2010-15

The Commonwealth of Massachusetts
Executive Office of Health & Human Services
Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118-2439

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Lieutenant Governor

JudyAnn Bigby, M.D.
Secretary

Elin M. Howe
Commissioner

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2010

MA

Re: Appeal of - Final Decision

Dear :

Enclosed please find the recommended decision of the hearing officer in the above appeal. A fair hearing was held on the appeal of your eligibility determination.

The hearing officer made findings of fact, proposed conclusions of law and a recommended decision. After reviewing the hearing officer's recommended decision, I find that it is in accordance with the law and with DDS regulations. Your appeal is therefore DENIED.

You, or any person aggrieved by this decision may appeal to the Superior Court in accordance with Massachusetts General Laws, Chapter 30A. The regulations governing the appeal process are 115 CMR 6.30-6.34 and 801 CMR 1.01-1.04.

Sincerely,

Elin M. Howe
Commissioner

EMH/ecw
cc: Jeanne Adamo, Hearing Officer
Amanda Chalmers, Regional Director
Marianne Meacham, General Counsel
Barbara Green Whitbeck, Assistant General Counsel
Paula Potvin, Regional Eligibility Manager
Patricia Shook, Psychologist

Sean Dugan, DCF
Victor Hernandez, DDS
File

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES

In Re: Appeal of [redacted]

This decision is issued pursuant to the regulations of the Department of Developmental Services 115 CMR 6.30 – 6.34 (formerly known as Department of Mental Retardation, hereinafter referred to as "DDS" or "Department") and M.G.L. c. 30A. A fair hearing was held on [redacted], 2010 at the [redacted] in [redacted], Massachusetts.

Those present at the hearing were:

[redacted]	Appellant
Sean Dugan	DCF Social Worker
[redacted]	Clinical Coordinator [redacted]
Barbara Green Whitbeck, Esq.	Counsel for DDS
Patricia Shook. Ph. D.	Licensed Psychologist
Paula Potvin	Observer, DDS Eligibility Manager

The Fair Hearing proceeded under the informal rules concerning evidence with approximately one and one-half hours of testimony presented. The Appellant's evidence consists of sworn oral testimony from [redacted], the Appellant's Social Worker, and [redacted], the Appellant's Clinical Coordinator. The evidence presented on behalf of the Department consists of fourteen exhibits and sworn oral testimony from Dr. Patricia Shook, DDS's Licensed Psychologist.

At the close of the fair hearing, the Appellant requested and was granted an additional three weeks time, [redacted] to submit further evidence in this matter, and the Department was allowed until [redacted] to review and respond. No additional evidence was forthcoming; the record was closed on [redacted], 2010.

ISSUE PRESENTED:

Whether the Appellant is eligible for DDS services by reason of Mental Retardation as defined in 115 CMR 6.04(1)

BACKGROUND:

The Appellant, Mr. [redacted], is a nineteen year old male who is under the care of the Department of Children and Families, currently living in a foster home administered through [redacted]. The Appellant is not currently under legal guardianship.

The Appellant does not have an immediate nuclear family. Prior to receiving supportive services from DCF, the Appellant lived with a great aunt related through marriage from age four through age fourteen until the Appellant could not longer be managed by his aunt. The Appellant has received Special Education services through the public school system and technical instruction at the [redacted], where he received training to help him gain employable skills. The Appellant has a lengthy history of behavioral, emotional, and cognitive difficulties and has been hospitalized several times for auditory hallucinations, threats of self-harm and harming/killing animals. The Appellant's mental health difficulties have been treated in outpatient counseling as well as through inpatient psychiatric hospitalizations.

The Appellant applied for DDS adult services on [redacted], 2009 and was found to be ineligible based on a failure to meet the criteria for a diagnosis of Mental Retardation as defined in 115 CMR 2.01. An appeal of the denial of services was submitted and an Informal Conference was held on [redacted] 2009, at which time the Appellant's ineligibility ruling was upheld. The Appellant appealed that decision and a Fair Hearing was held on [redacted], 2010. The Appellant was present at the hearing along with his DCF Social worker and Clinical Coordinator from [redacted]. Mr. Sean Dugan, DCF Social Worker, served as the Appellant's authorized representative.

SUMMARY OF THE EVIDENCE PRESENTED:

EXHIBITS:

The Department submitted the following exhibits which were accepted into evidence:

DDS Exhibit #1
Curriculum Vita of Patricia Shook, Ph. D.

DDS Exhibit #2
Excerpts from 115 CMR 6.04 General Eligibility

DDS Exhibit #3
Excerpts from 115 CMR 2.01 Definitions

DDS Exhibit #4
DDS Adult Eligibility Determination for [redacted], dated [redacted], 2009.

DDS Exhibit #5
Department's Eligibility Determination Notification, denying eligibility to [redacted], signed by Veronica Wolfe, dated [redacted], 2009.

DDS Exhibit #6

Letter to Ms. Amanda Chalmers, Northeast Regional Director, from Sean Dugan, DCF Social Worker, requesting an appeal of the Department's finding of ineligibility, received by DDS on [redacted] 2009.

DDS Exhibit #7

DDS's Decision Letter re: Informal Conference for [redacted], signed by Veronica Wolfe, Regional Eligibility Manager, dated [redacted] 2009.

DDS Exhibit #8

DDS's Fair Hearing Schedule Notice, dated [redacted] 2009, sent from Elisabete Wolfgang, Hearing Administrator, to [redacted].

DDS Exhibit #9

Psycho-Educational Assessment of the Appellant at the Appellant's age of 12 years, with the results of a W-J III and other evaluations, conducted by [redacted], School Psychologist, dated [redacted] 2002.

DDS Exhibit #10

Psychological Assessment of the Appellant at the Appellant's age of 11 years, with the results of a WISC III and other evaluations, conducted by [redacted], Ed. D.; the report is undated as the first page of the report is not present.

DDS Exhibit #11

Neuropsychological Evaluation Report by [redacted], Ph. D., with results of a WAIS-III and other evaluations, administered to the Appellant on [redacted], 2008 at the Appellants age of 17 years, [redacted].

DDS Exhibit #12

Psychological Examination Report by [redacted], Psy. D., with results of a WAIS-III and other evaluations, administered on [redacted] 2009 at the Appellants age of 18 years, [redacted].

DDS Exhibit #13

One page written explanation with three corroborating documents outlining the technical error made by Dr. [redacted] in calculating the scores of the WAIS-III reported in DDS Exhibit #11; the one page explanation is signed by Dr. Patricia Shook and dated [redacted] 2010.

DDS Exhibit #14

Table B.1 of the WAIS-III technical manual regarding Statistical Significance.

No exhibits were submitted by the Appellant.

OPENING STATEMENTS:

Appellant's Opening Statement:
The Appellant's DCF Social Worker, Mr. Sean Dugan, spoke on behalf of the Appellant. Mr. Dugan stated that the Appellant is not currently under guardianship but that guardianship is being sought; there has been a paper work problem but that problem has been addressed and guardianship should be in place soon. Mr. Dugan stated the Appellant clearly will be in need of services when he ages out of his current program. DMH has reportedly refused services for the Appellant due to his mental retardation. Mr. Sean Dugan stated that he is the Appellant's social worker, and is tying to be proactive in applying for agency services. He has not submitted any documents as exhibits but will be asking for additional time to obtain a document from the Appellant's psychiatrist, Dr. [redacted].

DDS's Opening Statement:
Attorney Barbara Green Whitbeck represented DDS stating that the Department has set the standards by which individuals are determined eligible and the record will show that the finding of ineligibility is consistent with the Department's regulations. Attorney Whitbeck stated that the Department does not dispute the Appellant is in need of services; the evidence in this matter supports a history of psychiatric and emotional difficulties and the need for support in many areas. However, the Department's expert, Dr. Patricia Shook, will testify and will explain why the Appellant does not meet the criteria for sub-average intellectual functioning as required for a finding of eligibility of DDS supports; the evidence shows that the Appellant is not eligible for Department services as he does not meet all requirements for eligibility.

FINDING OF FACTS:

The following facts, which are the basis for conclusions made in this case, emerged from a review of the documents entered into evidence and the testimony presented by witnesses.

1. The Appellant is under the care of the Massachusetts Department of Children and Families (DCF). (Testimony, Mr. Dugan)

2. The Appellant is currently living in [redacted], Massachusetts in Foster Care provided through [redacted]. (Testimony, Mr. Dugan)

3. Appellant is not currently under guardianship but guardianship is being sought and should be in place soon. (Testimony, Mr. Dugan)

4. The Appellant exhibited cognitive difficulties at an early age and was reportedly identified as mentally retarded based on educational evaluations in the first, second and fourth grades that resulted in below average scores in the Mildly Retarded to Borderline range. These early evaluations are not in evidence. (DDS Exhibits #9 & #10)

5. The Appellant has a history of significant behavior problems and problems with anxiety. There have been reported indications of a language based learning disability. The Appellant has received diagnoses that include: Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), Psychotic Disorder Not Otherwise

Specified (NOS), Major Depressive Disorder, and Bipolar Disorder. (DDS Exhibits #4, #9)

6. The Appellant's mental health difficulties have been treated in outpatient counseling as well as through inpatient psychiatric hospitalizations. (DDS Exhibit #12)

7. In order to be eligible for DDS adult services, Department regulations require the person to have significantly sub-average intellectual functioning manifesting before age 18 and existing concurrently and related to significant limitations in adaptive functioning. The specific regulations and definitions are found in 115 CMR 6.04 and 2.01 (DDS Exhibits #2 and #3 & Testimony Dr. Shook).

8. The Department has defined "significantly sub-average intellectual functioning" as an intelligence test score that is indicated by a score of 70 or below as determined from the findings of assessment using valid and comprehensive, individual measures of intelligence that are administered in standardized formats and interpreted by qualified practitioners. The regulations have both a cognitive and an adaptive functioning component; to meet the adaptive functioning component of the regulations a person must have "significant limitations in adaptive functioning" existing concurrently and related to the sub-average intellectual functioning. The regulations require that both components must be present to be eligible for Department services. (Testimony Dr. Shook)

9. The following assessments are in evidence:

EXHIBIT	AGE	DATE	ASSESSMENTS ADMINISTERED
DDS#9	11 years	[redacted] 2002	Differential Ability Scales (DAS) Woodcock-Johnson III (WJIII) selected tests Adaptive Behavior Assessment (ABAS)
DDS#10	11 years	2002	WISC-III
DDS#11	17 years	[redacted] 2008	WAIS III
DDS#12	18 years	[redacted] 2009	WAIS-III- Vineland Adaptive Behavior Scales (VABS)

10. The first cognitive assessment in evidence was administered by [redacted], School Psychologist, at the Appellant's age of eleven years using the Woodcock-Johnson III (WJIII) and the Differential Ability Scales (DAS). (DDS Exhibit #9)

11. Mental Retardation generally exhibits as a flat score; uneven cognitive abilities with clusters in the average range are not generally seen with Mental Retardation. (Dr. [redacted] DDS Exhibit #9 & Testimony Dr. Shook)

12. [redacted], School Psychologist, reported that although the Appellant was identified as being mentally retarded, his test results did not support the identification of Mental Retardation. (DDS Exhibit #9)

13. The second cognitive assessment in evidence was performed by [redacted], Ed. D. and also administered to the Appellant at age eleven years. The exact date is

unknown as the first page of the assessment is missing. (DDS Exhibit #10)

14. Dr. [redacted] notes a 1997 neurological exam by Dr. [redacted] that resulted in a diagnosis of Attachment Disorder. (DDS Exhibit #10)

15. Dr. [redacted] administered a Wechsler Intelligence Scale for Children- Third Edition (WISC-III) to the Appellant at age eleven that resulted in a Full Scale IQ of 73, in the Borderline Range of intelligence. (DDS Exhibit #10)

16. Dr. [redacted] noted that the Appellant's ability to maintain attention had deteriorated when taking the Vocabulary and Comprehension subtests and that this may have had an impact on his poor performance in these areas. (DDS Exhibit #10)

17. Dr. [redacted]'s assessment of the Appellant at age eleven included an evaluation of Attention/Executive Skills. The Appellant fell in the clinical range for attention problems on the Child Behavior Checklist (CBCL) completed by his parents and in the clinical range on the Hyperactivity-Impulsivity subscale of the Teacher Report Form (TRF) completed by his teachers. The Appellant's teachers rated as most problematic the Appellant's difficulty concentrating and sitting still, his restlessness and difficulty following directions, and his distractibility and impulsivity. (DDS Exhibit #10)

18. The third cognitive evaluation in evidence is a WAIS-III administered by Neuropsychologist, [redacted], Ph.D. in 2008 at the Appellant's age of seventeen (DDS Exhibit #11)

19. Dr. [redacted] did not administer all five subtests that comprise the Performance Scale of the WAIS-III; Dr. [redacted] administered four of the five subtests. (DDS Exhibit#11)

20. It is acceptable to administer only four of the five subtests of the Performance Scale in the WAIS-III IQ assessment when the circumstance are such that it is not possible to appropriately administer all five subtests. However, The WAIS-III technical manual instructions must be followed to calculate a valid Performance Scale Score when using only four subtest results. (Dr. Shook Testimony & DDS Exhibit #13a)

21. Dr. [redacted] made an error in calculating the Performance Scale score. Dr. [redacted] left out one step in the process that is required to properly determine a valid score; he failed to use Table A.10 (DDS Exhibit #13b) when calculating the Appellant's Performance Scale score. (Testimony Dr. Shook & DDS Exhibits #11, #13 through #13d)

22. To properly calculate the Performance Scale of the WAIS-III with only four subtests, the psychologist is required to "prorate" the Performance Scale IQ. Prorating instructions are given on page 59 of the WAIS-III technical manual (DDS Exhibit #13a) where it dictates a precise procedure regarding which subtests may be used as alternatives and the manner in which the scores must be calculated. (Dr. Shook Testimony & DDS Exhibit #13a)

23. The prorating procedure of the WAIS-III manual requires that the results of the four subtests are added together, then multiplied by 1.25 and rounded to the nearest whole number, which is then used as the value that must be matched to table of prorated sums

scores (Table A.10 found at DDS Exhibit #13b); this process will result in a prorated score number. This step of using Table A.10 is vital in determining the proper sum value of subtest scores when using four rather than five subtests to calculate a Performance Scale; Dr. [redacted] did not perform this step in the process. The final step in the prorating procedure is to match the prorated score number obtained from Table A.10 (DDS Exhibit #13b) to a table of score equivalents found at Table A.4 (DDS Exhibit #13c) in the WAIS-III technical manual; Dr. [redacted] performed this step but did so using the incorrect number value because he failed to use Table A.10. As a result, the value of the Performance Scale noted by Dr. [redacted] in his evaluation has been inflated and the resulting Full Scale IQ score was similarly impacted; the proper Full Scale IQ score is 72, not 70 as reported. (Testimony Dr. Shook & DDS Exhibits #13 through #13c)

24. Due to the error in calculating a prorated Performance Scale score, the third cognitive evaluation in evidence (WAIS-III administered by Neuropsychologist, [redacted], Ph.D. in 2008) has a reported Full Scale IQ that is wrong; the actual Full Scale IQ score should be 72, in the Borderline Range of intelligence and not 70, which is the high end of Mild Mental Retardation. (Testimony Dr. Shook & DDS Exhibits #11 & #13 through #13c)

25. The fourth cognitive assessment in evidence was administered by [redacted], Psy. D., at the Appellant's age of eighteen using the Wechsler Adult Intelligence Scale- third Edition (WAIS-III) and the Vineland Adaptive Behavior Scales (VABS). Dr. [redacted] reported a Verbal IQ of 64, Performance IQ of 83 and Full Scale IQ of 70, at the top of the Mild Range of Mental Retardation but stated that these results of the WAIS-III administered to the Appellant must be interpreted with caution in that the Verbal IQ of 64 is notably less developed than his Performance IQ of 83. (DDS Exhibit #12)

26. The marked variation between the Appellant's Verbal IQ of 64 and Performance IQ of 83 in the WAIS-III conducted by Dr. [redacted] is statistically significant; when the discrepancy between a Verbal IQ and Performance IQ is statistically significant, a Full Scale IQ score is not considered to be a valid indicator of overall cognition. Therefore, the Full Scale IQ score of 70 noted in the 2009 WAIS-III is not considered a valid indicator of the Appellant's cognition. (Dr. Shook Testimony)

27. The Vineland Adaptive Behavior Scales (VABS) assessment conducted by Dr. [redacted] resulted in a standard which corresponds to an adaptive level of Low compared to the population as a whole and Moderate compared to all persons with Mental Retardation. (Exhibit #12)

28. Dr. Shook is a Ph.D. Licensed Clinical Psychologist with over twenty years of experience in the field of Mental Retardation and has been employed by DDS's [redacted] Region for approximately four and one-half years as the [redacted] Region Eligibility Psychologist. As the [redacted] Region's Eligibility Psychologist, Dr. Shook is responsible for making all determinations regarding eligibility for children and adults applying for Department services through the [redacted] Region. (DDS Exhibit #1)

29. To make a determination regarding eligibility, Dr. Shook looks primarily at comprehensive tests of intellectual functioning, as many as possible, and when IQ is determined to be in the Mild Range of intelligence, she looks at adaptive behavior

assessment results. Dr. Shook also looks at documents related to psychiatric information and how a psychiatric condition may have impacted testing results. (Testimony Dr. Shook)

30. In determining eligibility, Dr. Shook looks for intellectual deficits with a Full Scale IQ of 70 or below; looks at whether the intellectual deficits manifested during the developmental period prior to age 18; looks for adaptive behavior deficits related to cognitive deficits; and, looks at whether the cognitive or adaptive behavior deficits are due to psychiatric illness or other causes unrelated to Mental Retardation. (Testimony Dr. Shook)

31. Dr. Shook has testified that in accordance with Department regulation the Appellant's adaptive functioning test results are not considered until it has been determined that the Appellant meets the Department's cognitive deficit requirement of two standard deviations below the mean. Department eligibility regulations require that Mental Retardation exists concurrently and is related to significant limitations in adaptive functioning. The Department has interpreted their regulation to mean that the first requirement for eligibility is a diagnosis of Mental Retardation and a second requirement is significant limitations in adaptive functioning related to the Mental Retardation. This is the Department's practice since significant limitations in adaptive functioning can be the result of conditions other than Mental Retardation. Significant limitations in adaptive functioning can be caused by mental illness, significant psychological problems, and, or, other medical problems that impede upon an individuals ability to function. Thus a finding of significant limitation in adaptive functioning is considered only after an individual as been determined to meet the cognitive requirement within the definition of Mental Retardation. (Testimony Dr. Shook)

32. Dr. Shook made her determination of ineligibility for the Appellant due to the fact that the Appellant has a pattern of scoring in the Borderline range of intelligence, outside the range of intellectual functioning necessary for a diagnosis of Mental Retardation. In addition, the Appellant displayed a pattern of IQ testing with significant variability which is atypical of Mental Retardation, a pattern of IQ testing that can be associated with an inability to concentrate and other causes unrelated to Mental Retardation. Dr. Shook noted that the Appellant was able to score above the IQ level of Mental Retardation even with the problems he has due to his ADHD and significant mental health issues; ADHD and significant mental health issues impact upon an individual's ability to perform up to ones actual cognitive capacity.

33. Dr. Shook testified that in her clinical opinion, the Appellant is someone who is not Mentally Retarded, but someone whose mental health issues and problems associated with ADHD have impacted his performance on cognitive testing.

RECOMMENDED DECISION:

After a thorough review of all of the evidence, I find that the Appellant has not shown by a preponderance of the evidence that he meets the DDS eligibility criteria. I find that the weight of the evidence shows that the Appellant does not meet the Department's definition of Mental Retardation and therefore is not mentally retarded as that term is used in statute and regulation for the determination of DDS supports as defined in 115 CMR 2.01. My reasons are as follows:

REGULATORY REQUIREMENTS:

Massachusetts General Law c. 123B, section 1, defines a mentally retarded person as "a person who, as a result of inadequately developed or impaired intelligence, as determined by clinical authorities as described in the regulations of the department, is substantially limited in his ability to learn or adapt, as judged by established standards available for the evaluation of a person's ability to function in the community." In accordance with statutory and regulatory authority, the Department has promulgated regulations both defining Mental Retardation (Exhibit #3) and setting regulatory standards by which an individual may be determined eligible for DDS services (Exhibit #2).

In order to be eligible for DDS supports, an individual who is 18 year of age or older must meet the criteria for general eligibility requirements set forth at 115 CMR 6.04 & the definitions set forth at 115 CMR 2.01 as follows:

The General Eligibility requirements for services from the Department of Developmental Services (DDS) are found in 115 CMR 6.04 where it states the following:

> "persons who are 18 years of age or older are eligible for supports provided, purchased, or arranged by the Department if the person:
>
> a) Is domiciled in the Commonwealth; and
> b) Is a person with Mental Retardation as defined in 115 CMR 2.01"

The Department's definition of "Mental Retardation" found in 115 CMR 2.01 with its incorporated definition of "significantly sub-average intellectual functioning" and "significant limitations in adaptive functioning" is stated as follows:

> "Mental retardation means significantly sub-average intellectual functioning existing concurrently and related to significant limitations in adaptive functioning. Mental retardation manifests before age 18."

The Department's definition of "significantly sub-average intellectual functioning" found in 115 CMR 2.01 is stated as follows:

> "...an intelligence test score that is indicated by a score of 70 or below as determined from the findings of assessment using valid and comprehensive, individual measures of intelligence that are administered in standardized formats and interpreted by qualified practitioners."

And, the Department's definition of "significant limitation in adaptive functioning" found in 115 CMR 2.01 requires a test score of 70 to meet the requirement of two standard deviations below the mean or a test score of 77 to meet the requirement 1.5 standard deviations below the mean, and is stated as follows:

"...an overall composite adaptive functioning limitation that is two standard deviations below the mean or adaptive functioning limitations in two out of three domains at 1.5 standard deviations below the mean of the appropriate norming sample determined from the findings of assessment using a comprehensive, standardized measure of adaptive behavior, interpreted by a qualified practitioner. The domains of adaptive functioning that are assessed shall be

a) areas of independent living/practical skills;
b) cognitive, communication, and academic/conceptual skills; and
c) social competence/social skills."

CONCLUSIONS:

- The Appellant has met the domicile requirement for eligibility. The issue in question is whether the Appellant has met his burden of proving by a preponderance of the evidence that he is a person with Mental Retardation as that term us used and defined by the Department of Developmental Services.

- The time of onset is not at issue in this case as the evidence and testimony indicates that the Appellant had been described as mentally retarded during his early childhood years and did receive special education during his developmental period. The question before us is the level of the Appellant's cognitive deficit, specifically if the Appellant is diagnosed with Mild Mental Retardation which must be established by FSIQ at or below 70 that is not the result of other causes unrelated to Mental Retardation.

- The Appellant has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), Psychotic Disorder Not Otherwise Specified (NOS), Major Depressive Disorder, Bipolar Disorder, and there have been reported indications of a language based learning disability. The evidence shows that the Appellant has exhibited significant behavior problems and problems with anxiety. These disorders cause difficulties with maintaining attention; they impact upon ones ability to perform and can result in lower test scores that are not reflective of limited cognition but rather due to problems associated with the Appellant's multiple disorders.

- The following cognitive assessment results are in evidence:

EXHIBIT	DATE	AGE	TEST	OVERALL IQ VALUE	IQ CLASSIFICATION
DDS#9	2002	11	WJ-III (some subtests)	None	"Unevenly developed cognitive ability"
DDS#9	2002	11	DAS	(GCA) 65	"Not best Indicator"
DDS#9	2002	11	ABAS	(GAC) 43 & 78	Highly variable levels of functioning
DDS#10	2002	11	WISC-III	(FS) 73	Borderline Range- (with high variability)
DDS#11	2008	17	WAIS-III	(FS) 72*	Borderline Range – (after technical correction)
DDS#12	2009	18	WAIS-III	(FS) 70	Mild Mental Retardation- (high variability)

*represents the corrected 72 Full Scale value which had been initially reported as Full Scale of 70

- The 2002 WJ-III (DDS Exhibit #9) that was conducted at the Appellant's age of eleven showed significant variability; Mental Retardation typically presents as a global cognitive deficit and not with significant variance in testing results. Variability in testing results

with some scores in the average range of intelligence is atypical for a diagnosis of Mental Retardation. Dr. [redacted], the psychologist administrating the WJ-III and DAS, reported that although the Appellant had been identified as mentally retarded, the results do not support a diagnosis of Mental Retardation. Significant weight was given to this evaluation as an early indication of the Appellant's cognitive ability falling above the level of Mental Retardation.

- The 2002 WISC-III (DDS Exhibit #10) that was also conducted at the Appellant's age of eleven confirmed the presence of significant variability in the Appellant's test scores and a cognitive level of intelligence that is above Mental Retardation; the results placed the Appellant within the Borderline level of intelligence. The Appellant scored above the range of intelligence required for a diagnosis of Mental Retardation even though he became more fidgety and had difficulty holding his attention as the session progressed. Significant weight was given to this evaluation as an indication that although the Appellant's cognitive ability was impacted by his difficulties with attention, nonetheless, he was able to score above the level required for a diagnosis of Mental Retardation.

- The 2008 WAIS-III (DDS Exhibit #11) that was conducted at the Appellant's age of seventeen reported a Full Scale IQ of 70 and, Dr. [redacted], the psychologist who conducted the WAIS-III, reported that the Appellant was functioning in Borderline to Mildly impaired ranges of intellectual ability overall. However, the Full Scale IQ of 70 has been shown to be an error in calculation; the true Full Scale IQ, when calculated in accordance with the WAIS-III technical requirements, results in a Full Scale IQ of 72. A Full Scale IQ of 72 falls in the Borderline Range of intelligence, above the level required for a diagnosis of Mental Retardation. No weight was given to Dr. [redacted]'s assessment that the Appellant's Full Scale IQ was scored at 70; weight was given to the corrected Full Scale IQ score of 72.

- The 2009 WAIS-III (DDS Exhibit #12) that was conducted at the Appellant's age of eighteen reported a Full Scale IQ of 70. However, little weight was given to the Full Scale IQ score of 70 reported in this evaluation, as Dr. [redacted], the licensed psychologist conducting the test, also reported that "caution should be used in interpreting the results". Dr. [redacted] reported the need for caution in interpreting the Full Scale score because the 64 Verbal IQ score and the 83 Performance IQ score, which were used to calculate the Full Scale IQ, represents a significant variance. When the variance is determined to be "significant", the resulting Full Scale IQ calculation is not considered a valid indication of overall intelligence.

- In order to obtain credit on cognitive tests, an individual must give the proper information or perform the requested task. The Appellant would not score out of the range of Mental Retardation if he did not have the cognitive capacity to do so. On the other hand, the Appellant may perform poorer on a test due to multiple reasons, such as an inability to attend to task and other difficulties associated with the Appellant's ADHD and mental illness. The Appellant scored in the Borderline Range of cognition, above the level required for a diagnosis of Mental Retardation, on all but one of the IQ tests in evidence. The one IQ test that resulted in a score that fell at the level required for a diagnosis of Mental Retardation was calculated using a Verbal score and a Performance score that showed significant variability; when significant variability is present, the Full Scale score is not a valid indicator of overall intelligence. With this type of variability, other causative factors that could possible mitigate the test results must be carefully considered. In the Appellant's situation, his ADHD and mental illness more likely than

not negatively impacted upon his performance.

- While the Appellant's adaptive function test results did not rule out a possible diagnosis of Mental Retardation, regulations do not allow eligibility to be determined based on adaptive functioning alone; adaptive functioning deficits can be result of conditions other than Mental Retardation. Significant limitations in adaptive functioning can be caused by mental illness and other medical problems that impede upon an individuals ability to function. A person very well could be functioning in the range of Mental Retardation but unless it is demonstrated through valid IQ test results that the cause of the significant adaptive deficits is due to Mental Retardation, eligibility for DDS services is not allowed. In the Appellant's case, there is evidence of significant mental disabilities that could impede upon his ability to function. Therefore the results of the Appellant's adaptive functioning tests are not a consideration in this matter.

In summary, upon a comprehensive review of the oral testimony and documentary evidence submitted in this matter, I find that the Appellant has not met the burden of proof in this matter and has not demonstrated by a preponderance of the evidence that he meets the Department's definition of Mental Retardation. The preponderance of the evidence points to an overall cognitive ability falling above the range required for eligibility of DDS services. A finding of DDS eligibility cannot be made without an overall cognitive ability in the range indicated by a valid FSIQ score of 70 or below. As the Appellant has not met the burden of proof in this matter, I cannot find for the Appellant. I further find that the evidence presented by DDS supports a finding that DDS followed established standards and procedures in considering the Appellant's eligibility. Therefore, DDS's determination of ineligibly is upheld.

APPEAL:

Any person aggrieved by a final decision of the Department may appeal to the Superior Court in accordance with M.G.L.c.30A [115CMR 6.34(5)]

Date:_____

_____

Jeanne Adamo
Hearing Officer