbed category.

The report included the following statements relevant to this matter.

Claimant had strong pre-academic skills; his parents' concerns relevant to educational programs were "mainly in the area of behavior and social emotional."

Communication Development: [Claimant] speaks in sentences with come errors in syntax and morphology. He understands simple vocabulary in both Spanish and English. [Claimant] answers and asks questions and will communicate his needs. He uses his imagination when playing (e.g. when playing with a glitter bottle he said "There's a mermaid in there."). [Claimant] also at times will engage in pretend play with other children (e.g. He pretended to buy items from a store from other students). His speech and language skills are age-appropriate at this time.

Social/Emotional/Behavioral: He can name a friend that he frequently spends time with. He prefers to play with similar aged peers. He participates in group games. He is able to stay busy and content for at least 15 minutes if it is a new activity of interest.

Health: [Claimant] is in progress for neurology evaluation for seizure disorder vs. brain dysfunctions.

Adaptive/Daily Living Skills: He is able to put on his shoes. He is potty trained. He is able to wash his hands and face independently. He is able to use a computer to play educational games.

> Areas of necessity explained in terms of goals and objectives in order that student receives educational benefits:
> [Claimant]'s lack of control impede his ability to access the general education curriculum.
>
> Does child's behavior impede learning of self or others?
> [Claimant] exhibits outbursts that impede learning to self and others. These behaviors included throwing his body on the ground, spitting, hitting objects and people, kicking at the air, objects and people, screaming, pulling electrical cords from outlets and the appliances, and throwing things. He had begun to leave the classroom without permission and refused to return to the classroom.

9. On November 4, 2016, the annual IEP meeting occurred and thereafter a report was issued. Among other things, the team discussed the results of the initial assessment, including in the areas of Autism and Speech, and the special education services to be provided to claimant.

At this IEP meeting, claimant's parents reported that Dr. Moorjani had diagnosed claimant with Autism recently and his parents signed a release of information so the district could contact Dr. Moorjani for additional information. However, no evidence was offered that Dr. Moorjani provided a response to the release of information.

In the report, the following statements were made that are relevant to this proceeding:

> Psychologist (Pavalich) reported that [claimant] was able to exhibit appropriate social affect. In the area of reciprocal social interaction, he had poor eye gaze that may be

> influenced by his hyperactivity. He responded appropriately with facial expressions. In the area Restricted/Repetitive behaviors he did not display [sic][3]
>
> According to the assessment results, [claimant]'s behaviors are not likely related to autism but perhaps something else. Due to the severe neglect [claimant] experienced in early years.
>
> Speech pathologist reported that [claimant] does not exhibit a speech/language impairment.
>
> The team discussed emotional disturbance criteria due to [claimant]'s emotional issues, particularly his inability to build and maintain relationships with peers and adults in and outside of school. The team agrees that [claimant] meets criteria for this qualification.

10. On January 17, 2017, the team met to discuss the appropriateness of an environmental aide to support claimant's behavior as well as the length of claimant's school day. They discussed his behavioral issues both at home and at school.

Claimant's mother reported that his medication had been modified; the Clonidine had been increased, and Oxcarbazepine (anti-seizure medication) had been added.

The team noted that there had been a Related Services Independence Assistance Evaluation undertaken, and the assessment was scheduled to be completed in February 2017.

[3] There is missing language.

Also, the principal noted that the day ended about 12:30 p.m. for claimant, and he was unable to follow directions or complete tasks after that time. The psychologist noted that claimant had a short window of meaningful interaction. For about 15 minutes, he processed adult directed activity. This is difficult for providing social skill instruction because he losses interest or does not pay attention. Sometimes, he does not remember his own actions just a few minutes previously.

Based on the discussions, the team decided (1) "to place an Environmental Paraeducator in the Resource Program," and (2) not to switch him to a shorter schedule. In their opinion, the medication change and the aide on site with claimant should be examined for effectiveness before shortening the school day.

11. The next IEP meeting occurred on February 10, 2017, and thereafter a report was issued. The purpose of the meeting/amendment was to review recent developments, to review the RISA and to discuss the level of services necessary for claimant.

The team discussed the most recent modification in his medication, that claimant's physician had withdrawn the Clonidine prescription, and that it had not been a good change; the team discussed the impact of the change in medication on claimant's behavior, the disruptive behavior and the behavior interventions. The presence of the paraeducator had not been successful.

12. The next IEP meeting occurred on March 24, 2017, and a report was issued. The purpose of the meeting is not stated in the report. However, the report focused on the team discussion about claimant's disruptive behavior.

13. Claimant submitted a letter from Candace Leonard, the ECE director at Family YMCA of the Desert, dated April 22, 2016. This letter was submitted to the district's director of special education on behalf of her staff. In the letter, Ms. Leonard

expressed concern about claimant's development, stated that a full assessment was needed and specifically stated:

> We participated in a screening process with [claimant], The Ages & Stages Questionnaire (ASQ-3), and the results indicated that further assessment may be needed in the areas of gross motor skills, problem solving skills and personal-social development. In addition, [claimant] has exhibited behaviors in the classroom that are very concerning including, aggression, sensory-seeking behaviors and moments of regression.

No evidence was offered regarding the ASQ-3, the data measured, the scores achieved or interpretation of the scores.

SERVICE AGENCY ASSESSMENT

Epilepsy

14. Hee Chan Park, M.D., assessed claimant to determine whether he is eligible to receive regional center services based on Epilepsy. He is a board-certified pediatrician, licensed as a physician and surgeon in California, and a service agency consulting physician. At minimum, Dr. Park reviewed the reports from Hope Neurologic Center (Exhibits 6 and D) that are part of the record in this case.

15. Dr. Park defined Epilepsy as two or more documented seizures or epilepsy syndrome. Epilepsy can be mild to severe. A mild condition exits when the seizure like activity may occur once every few years. While a severe condition may exist when the person has seizure activity every 15 minutes or so.

All types and intensity levels of epilepsy are not considered substantially handicapping, and he gave some examples. For patients who have seizure activity infrequently, and the seizure activity lasts a few minutes and does not cause damage, these patients are able to perform activities of daily living without problems. However, there are patients who have daily seizure activity, that may last 15 minutes and the seizure activity involves rhythmic jerking movements, followed by hours of postictal, followed by days that these patients are only able to sleep; these patients are severe and cannot perform activities of daily living; these patients need some help.

Epilepsy can be controlled with medication. There can be break through seizures, even with medication. The goal of having medication is to suppress repetitive seizure activity; when the break through seizures occur, they can be controlled but with a different type of medication.

16. In determining whether claimant is eligible to receive services, Dr. Park considered the following information that he obtained from the medical records.

- Based on the video EEG, there is a propensity for focal onset seizures; but there is no evidence of clinical seizures but there is an EEG finding quite suggestive of clinical seizures, the propensity to develop into focal onset seizures.
- His previous symptom of seizure activity was zoning out, staring episodes and behavior issues. Now that he is on anti-seizure medication twice a day (that started on December 12, 2016), his seizure activity is quite controlled, and he is no longer having seizure activity.

In Dr. Park's opinion, claimant's seizures are controlled; the seizures do not substantially impair his ability to perform his activities of daily living. Therefore, claimant does not meet the criteria to be eligible to receive regional center services based on the severity of his seizure disorder.

17. Claimant asked Dr. Park to consider additional symptoms.

When claimant has an anxiety attack, he tenses his body, starts shaking and zoning out. It takes him awhile to calm down. In Dr. Park's opinion, based on the video and report that he observed, these activities are not correlating with the seizures at the time; this activity did not impair claimant's ability to perform daily activities. If these symptoms continue, claimant should be reevaluated.

Regarding behavioral activities, Dr. Park explained that behaviors such as "random tics" could be seizures; but anger outbursts are not seizures.

Based on the foregoing, Dr. Park did not change his opinion.

Autism Spectrum Disorder

18. Paul Greenwald, Ph.D., is the service agency's psychologist who evaluated claimant's packet to determine whether he was eligible to receive services based on Autism Spectrum Disorder. Dr. Greenwald holds a doctorate in psychology and is licensed as a psychologist in the State of California. He has been a service agency staff psychologist since 2008.

19. In determining eligibility, the service agency relies on the eligibility criteria for regional center services under the Lanterman Act and regulations and the diagnostic criteria set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5).

20. The diagnostic criteria for Autism Spectrum Disorder are:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative not exhaustive, see text):

1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to

reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.

2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
3. Deficits in developing, maintaining, and understanding relationships, ranging for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interests in peers.

SPECIFY CURRENT SEVERITY

Severity is based on social communication impairments and restricted, repetitive patterns of behavior . . .

B. Restrictive, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive, see text):

1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same routine or eat same food every day).

3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative [*sic*] interests).
4. Hyper- or hyporeactivity [*sic*] to sensory input or unusual interest in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

SPECIFY CURRENT SEVERITY

Severity is based on social **communication impairments and restricted, repetitive patterns of behavior** . . .

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in early life).
D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning. . .

21. Dr. Greenwald noted that many individuals with alternative diagnoses will manifest some of the behaviors typical of individuals who have Autism Spectrum Disorder[4] but not all. For example, children with a diagnosis of Attention Deficit Hyperactivity Disorder may flap their hands when they get excited but not show the other deficits, such as reciprocal social communication; these children may interact with other children, play games and show imagination and imitation in their play.

[4] Dr. Greenwald described some of the typical autistic behaviors; they include, flapping hands and fingers, spinning like a top, walking and running on tiptoes.

22. To render his opinion, Dr. Greenwald reviewed the IEP reports and medical records included as exhibits in this case. He explained the bases for his opinion that claimant was not eligible to receive regional center services.

- On August 26, 2016, in the IEP evaluation report, claimant qualified to receive special education services based on the qualifying condition of emotional disturbance, a psychiatric condition. This is not a qualifying condition for regional center services; it is an excluded condition; an individual is not eligible to receive services based solely on a psychiatric condition.
  In the August 2016 medical record, under assessment, Autism is identified but the diagnosis is child and adolescent antisocial behavior. This suggested to Dr. Greenwald that the doctor was ruling in or ruling out Autism versus behavioral issues. The diagnostic conclusion was child and adolescent antisocial behavior, not Autism.
- The annual IEP report, dated November 4, 2016, does not support a diagnosis of Autism Spectrum Disorder for several reasons. Five months later, the qualifying condition did not change. Further, the team met to discuss the assessments that had been performed, including the Autism and Speech assessments. In rendering this opinion, Dr. Greenwald cited relevant statements in the November IEP report (Finding 9).
- The report, from Dr. Moorjani, dated December 12, 2016, does not support a diagnosis of Autism Spectrum Disorder. Under mental status, she stated: active, alert and playful and cooperative; speech was intact. Those are not descriptions that would apply to a child with Autism.

23. Based on the diagnostic criteria in the DSM-5 and the evidence in the record, claimant does not have Autism Spectrum Disorder.

In summary, to be diagnosed with Autism Spectrum Disorder, an individual must have:

- Deficits in reciprocal social communication, and
- Either or both: (1) patterns of stereotype and/or repetitive behavior or interests, and/or (2) sensory processing anomalies.

Based on the evidence in the record, there are multiple indicators that claimant has no deficit in reciprocal social communication, given reports of imaginative play, cooperative behavior and interactive behavior with adults and with other students. There is no clear presentation of either of the other two criteria. Further, one of the possible qualifying conditions for special education services is Autism. The district does not rely on the DSM-5 criteria when evaluating students for special education services but has more generous assessment criteria. Based on its assessments, claimant did not satisfy the district's criteria for special education services based on Autism.

Based on the foregoing, claimant is not eligible to receive regional center services based on Autism Spectrum Disorder.

24. Claimant argued that the service agency should have performed its own assessment of claimant.

The service agency is required to review all packets submitted for consideration. However, the service agency is not required to assess every individual who requests services. In some instances, a decision regarding eligibility can be made based on the submitted documents.

In Dr. Greenwald's opinion, he had sufficient documentation to evaluate this case. He explained that, per claimant's records, claimant's behaviors were outlined and presented; in the medical records, there are diagnostic conclusions (of child and adolescent antisocial behavior rather than Autism); utilizing its criteria for special education services, the district determined claimant was eligible to receive special

education services based emotional disturbance; emotional disturbance is not a developmental disability; the district performed an independent Autism assessment and found that claimant did not meet their generous criteria for Autism. In addition, the IEP referred to behaviors inconsistent with a diagnosis of Autism Spectrum Disorder.

LEGAL CONCLUSIONS

STATUTES AND REGULATIONS

1. Welfare and Institutions Code section 4512 states, in part:

(a) "Developmental disability" means 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. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this 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 an intellectual disability, but shall not include other handicapping conditions that are solely physical in nature.

[¶] . . . [¶]

(1) "Substantial disability" means the existence of significant functional limitations in three or more of the following areas of major life activity, as determined by a regional center, and as appropriate to the age of the person: (1) Self-care. (2) Receptive and expressive language. (3) Learning. (4) Mobility. (5) Self-direction. (6) Capacity for independent living. (7) Economic self-sufficiency . . .

2. California Code of Regulations, title 17, section 54000, states:

(a) "Developmental Disability" means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to 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.

3. California Code of Regulations, title 17, section 54001, states in pertinent part:

(a) "Substantial disability" means:

(1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and

(2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:

(A) Learning;

(B) Self-care;

(C) Mobility;

(D) Receptive and expressive language;

(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. . . .

BURDEN OF PROOF

4. As claimant seeks eligibility, he bears the burden of proof by a preponderance of the evidence. (Evid. Code, §§ 500, 115.)

EVALUATION

5. Claimant is a five-year old male who lives at home with his adoptive parents. He applied to receive regional center services on the bases of Epilepsy and Autism Spectrum Disorder.

Claimant has serious behavioral issues both at school and at home. He has had some seizures. Prior to the hearing in this case, he had had medical evaluations, school assessments and IEP team meetings. As of December 2016, claimant's seizures were controlled with medication. There is no evidence that seizures impair claimant's ability to engage in activities of daily living. Based on the evidence in the record, it was not established that claimant satisfies the diagnostic criteria for Autism Spectrum Disorder.

6. Claimant is not eligible to receive regional center services.

ORDER

Claimant's appeal is denied. Claimant is not eligible to receive regional center services from the Inland Regional Center.

DATED: May 8, 2017

_____

VALLERA J. JOHNSON

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.