BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of:

CLAIMANT

and

SAN DIEGO REGIONAL CENTER, Service Agency.

DDS No. CS0027723

OAH No. 2025060743

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter by videoconference on July 24, 2025.

Claimant's father/conservator, who is an attorney, represented claimant.

Bridgette Webster, Attorney, represented San Diego Regional Center (SDRC).

Oral and documentary evidence was received. The record was closed, and the matter was submitted for decision on July 24, 2025.

ISSUE

Should claimant be allowed to purchase vision therapy in her Self-Determination Program (SDP) spending plan?

FACTUAL FINDINGS

Jurisdictional Matters

1. Claimant, a twenty-year-old female, is eligible for regional center services based on her diagnosis of autism. Claimant participates in the SDP and requested she be allowed to purchase vision therapy in her SDP spending plan. She was not seeking an increase in her SDP budget.

2. On June 16, 2025, SDRC issued a Notice of Action (NOA) to claimant advising it was denying her request. SDRC asserted vision therapy is not considered an evidence-based treatment and regional centers are prohibited from purchasing experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown. Further, services and supports must be directed toward alleviating the developmental disability and vision therapy is not related to claimant's developmental disability of autism. SDRC cited Welfare and Institutions Code sections 4512, subdivision (b), 4648, subdivision (a)(17), and 4685.8, subdivision (c)(6), in support of its position.

3. On June 17, 2025, SDRC received claimant's appeal with the arguments in support of her request. Claimant asserted that SDRC's assertions that "[v]ision therapy

is not considered an evidence-based treatment" and "[v]ision therapy is not related to [claimant's] developmental disability of autism" were incorrect.

4. Thereafter, this hearing followed.

Self-Determination Program

5. In 2013, the Legislature enacted Welfare and Institutions Code section 4685.8, requiring the Department of Developmental Services (DDS) to implement a statewide SDP to provide individuals and their families with more freedom, control, and responsibility in choosing services and supports to help them meet objectives in their Individual Program Plan (IPP). DDS began pilot programs in certain regional centers, and oversaw statewide working groups from various regional centers and consumer groups to develop policies and procedures to implement the program.

6. Starting July 1, 2021, the SDP was available to all eligible regional center consumers who wished to use it. All regional center consumers now have the option to have their services delivered through the SDP model or continue to receive services in the traditional model. With the SDP model, while participants have more choice over which services they receive and who delivers those services, participants also have more responsibility because they must manage their own budget resources with the assistance of a Financial Management Service and support from the regional centers. The regional centers must certify that the cost of the SDP does not exceed the cost if claimant were to remain in the traditional service model.

7. After the budget is certified, the participant and regional center must develop a spending plan identifying the cost of each good, service, and support that will be purchased with regional center funds. Each item in the spending plan must relate to goals in the participant's IPP and be identified by a specific service code from

a list of codes DDS publishes. A participant can annually transfer up to 10 percent of the funds in any budget category to other budget categories without regional center approval. Transfers exceeding 10 percent require regional center approval.

Evidence Introduced at Hearing

8. SDRC SDP Program Manager David Webb-Rex, SDRC Community Services Manager Saralynn Keenan, SDRC Medical Consultant Theodora Nelson, M.D., and claimant's parents testified and various documents were introduced. The factual findings are based on their testimony and those exhibits.

SDP SERVICE DEFINITIONS

9. The June 7, 2018, SDP Service Definitions defined various services. One service listed was "Communication Support," which was defined, in part, as:

> Communication support services includes communication aides necessary to facilitate and assist persons with . . . vision impairment, . . . and who have a limited ability to read, write, speak or understand English (Limited English Proficient or LEP skills). The purpose of this service is to assist individuals to effectively communicate with service providers, family, friends, coworkers, and the general public. The following are allowable communication aides, as specified in the participant's IPP:
>
> 1. Facilitators;
>
> 2. Interpreters and interpreter services;

> 3. Translators and translator services; and
>
> 4. Readers and reading services.
>
> This service also includes supports for the participant to use computer technology to assist in communication. Such supports include training in the use of the technology, assessment of need for ongoing training and support, and identification of resources for the support. This service is limited to personnel providing assistance and does not include the purchase of equipment or supplies.
>
> Communication support services include evaluation for, and training in the use of, communication aides, including for individuals with LEP skills, as specified in the participant's IPP.

DDS DIRECTIVE

10. DDS issued a Directive on July 8, 2024, the subject of which was "Self-Determination Program: Updated Goods and Services." The purpose of the Directive was to "provide additional guidance regarding goods and services in the SDP," noting that Coordinated Career Pathways was being added "as a service to be funded outside of the SDP participant's budget." The Directive further stated that: "Before including any good or service in an individual budget or SDP spending plan, the planning team must first be clear about how the good or service addresses an identified need or goal in the IPP." Further, "SDP funds can only be used for goods and services that: have been approved by the federal Centers for Medicare and Medicaid Services; and are not

available through other funding sources (e.g., Medi-Cal, In-Home Supportive Services, schools, etc.)."

11. Enclosure A to the DDS Directive "provides detailed information about how the participant and the planning team can determine if a good or service addresses a need or goal in the IPP. The DDS Directive also referenced Enclosures B and C, but those were not attached to the exhibit introduced at hearing.

12. Enclosure A identified several steps the participant should consider when developing the spending plan. Step 1 requires the good or service in the spending plan to address an identified need or goal in the IPP. Step 2 requires the participant to determine if the good or service can be provided by a natural support or generic service. Step 3 requires consideration of whether the good or service is allowed by the Medicaid waiver. Step 4 sets forth provider qualifications. Step 5 explains how Participant-Directed goods and services may be used. Step 6 details the spending plan development and review process including a requirement that "the regional center reviews the spending plan for compliance with state law, including verification that the identified goods and services are eligible for federal financial participation . . . ."

CLAIMANT'S 2016 SDRC INTAKE RECORDS

13. Claimant's SDRC intake records contained information similar to that documented in the other records that are listed below. Claimant was reported to have been developing normally until age 28 months when she regressed. Currently, claimant made noises but did not speak. The family had recently moved from New Jersey where she had been receiving services since preschool, both through her school and privately. Services include speech, occupational, and physical therapies.

CLAIMANT'S 2017 IPP

14. Claimant's February 6, 2017, initial IPP, when she was 12 years old, contained information regarding claimant, her needs, and the supports she received. She required physical assistance and verbal prompting to complete tasks. She was ambulatory but had extreme difficulty with motor planning. Her fine motor skills were not age-appropriate.

15. She was unable to write and used a letterboard using one index finger. She was nonverbal and had tried various communication devices without success. She had been using a letterboard since fifth grade. She had difficulty communicating her wants and needs. She was being homeschooled through a charter school and her Individualized Education Program (IEP) was completed in January 2017. The school offered speech, occupational, and physical therapies but those were not currently being utilized due to claimant's anxiety issues.

16. Claimant was sensitive to noises and new places, and could become overwhelmed in crowds. She would tantrum when frustrated and previously had behavior services in New Jersey. She required constant supervision to keep her safe. There were "no concerns" with claimant's vision or hearing. Claimant was provided with information regarding generic resources and would provide applicable insurance denials to SDRC.

CLAIMANT'S 2019 IPP

17. Claimant's October 24, 2019, IPP, when she was 15 years old, contained information regarding claimant, and the services and supports she received. Claimant was primarily expressively nonverbal. She had not had formal speech services since the family moved to California. Her parents felt that "motor planning interfered with

[claimant’s] successful attempts to use various communication devices.” Through claimant’s school programs, she connected with consultants/specialists weekly using teletherapy. She used a letterboard and an app on her iPad/iPhone to communicate her basic needs. She could answer some yes or no questions. Her parents felt her tantrums were due to her frustration with communication. Her parents felt she had good receptive language skills. She was inconsistent with her use of eye contact. No communication formal outcome was requested at that time.

18. Claimant was currently in the ninth grade through a charter/home school program. She performed at grade level with the modified curriculum, but her anxiety and motor planning issues impeded her learning and academic skills development. Claimant did not write and primarily used a letterboard to communicate. Her parents were going to see what services/therapies claimant could receive through the charter school. Claimant liked to be involved, engaged, and have things to do. She could become anxious in crowds and was sensitive to certain noises.

19. She engaged in self-injurious behaviors once or twice per month. She previously received behavior services in New Jersey and her parents were interested in exploring potential additional behavior services and parent training. Claimant’s parents would pursue behavioral services with their insurance provider and provide SDRC with any denials of that request. The health and fitness section the IPP noted there were “no concerns with [claimant’s] vision or hearing.” Claimant required constant supervision to keep her safe. SDRC would assist claimant with identifying generic resources and would complete a respite assessment.

CLAIMANT'S 2022 IPP

20. Claimant's October 31, 2022, IPP noted claimant's abilities, needs, and services provided. She did "not use words to communicate and [was] primarily nonverbal." Her parents continued to feel that her motor planning interfered with her successful attempts to use various communication devices. She continued to receive services through her school program, including speech therapy, occupational therapy, counseling and parent consultation. Claimant's anxiety and motor planning issues impeded her learning and academic skills development. She had trouble engaging with others and only interacted with her parents. They were going to look into services the school could provide to improve claimant's social skills. The health and wellness section continued to note there were "no concerns about her vision or hearing." The "Other Health Information" section noted: "With correction, her vision is normal."

21. Claimant continued to struggle with emotional regulation. Her disruptive behaviors interfered with social participation almost every day. She was sensitive to certain noises and new places. She had trouble in social situations and became overwhelmed in crowds. She was not physically aggressive or self-injurious. She continued to have difficulty sleeping. Her emotional outbursts occurred less than once a month and required intervention. Her behaviors were reportedly a result of her increased boredom. Claimant was going to request the school develop an IEP to meet claimant's needs.

CLAIMANT'S 2023 SDRC NURSE ASSESSMENT

22. On August 28, 2023, a nurse assessment was performed per SDRC's request to assess the level of respite care needed. The assessment noted that claimant was 18 years old, and had diagnoses of autism, severe anxiety, pediatric autoimmune

neuropsychiatric disorders associated with streptococcal infections (PANDAS) syndrome, hypotonia, and a new diagnosis of seizure disorder. Claimant was homeschooled due to her anxiety. It was reported that just after her second birthday, claimant had a fever, was seen by a physician and diagnosed with a bacterial infection but no antibiotic was prescribed. After she recovered, claimant began to regress and was diagnosed with autism. Over time, both claimant's small motor skills dysfunction and her anxiety have increased.

23. Following that assessment, SDRC recommended LVN-level respite care.

CLAIMANT'S 2023 OPTOMETRY EVALUATION

24. A Visual Function and Perceptual-Motor Skill Evaluation was performed by Susan Daniel, O.D., of Daniel and Davis Optometry, a part of Total Vision, on May 10, 2023. In her report, Dr. Daniel listed the reason for the referral as being "for a comprehensive developmental vision evaluation to determine whether a visual information processing problem exists that may impact learning." The history section stated that claimant's parents sought an evaluation for claimant's "vision tracking issues." In addition to claimant's history, the report also contained the results of the refractive examination, ocular health examination, functional vision and information processing evaluation which included eye-movement skills, accommodation, binocular vision, color vision, central/peripheral vision integration, autonomic nervous system balance, pointer in the straw, pull tube bilateral coordination, crossing the midline, visual motor integration, yoked prism testing, and La Barge electrotherapist testing/evaluations.

25. Dr. Daniel's impressions were: mild hyperopic refractive error-normal; pursuit eye-movement delay; saccadic eye-movement delay; binoculars vision delay -

convergence insufficiency; and central peripheral integration delay. Of note, none of these diagnoses are qualifying regional center diagnoses or are features of autism, as discussed below by Dr. Nelson. Dr. Daniel recommended an individualized Optometric Vision Therapy Program (vision therapy) to address claimant's visual functional and perceptual-motor skills so that she could "receive greater benefit from her home instruction and improve her spelling accuracy and stamina when communicating with her letterboard or keyboard." The therapy sessions could be done in Dr. Daniel's office or with claimant's parent by Zoom. The visual therapeutic learning activities would benefit claimant "to visually guide her motor movements leading to more accurate pointing to the letters on her letterboard/keyboard for communication with stamina." The report identified the goals of treatment and various devices that would be used in the vision therapy program.

COMMUNICATIONS WITH SDRC REGARDING VISION THERAPY REQUEST

26. SDRC Consumer ID Notes, commonly referred to as Title 19 notes, documented discussions between claimant and SDRC, as well as communications between SDRC staff. November 2024 entries documented information the family received and SDRC obtained regarding vision therapy. The vision therapy provider did not accept insurance and claimant's parents were privately funding that therapy, as well as paying for claimant's Augmentative Assistive Communication (AAC) therapy. One entry noted that claimant's consumer services coordinator (CSC) had sent claimant's request for vision therapy to the clinical services team to determine if that service could be "added into claimant's SDP funds."

27. December 2024 Title 19 notes documented the CSC's discussion with her program manager that vision therapy services cannot be added because they are not vendored services or services that would be offered through the traditional model. The

CSC was advised that claimant could obtain and provide insurance denial paperwork and how the services relate to claimant's developmental disability and consultations with the SDP and clinical teams could take place to see if it was possible to add that service in the future. Other notes documented communicating that information to claimant's parent. The notes clearly indicated that even if denial letters were obtained, the vision therapy request would still have to be presented to the SDP and clinical teams for approval.

28. On December 10, 2024, the CSC sent claimant a letter stating the following:

> Thank you lor talking on the phone with me on December 10, 2024 about adding vision, AAC speech therapy, and [occupational therapy] through [claimant's] self-determination budget. This letter is to explain the regional center's proposed decision. We are denying these services at this time. We are doing that because we can only add services to the budget that would have been paid through traditional services. In addition, the vision, AAC therapy are not vendored services. I believe you have agreed with this decision because of our phone call on 12/10/2024.
>
> Additionally, I would like to share the following information with you: if you are interested in adding these services to [claimant's] budget, we will need you to provide us with insurance denial paperwork and how the service relates to her developmental disability for each service. SDRC's clinical

> team will determine if the services can be added to the budget. If approved, a budget adjustment will be needed.
>
> If you agree with this decision, there is nothing further you need to do. If you wish to discuss this decision, please contact me.

The letter further advised claimant of her appeal rights.

29. At hearing, claimant asserted during both direct and cross-examinations, that SDRC misled claimant into thinking that once she provided the denial paperwork coupled with Dr. Daniel's recommendations, vision therapy would be funded. However, the Title 19 notes, as well as SDRC's December 10, 2024 letter, clearly showed that even if the insurance denial and information regarding how the service was related to claimant's developmental disability were received, SDRC's clinical team would still have to determine if the services could be provided. In fact, SDRC's letter clearly used the word "if." Nothing in that letter was unclear or misleading.

Insurance Denial

30. Blue Shield documents noted that on April 25, 2025, Dr. Daniel's $190 claim for services performed on December 29, 2023, was denied as she was "out-of-network" and the services provided were "Invalid, illegible, or omitted procedure code."

31. June 2025 Title 19 notes documented SDRC's receipt from claimant of the insurance denial. Another note documented Dr. Nelson's denial of the vision therapy request because it has not been shown to be evidence-based. Other notes documented claimant's agreement to removing vision therapy from her spending plan

so it could be approved, but that claimant disagreed with SDRC's denial and requested SDRC issue an NOA.

CLAIMANT'S 2025 IPP AND AMENDMENTS

32. Claimant's January 2, 2025, IPP contained information regarding claimant and the services and supports she receives. Her communication skills continued to improve but were a "work in progress." Claimant communicates using AAC devices such as the Lamp Word for Life (LAMP) application on her iPad, a regular computer keyboard, or a laminated QWERTY keyboard print out. Her parents feel that motor planning interferes with claimant's successful attempts to use various communication devices. It is difficult for her to initiate requests and she will bring items to others to demonstrate her needs. Her parents feel she has good receptive language skills but her response to yes or no questions and her use of eye contact are both inconsistent.

33. Claimant can get easily frustrated when communicating with others and needs assistance or guidance from her parents. Due to anxiety, claimant has trouble in social situations and can become overwhelmed in crowds. She is sensitive to certain noises and new places. She requires supervision in all settings for safety. At the time of this IPP, claimant was being homeschooled through a charter schools and was expected to graduate in January 2025. Claimant's IEP noted her multiple disabilities which made her eligible for services through her school. Due to her seizures, claimant was eligible for LVN services. SDRC funded FTS supports, LVN respite, community living supports, community integration support, and individual training and transportation. The IPP noted the programs claimant attends.

34. A March 11, 2025, IPP amendment documented that Claimant "will increase her communication with support from AAC device [*sic*] and training as

needed through January 31, 2026." Effective April 1, 2025, this newly identified service provided by "Spellers" would be funded by SDRC. Claimant's spending plan was changed to reflect the addition of Service Code 360 for this new service.

35. The June 13, 2025, IPP amendment documented that Service Code 333 was added to allow claimant's parent to attend an SDP conference.

SDP INDIVIDUAL BUDGET AND SPENDING PLAN

36. Claimant's SDP individual budget of $71,093.52 was approved in December 2024. These costs included SDP services, respite, art classes, music therapy, and conference fees.

37. Claimant's April 1, 2025, SDP spending plan identified the services claimant received, the service codes, the IPP outcome the service addressed, the service provider, and the rates and cost for each service. A $5,000 cost to provide assistance/coaching so claimant could "effectively use her AAC device and be able to communicate effectively" was listed. The spending plan totaled $71,093.52.

38. Claimant's May 1, 2025, SDP spending plan contained information similar to the April 1, 2025 spending plan. The difference in this plan was that $7,500 was now listed for the assistance/coaching service, although the total of $71,093.52 remained unchanged as funds had been reallocated from other categories.

39. Claimant's July 1, 2025, spending plan contained a few new additions for non-medical transportation services. Again, the spending plan total remained the same at $71,093.52.

EMAILS BETWEEN CLAIMANT AND SDRC

40. In a June 3, 2025, email to claimant's CSC, claimant's father requested SDRC approve three revisions to claimant's spending plan, including adding vision therapy as a new service to be provided by Susan Daniel Optometry Consulting, APC, under Code 369. He attached the previously requested Blue Shield denial of coverage and reallocated funds for the vision therapy costs for the next six months, from funds previously allocated to Code 360, so that the total SDP budget did not increase.

41. In response thereto, on that same date, the CSC emailed claimant's father twice advising that "all items were good except for the new [Code 369]." The SDP team needed further clarification or a treatment plan of how the program/service would look when claimant was attending and asked if he would prefer to reach out to the team directly or do it through the CSC.

42. Later that same day claimant's father sent a responsive email to the CSC providing the treatment plan from Dr. Daniel's report. He asked if that treatment plan "will satisfy the SDP team."

43. The CSC responded that same day thanking claimant for providing that information and asking if there was "an official treatment plan with a physical signature from the provider?" The CSC also asked if claimant "could provide more justification on how it supports the disability?" The CSC acknowledged, "I know it's a lot of back and forth but the SDP wants specific [information] to approve this."

44. First thing the following morning, on June 4, 2025, claimant sent an email attaching Dr. Daniel's full evaluation which set forth the treatment plan. Claimant pointed out specifics of that plan and how they were recommended to improve claimant's ability to visually guide her motor movements leading to more accurate

pointing to the letters on her letterboard/keyboard for communication with stamina. The goals were also to improve claimant's ability to have binocular control in all gazes and distances, improve her ocular motor skills and visual skills to scan horizontally, vertically and diagonally quickly and accurately, improve her visual motor integration skills so she could look and point simultaneously with stamina, and to improve her central/peripheral visual integration ability so she could have better postural control and balance with spatial organization while doing a central task. Claimant asked whether the information was sufficient, and requested a conference call with the SDP team if it was not.

45. On June 4, 2025, claimant's CSC replied advising that the information had been sent to both the SDP team and the clinical team. The CSC would follow up with claimant once she heard back.

46. On June 10, 2025, claimant inquired if the vision therapy was acceptable so that the spending plan could be revised. The CSC replied that she was still working with SDP regarding this matter and should have an answer by the end of the week. The SDP team was asking if the provider (Dr. Daniel) was out of network as that was what was listed on the denial letter.

47. On June 10, 2025, claimant replied that Dr. Daniel is not an in network provider for Blue Shield. There are no doctors providing vision therapy in the Blue Shield network because the plan does not cover vision therapy which was listed in the explanation for the denial which identified the procedure codes as being "invalid" for coverage under claimant's plan.

48. In his June 13, 2025, email to claimant's CSC, claimant's father thanked the CSC for "relaying the denial of vision therapy by the phantoms at the 'clinical

services department.'" He disagreed with the decision and would "pursue all of our available remedies under the law to correct this baseless and arbitrary denial, including the reimbursement of our current vision therapy costs and all attorney's fees and costs." He wrote further: "I have evidence that your organization purposely obstructed us with bad faith insurance requests that were intended only to dissuade us from a necessary service for our disabled daughter." He attached "the further revision to [claimant's] Spending Plan that we are being forced to accept in order to obtain the other revisions expeditiously." He asked the CSC to provide him with the name and contact information for the new CSC noting, "You seem like a decent person forced by faceless bureaucrats to relay indefensible position [*sic*] (as has been the case with all of our service coordinators)."

MR. WEBB-REX'S TESTIMONY

49. Mr. Webb-Rex testified that SDRC's reasons for denying claimant's request to fund vision therapy were because the federal waiver does not authorize funding vision therapy, vision therapy does not meet the SDP definition of communication support, vision therapy was not an authorized service identified in claimant's IPP, funding must comply with the DDS directives and vision therapy does not, there are generic resources available to respondent such as claimant's school district or her insurance, and it must be a service that could be funded under the traditional services method and vision therapy could not be funded under that method because it is experimental. He explained that because the purpose of the referral to Dr. Daniel was to determine whether claimant's vision issues impacted her learning, this made vision therapy a service the school district would fund if allowed.

50. On cross-examination, Mr. Webb-Rex conceded that claimant is no longer in school as she has graduated, and her insurance denied her request for

funding, so those generic resources are not available, but testified the primary reason for the denial was because vision therapy is not evidence-based and is an experimental therapy.

MS. KEENAN'S TESTIMONY

51. Ms. Keenan's duties include overseeing a variety of services vendored with SDRC. She reviewed Dr. Daniel's website to determine if Dr. Daniel met the criteria to be an SDRC vendor, even though Dr. Daniel was not applying to be a vendor, because "optometry services can be funded through generic resources," although that answer was unclear. Ms. Keenan determined that vision therapy does not meet the standards to be an evidence-based therapy so SDRC could not fund it. Further, SDRC cannot fund services that do not treat or alleviate a developmental disability. She also received input from the clinical team when reaching her decision.

DR. NELSON'S TESTIMONY

52. Dr. Nelson is part of the SDRC clinical team whose duties include participating in eligibility determinations, advocating for consumers, and performing medical evaluations. She concluded that claimant's request could not be funded because services must be related to the clinical eligibility diagnosis (here autism), and vision therapy is not an evidence-based therapy for treating developmental disabilities.

53. Dr. Nelson could find no studies showing that vision therapy is an evidence-based therapy. She testified about studies and an OAH decision she reviewed, which are referenced below.

54. Dr. Nelson agreed that individuals with autism can have vision issues. However, she found no studies that concluded that vision therapy is an evidence-

based treatment for developmental disabilities or that convergence insufficiency is autism-related. Thus, she determined SDRC cannot fund it.

2024 OAH DECISION REGARDING VISION THERAPY

55. On June 26, 2024, *In the Matter of Claimant and Valley Mountain Regional Center*, DDS No. CS0013599, OAH No. 2024030966, OAH issued a decision denying that claimant's request for vision therapy services on the grounds that claimant had not produced evidence demonstrating that his request for vision therapy alleviated his autism and regional centers are prohibited from funding experimental services and supports. In that case, claimant failed to establish that vision therapy is a generally accepted method for treating individuals with a developmental disability, that its use was evidence-based, or that it was not experimental, and for those reasons, claimant's request for vision therapy services in that matter was denied.

56. That decision referenced several articles and a hospital website that were introduced in that hearing. Dr. Nelson testified she reviewed those articles as part of her evaluation of claimant's request in this matter. She found that the decision correctly summarized the articles and hospital website, and supported her own findings that vision therapy is not evidence-based. Vision therapy is also not a treatment for autism. Further, claimant's diagnosis of convergence insufficiency is not a qualifying developmental disability under the Lanterman Act so treatment for that condition is not allowed.

SDRC'S ARTICLES INTRODUCED

57. Dr. Nelson also referenced additional articles she reviewed that were introduced in this matter. She testified that those articles supported her conclusions.

58. An article published in Evaluation and Program Planning, titled "Evidence-based practices in the field of intellectual and developmental disabilities: An international consensus approach," presented and discussed "an evidence-based conceptual model and measurement framework that integrated" three perspectives on evidence, namely empirical-analytical (emphasizes experimental or scientific evidence), phenomenological-existential (emphasizes reported experiences of well-being concerning the intervention), and post-structural (emphasizes public policy principles such as inclusion, self-determination, participation, and empowerment). The article noted that the "concept and application of evidence-based practices started originally in medicine in the 1990s and has spread rapidly to many social and behavioral disciplines," including to developmental disabilities. Evidence-based practices "generally refer to the use of current best evidence in making clinical decisions about the interventions and/or supports that service recipients receive in specific situations." The article noted that because evidence-based practices have become increasingly advocated for and used in the developmental disabilities field, "it is important to address and integrate the issues raised by" the three evidence perspectives and concluded by discussing "five issues that need to be addressed in the future conceptualization, measurement and application of evidence-based practices."

59. An article published by the University of South Carolina, College of Pharmacy, in 2018, titled, Getting Rigorous with Scientific Rigor," noted that in 2015, the National Institute of Health (NIH) "announced its implementation of rigor and transparency" and "reviewers of NIH grants are now required to consider scientific rigor in their final evaluation." The article discussed the importance of scientific rigor, including how it can lead to the acceptance of research results.

60. An August 10, 2023, article published by NIH, titled "Addressing Rigor in Scientific Studies," discussed the importance of discerning reputable studies because inaccurate or untrustworthy information can have dire consequences. The article noted that "the sheer number of published studies make[s] it increasingly difficult to determine which findings are worthy of attention." NIH has been emphasizing for more than a decade that "the rigor and transparency of a study are key for gleaning the robustness of its results. This includes the design, implementation, analysis, and interpretation of experiments. If a study's validity isn't known, the rest is moot." The article then provided ways to determine whether a study was rigorous.

61. An article published July 26, 2017, titled "Vision Training Not Proven to Make Vision Sharper," noted that vision therapy consisted of eye exercises sometimes recommended for children having difficulty learning to read or write. However, there was "no scientific evidence that they work." The article noted:

> The American Academy of Ophthalmology joined with other groups in 2014 to issue a statement about vision therapy. That statement says that:
>
> "Currently, there is no adequate scientific evidence to support the view that subtle eye or visual problems cause learning disabilities. Furthermore, the evidence does not support the concept that vision therapy or tinted lenses or filters are effective, directly or indirectly, in the treatment of learning disabilities. Thus, the claim that vision therapy improves visual efficiency cannot be substantiated."

CLAIMANT'S PARENTS' TESTIMONY

Claimant's Father's Testimony

62. Claimant's father testified that claimant is currently 20 years old, and graduated from high school in January 2025. She has been nonverbal since she was three years old. She has found some ways to communicate but "life is a terrible struggle" for her because she cannot express her wants and needs. It is "excruciatingly difficult" for her to communicate. In addition, she has no dexterity in her hand so cannot sign and lacks stamina to use her AAC devices.

63. Claimant receives AAC therapy to help her navigate the devices, but the therapy does not address her lack of accuracy or the stamina she needs to work the devices. The vision therapy she previously received with Dr. Daniel increased both her accuracy and her stamina. Claimant is requesting that SDRC fund that therapy again because it benefited claimant.

64. Claimant's father showed what the keyboard and devices claimant uses look like and how they require her to press buttons to get to several screens in order to communicate. Claimant lacks the ability to strike the correct letters with accuracy and lacks the stamina to work the keyboard or devices for any length of time.

65. Claimant's convergence insufficiency prevents her from having her eyes move together effectively to identify the correct icons on her keyboards so that she can effectively communicate. Part of claimant's autism diagnosis includes her inability to verbally communicate and vision therapy improves her ability to communicate through the use of her AAC devices.

Claimant’s Mother’s Testimony

66. Claimant’s mother has a bachelor’s degree in speech/language pathology and is certified to teach deaf individuals and teach assistive technology. She knows and teaches sign language. She also received training from the individual who developed LAMP and is extremely familiar with that tool.

67. Claimant’s mother has taken all kinds of courses and trainings to provide claimant with all the support she can. Despite those efforts, claimant has not made the expected progress. She described the devices claimant uses and the difficulties she encounters, consistent with the testimony offered by her husband. Because of her dexterity issues, claimant only uses her pointer finger to push the buttons on her devices. Claimant is unable to use sign language because of her dexterity issues.

68. The vision therapy claimant previously received helped her to operate her devices as she was “really struggling to scan and zone in” on the icons. Vision therapy helped her with her eye conversion and scanning. Claimant’s mother described the therapy given, testifying it was safe and increased claimant’s accuracy and stamina.

69. The AAC devices are vital as they are claimant’s only means of communicating. Claimant remains nonverbal even despite all the modeling instructions she has been given.

CLAIMANT’S ARTICLES INTRODUCED

70. The Abstract of an October 13, 2008, article published by JAMA Ophthalmology, was titled, “Randomized Clinical Trial of Treatments for Symptomatic Convergence Insufficiency in Children.” The objective of the study was to “compare

home-based pencil push-ups (HBPP), home-based computer vergence/accommodative therapy and pencil push-ups (HBCVAT+), office-based vergence/accommodative therapy with home reinforcement (OBVAT), and office-based placebo therapy with home reinforcement (OBPT) as treatments for symptomatic convergence insufficiency." The method of this study was a randomized clinical trial in which 221 children ages 9 to 17 with symptomatic convergence insufficiency were assigned to one of these four treatments. The conclusion was that 12 weeks of OBVAT resulted in significantly greater improvement in symptoms and clinical measures of near point of convergence and positive fusional vergence and a greater percentage of patients reaching the predetermined criteria of success compared with the other three methods. The application to clinical practice was that OBVAT was an effective treatment for children with symptomatic convergence insufficiency.

Dr. Nelson was asked about this study during her testimony. She agreed this was a valid study, but nothing in it referenced using these treatments with individuals with developmental disabilities or established that vision therapy is evidence-based or not experimental.

71. The Abstract of a March 2018 article titled "Accommodative Function in Individuals with Autism Spectrum Disorder," published in Optometry and Vision Science, reported on a study which "investigated accommodative function in children with [autism spectrum disorder], in conjunction with other vision measures with habitual refractive corrections." The "aim of this study was to investigate how accommodative accuracy and near visual function in [autism spectrum disorder] compared with typically developing control subjects." The study concluded that children with autism spectrum disorder "were significantly more likely to have

accommodative deficits (and associated near visual deficits) in their presenting refractive date then typically developing children. Appraisal of refractive error, accommodation, and [near visual acuity] should be considered in visual assessment of children with [autism spectrum disorder]."

Nothing in this study established that vision therapy is evidence-based or not experimental.

72. The Abstract of a July 2018 article published in Clinical and Experimental Ophthalmology, titled "Vision in children with autism spectrum disorder: a critical review," from "Optometry Australia," was a review that "will summarise[1] our current knowledge of key aspects of visual functions and optometric profile of [autism spectrum disorder]."

Nothing in this Abstract established that vision therapy is evidence-based or not experimental.

73. A 2008 "informational paper" by the College of Optometrists in Vision Development (COVD) noted that "[i]ndividuals with autism have difficulty with processing and responding to information from their senses, and with communication and social interaction. Visual problems are very common in individuals with autism." The paper referenced the visual evaluation and testing that may be performed and what may be recommended depending on the testing results. The paper noted that treatment programs are coordinated with others participating in the multidisciplinary

---

[1] The Australian spelling was used in the article.

management of patient. Further, "members of COVD are optometrists who specialize in examining children and adults with developmental disabilities, including autism."

Nothing in this informational paper established that vision therapy is evidence-based or not experimental.

Position Statements

74. SDRC's Position Statement set forth the reasons for its denial, citing to the laws set forth in its NOA, as well as Welfare and Institutions Code section 4686.2, subdivision (d)(3), which defines "evidence-based." SDRC asserted it was prohibited from paying for experimental services and that vision therapy has not been clinically determined or scientifically proven to be an effective treatment for individuals with developmental disabilities. SDRC is required to meet the Federal Home Community Based Services Waiver standards and those prohibit funding services that are experimental or not evidence-based.

75. Claimant's Position Statement noted that claimant is nonverbal and uses AAC devices to communicate, specifically a letterboard, keyboards and a LAMP application on her iPad. She communicates by pressing letters or icons using her index finger, but her disabilities limit her accuracy and stamina on those AAC devices. Vision therapy was being requested because it increases claimant's accuracy and stamina and will improve her ability to communicate, which in turn improves the quality of her life. Claimant asserted that vision therapy is evidence based because it is "based on the quantitative testing results from optometric testing conducted by [Dr. Daniel]" and the recommended vision therapy "addresses [claimant's] specific vision deficiencies." Claimant next asserted that there was nothing "experimental" or not "safe" regarding the vision therapy exercises that Dr. Daniel would be providing. Moreover, claimant

previously received vision therapy in 2023 without any complications and had improvements in her accuracy and stamina on her AAC devices. Claimant also refuted SDRC's assertion that vision therapy was not related to her developmental disability of autism given the broad definition of autism and the fact that claimant's disabilities were not limited to autism. Claimant then listed her many disabilities as documented in records she provided to SDRC, noting that her aphasia is why she is nonverbal and her hypotonia is why she has stamina difficulties. Claimant asserted the vision therapy would address the challenges caused by claimant's aphasia, hypotonia, and motor planning disabilities. Claimant asserted that SDRC acted in bad faith in arbitrarily denying vision therapy and unnecessarily delaying the approval process solely to inconvenience and dissuade claimant from pursuing that therapy. Claimant also asserted that the denial was inconsistent with SDRC's recent approval of AAC therapy which will provide assistance and coaching so claimant can effectively use her AAC device to be able to communicate effectively. Vision therapy would similarly increase her ability to communicate effectively because it will improve her accuracy and stamina on the AAC devices she uses to communicate.

LEGAL CONCLUSIONS

Purpose of the Lanterman Act

1. The purpose of the Lanterman Developmental Disabilities Act (Lanterman Act) is to provide a "pattern of facilities and services . . . sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life." (Welf. & Inst. Code § 4501; *Association of Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.)

Burden and Standard of Proof

2. Each party asserting a claim or defense has the burden of proof for establishing the facts essential to that specific claim or defense. (Evid. Code, §§ 110, 115, 500; *McCoy v. Bd. of Retirement* (1986) 183 Cal.App.3d 1044, 1051, footnote 5.) In this case, claimant bears the burden to prove SDRC should allow her to use her SDP spending plan to fund the service she seeks.

3. The standard by which each party must prove those matters is the "preponderance of the evidence" standard. (Evid. Code, § 115.)

4. A preponderance of the evidence means that the evidence on one side outweighs or is more than the evidence on the other side, not necessarily in number of witnesses or quantity, but in its persuasive effect on those to whom it is addressed. It is "evidence that has more convincing force than that opposed to it." (*People ex rel. Brown v. Tri-Union Seafoods, LLC* (2009) 171 Cal.App.4th 1549, 1567.)

The Lanterman Act, DDS, and Regional Centers

5. The Lanterman Act is found at Welfare and Institutions Code section 4500 et seq.

6. Welfare and Institutions Code section 4501 sets forth the state's responsibility and duties.

7. Welfare and Institutions Code section 4512 defines services and supports. Subdivision (b) states in part:

> "Services and supports for persons with developmental disabilities" means specialized services and supports or

> special adaptations of generic services and supports directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of an independent, productive, and normal life. The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option. . . .

8. Welfare and Institutions Code section 4646, states in part:

> (a) It is the intent of the Legislature to ensure that the individual program plan and provision of services and supports by the regional center system is centered on the individual and the family of the individual with developmental disabilities and takes into account the needs and preferences of the individual and the family, if appropriate, as well as promoting community integration, independent, productive, and normal lives, and stable and

> healthy environments. It is the further intent of the Legislature to ensure that the provision of services to consumers and their families be effective in meeting the goals stated in the individual program plan, reflect the preferences and choices of the consumer, and reflect the cost-effective use of public resources.
>
> (b) The individual program plan is developed through a process of individualized needs determination. The individual with developmental disabilities and, if appropriate, the individual's parents, legal guardian or conservator, or authorized representative, shall have the opportunity to actively participate in the development of the plan. . . .

9. Welfare and Institutions Code section 4646.4, subdivision (a), requires regional centers to establish an internal process to ensure adherence with federal and state laws and regulations, and when purchasing services and supports, regional centers must conform to the purchase of service policies, utilize generic resources and other sources of funding, consider the family's responsibility, and consider information regarding the individual's need for service, barrier to access, and other information.

10. Welfare and Institutions Code section 4646.5, subdivision (a), sets forth the requirements of the planning process for the IPP.

11. Welfare and Institutions Code section 4648 requires regional centers to ensure that services and supports assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible. Regional centers must secure services

and supports that meet the needs of the consumer, as determined by the IPP. Regional centers must be fiscally responsible and may purchase services or supports through vendorization or contracting. Subdivision (a)(8) prohibits regional centers from using their funds "to supplant the budget of an agency that has responsibility to serve all members of the general public and is receiving public funds for providing those services." Subdivision (a)(17) prohibits regional centers from purchasing:

> experimental treatments, therapeutic services, or devices that have not been clinically determined or scientifically proven to be effective or safe or for which risks and complications are unknown. Experimental treatments or therapeutic services include experimental medical or nutritional therapy when the use of the product for that purpose is not a general physician practice. . . .

12. Welfare and Institutions Code section 4685.8, subdivision (c)(6), states in part: "The Self-Determination Program shall only fund services and supports provided pursuant to this division that the federal Centers for Medicare and Medicaid Services determines are eligible for federal financial participation."

13. Although Welfare and Institutions Code section 4686.2, subdivision (c)(3), pertains to behavioral therapy, it does define "Evidence-based practice" as a decisionmaking process that integrates the best available scientifically rigorous research, clinical expertise, and individual's characteristics. Evidence-based practice is an approach to treatment rather than a specific treatment. Evidence-based practice promotes the collection, interpretation, integration, and continuous evaluation of valid, important, and applicable individual- or family-reported, clinically observed, and research-supported evidence. The best available evidence, matched to consumer

circumstances and preferences, is applied to ensure the quality of clinical judgments and facilitates the most cost-effective care.

14. A school providing services to a student under an autism disability is insufficient to establish eligibility for regional center services. Schools are governed by California Code of Regulations, Title 5 and regional centers are governed by California Code of Regulations, Title 17. Title 17 eligibility requirements for services are much more stringent than those of Title 5. Thus, even if claimant's school did provide vision therapy services, that did not mean SDRC must do so.

Evaluation

15. To be eligible for regional center services, the Lanterman Act requires the individual to have one of five qualifying diagnoses (intellectual developmental disorder, autism, cerebral palsy, epilepsy, or Fifth Category) that constitutes a substantial disability. (Welf. & Inst. Code, § 4512, subd. (a), and CCR, tit. 17, §§ 54000 and 54001.) Once eligible, regional centers may provide services and supports that are "directed toward the alleviation of a developmental disability or toward the social, personal, physical, or economic habilitation or rehabilitation of an individual with a developmental disability, or toward the achievement and maintenance of an independent, productive, and normal life" (Welf. and Inst. Code, § 4512, subd. (b)) and which "assist individuals with developmental disabilities in achieving the greatest self-sufficiency possible" (Welf. and Inst. Code, § 4648).

However, the Lanterman Act also places restrictions on the services that may be funded. Regional centers must look to generic resources. Regional centers must comply with their purchase of services agreements. Regional centers must comply with DDS Directives. Regional centers must comply with applicable laws, both state and federal. Regional centers must be cost-effective. Regional centers must fund services according to the needs outlined in the IPP. Regional centers are prohibited from purchasing services that are not evidence-based or are experimental. Regional centers may only fund services that Medicare and Medicaid determine can be funded.

Here, no evidence demonstrated that vision therapy is evidence-based or that it is not experimental. Nor did the evidence demonstrate it is a therapy used to treat individuals with developmental disabilities. While some studies have shown that vision therapy can be beneficial, others showed it was not, and in any event, those studies were insufficient to allow SDRC to fund claimant's request. Moreover, the research is not settled that vision therapy is an effective treatment. Claimant's parents' testimony about the benefits claimant received from vision therapy was simply not enough to prove that it is evidence-based or not experimental. Dr. Daniel's evaluation also did not establish that vision therapy is evidence-based or not experimental as those terms are defined in both research and the law.

In addition, while claimant's parents testified that vision therapy improved claimant's accuracy and stamina, which in turn improved her ability to communicate, and her inability to communicate is an aspect of claimant's autism, because no evidence showed that vision therapy was evidence-based or not experimental, or that Medicaid or Medicare authorized funding that service, SDRC may not fund it. Perhaps someday there will be evidence-based studies demonstrating that vision therapy is a proper service to treat Lanterman Act developmental disabilities, but currently there are no such studies.

Claimant's parents clearly want what is best for their daughter and have devoted their lives to caring for her. However, claimant failed to establish by a preponderance of the evidence that vision therapy is a generally accepted method for treating individuals with a developmental disability, that its use is evidence-based, or that it is not experimental. Claimant also failed to establish by a preponderance of the evidence that the Centers for Medicare and Medicaid Services have determined vision therapy is eligible for federal financial participation. SDRC may not use funds to purchase non-evidence-based or experimental services or those that Medicare and Medicaid have determined may not be funded.

On this record, claimant's request must be denied.

ORDER

Claimant's appeal of San Diego Regional Center's determination that she may not purchase vision therapy as a service in her SDP spending plan is denied. San Diego Regional Center's determination is affirmed, and it shall not fund vision therapy as a service in claimant's SDP spending plan.

DATE: July 30, 2025

MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings

BEFORE THE
DEPARTMENT OF DEVELOPMENTAL SERVICES
STATE OF CALIFORNIA

In the Matter of:

Claimant

OAH Case No. 2025060743

Vs**.**

DECISION BY THE DIRECTOR

San Diego Regional Center,

Respondent.

ORDER OF DECISION

On July 30, 2025, an Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH) issued a Proposed Decision in this matter.

The Proposed Decision is adopted by the Department of Developmental Services as its Decision in this matter. The Order of Decision, together with the Proposed Decision, constitute the Decision in this matter.

This is the final administrative Decision. Each party is bound by this Decision. Either party may request a reconsideration pursuant to Welfare and Institutions Code section 4712.5, subdivision (a)(1), within 15 days of receiving the Decision or appeal the Decision to a court of competent jurisdiction within 180 days of receiving the final Decision.

Attached is a fact sheet with information about what to do and expect after you receive this decision, and where to get help.

IT IS SO ORDERED on this day August 25, 2025.

Original signed by:
KATIE HORNBERGER for Director PETE CERVINKA
Ombudsperson