UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION	:	No. 2:12-md-02323-AB MDL No. 2323
THIS DOCUMENT RELATES TO: APPEAL OF SETTLEMENT CLASS MEMBER [redacted] REGARDING DENIAL OF REPRESENTATIVE CLAIMANT AWARD	:	**Hon. Anita B. Brody**

INTRODUCTION

This Claim has a lengthy and complex procedural history. In brief summary, in 2017, [redacted], a Retired NFL Football Player and Class Member, filed a Claim for benefits based upon a 2016 pre-Effective Date Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. That Claim was denied in 2018. Mr. [redacted] died shortly after the Notice of Denial issued, though his executrix and spouse, [redacted], asserts that Mr. [redacted] counsel failed to duly notify her. She soon filed a second Claim, pro se, for an award based on an asserted Qualifying Diagnosis of Death with CTE. That diagnosis too was denied, because it was out of time under the Settlement. Ms. [redacted] then was granted leave to (very) belatedly appeal the first Claim's denial.

Because Ms. [redacted] has not satisfied her burden of demonstrating that the Claims Administrator's original decision was clearly erroneous, the Appeal is denied.

FACTUAL AND PROCEDURAL BACKGROUND

While living, Mr. [redacted] submitted a Claim for a Pre-Effective Date Diagnosis of Level 1.5 Neurocognitive Impairment on April 6, 2017. Doc. 54366. That Diagnosis resulted from an examination performed on September 1, 2016, by neurologist Dr. [redacted] and supported by neuropsychologist Dr. [redacted]. Doc. 54103; Doc. 54104. The Claim was amended, though asserting the same Diagnosis, on November 22, 2017. Doc. 144783.

The Claim was reviewed by an AAP Consultant, who recommended denial. Doc. 227839. On April 4, 2018, the Claims Administrator adopted the AAP's analysis, writing:

The Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment was not made in a manner generally consistent with the settlement criteria.

Specifically, the mental status examination performed by the diagnosing physician describes an individual who is fully awake, alert, oriented x 3, with speech that is clear and fluent, appropriate behavior, and an MMSE score of 29/30 (missing only one point for delayed recall) and which is not consistent with either a severe decline in cognitive function, the presence of dementia, and/or a Level 1.5 Neurocognitive Impairment diagnosis. Particularly important is the MMSE score of 29/30, missing only one point on delayed recall, since this is not at all consistent with the Level 2.0 impairment assigned by the neuropsychological testing for the cognitive domain of Learning/Memory and strongly suggests the true functional abilities for Learning/Memory may be much greater than as reported on the neuropsychological testing results.

Additionally, the neuropsychological testing performed by Dr. [redacted] on 8/31/2016 is also not generally consistent with the settlement criteria for Level 1.5 Neurocognitive Impairment. Specifically, the behavioral observations describe an individual who arrived early for his appointment, was unaccompanied, dressed neatly, with no hygiene or grooming problems, oriented to person, place, and time, with a pleasant affect and a sense of humor, who was described as cooperative, polite, and charmingly courteous, and he was noted to have good comprehension of test instructions, with attention and concentration that were adequate for testing.

Review of the neuropsychological testing results suggests that full effort for performing well on the cognitive tests was not present, including borderline to failing scores on three of five BAP-recommended measures of performance validity (Reliable Digit Span, WAIS-IV Logical Memory Recognition, and WMS-IV Verbal Paired-Associate Recognition) and poor performance on the Booklet Category Test suggesting intentional under-performance. Additionally, the results contained many more variables derived from the same cognitive tests than would occur with the Settlement Battery, including redundant/overlapping variables, which can artificially increase the chances of finding low scores. Also, regarding the performance in the Visual-Perceptual domain, the impairment criteria were not met when considering the three Program-recommended scores, indicating a lack of true impairment in this cognitive domain.

Performance on the MMPI-2-RF also strongly suggested exaggeration of symptoms and non-credible memory complaints.

Doc. 165417 (paragraph breaks added).

Mr. [redacted] did not timely appeal this denial (by May 4, 2018). *Id.* On May 12, 2018, Mr. [redacted] died. Ms. [redacted] as his duly authorized Representative Claimant, then filed a second claim pro se. That second Claim—filed July 17, 2019—was for Death with CTE, based on a Diagnosis made in April of 2019. Doc. 211218; Doc. 211612. That second Claim was denied on July 29, 2019, because Section 6.3(f) of the Settlement Agreement permits CTE claims only for Players who died before the Final Approval Date—April 22, 2015. Ms. [redacted] did not appeal that second denial.

Now armed with new counsel, in December 2019, Ms. [redacted] requested permission to (a) appeal the April 2018 denial of the Level 1.5 Claim, nearly two years late; or (b) "refile" that first claim with additional information, which "support[ed] the veracity of the original 1.5 Neurocognitive Impairment Diagnosis and an Alzheimer's Disease Diagnosis provided in April 2017 that was never submitted." Doc. 218912. (Presumably that latter request would amount to a new Pre-Effective Date filing, though the deadline for filing such claims had passed in February 2019.) [1]

Special Master Pritchett granted Ms. [redacted] leave to appeal the Level 1.5 Claim.

The Claims Administrator struck Ms. [redacted] first appellate brief because it did not conform to Special Master Pritchett's order. Her revised Appeal, filed on May 27, 2020, and supported by briefing docketed on June 19, 2020, is the subject of this Opinion. Doc. 224786; Doc. 225772.

DISCUSSION

Ms. [redacted] has the burden of showing that the Claims Administrator clearly erred in denying Mr. [redacted] September 1, 2016 Pre-Effective Date Level 1.5 Impairment Diagnosis. While Ms. [redacted] counsel spends some time on that question—as I will discuss below—unfortunately some of the Appeal has a different import. In the briefing, her counsel argues:

> Evidence provided in this Appeal shows beyond any doubt that Mr. [redacted] suffered from Alzheimer's Disease (AD) by April 2017. The AD diagnosis was made by neurologist Dr. [redacted] when the player was living, but was never submitted to the Claims Administration Portal. AD does not appear overnight, so this later diagnosis corroborates the memory decline seen by neuropsychologist Dr. [redacted] and neurologist Dr. [redacted] in September 2016. In addition, Mr. [redacted] impairment was also confirmed after death by a brain autopsy showing AD, Parkinson's Disease, and Stage IV CTE.

Doc. 225772 (footnote omitted).

[1] Four days after the first Claim's filing, on April 10, 2017, in a separate evaluation, Dr. [redacted] diagnosed Mr. [redacted] with Alzheimer's Disease. Doc. 225772. That Diagnosis was not submitted to the Claims Administrator and consequently has not been evaluated by the Settlement Program's experts.

This argument rests on an implicit chain of logic: because Mr. [redacted] (allegedly) suffered Alzheimer's Disease by April 2017, and Stage IV CTE by May 2018, he must (therefore) have been eligible for a Level 1.5 Diagnosis as of September 2016. Because "the AAP never possessed what the Court and Claims Administration now possess" it made an error. The "autopsy also corroborates the Level 1.5 impairment diagnosed by Dr. [redacted] in September 2016." Thus, in closing, Ms. [redacted] seeks not only that I "overturn the AAP's denial of her husband's Level 1.5 diagnosis," but that I also "(1) correct the diagnosis to one of AD as of April 2017, which reflects the more critical impairment diagnosed by Dr. [redacted] while the patient was alive (confirmed by the autopsy); or (2) remand the claim to the AAP to consider the totality of the medical records."

Ms. [redacted] prayer for relief was not contemplated by Special Master Pritchett's decision to permit this out-of-time Appeal. Nor is it a permissible ground of appeal that the claimant should have been awarded a different Diagnosis based on evidence that was not before the Claims Administrator.[2] But even if these procedural obstacles were not dispositive, Ms. [redacted] theory rests on a mistaken premise about the relationship between the various Diagnoses under the Settlement Agreement.

In a clinical sense, Alzheimer's disease is a type of dementia. However, the Settlement's criteria for Alzheimer's disease and those for 1.5 Neurocognitive Impairment have very different technical specifications. As a member of our AAP Leadership Council explained in response to my inquiry:

> The DSM-5 criteria for Major Neurocognitive Disorder due to Alzheimer′s disease, for instance, indicates that for the ″probable″ Alzheimer′s disease designation there must either be evidence of a causative Alzheimer′s disease genetic mutation or all three of the following must be present: 1) clear evidence of decline in memory and learning and at least one other cognitive domain based on detailed history or serial neuropsychological testing, 2) steadily progressive, gradual decline in cognition without extended plateaus, and 3) no evidence of a mixed etiology (i.e. absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to the cognitive decline).
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> The requirement of a clear decline in memory and learning and at least one other cognitive domain is important because this would prevent the diagnosis of Alzheimer′s disease from being made in cognitively normal individuals. The DSM criteria goes on to specify that evidence of major neurocognitive disorder can be

[2] Appeal Rule 3(a) states that Appeals result from an "Appealable Notice." Appeal Rule 3(d) defines Appealable Notice as "a notice issued by the Claims Administrator announcing its final determination on a Claim." Appeal Rule 11(c) allows the appellant to submit a statement "setting forth the arguments of the Appellant on the issue(s) appealed" and limits citations to evidence before the Claims Administrator. Appeal Rule 23 again emphasizes that the record and evidence on Appeal is limited to what was before the Claims Administrator.

based on either detailed history information or serial neuropsychological testing results.

This is important because of the "or" which effectively separates the diagnostic requirements for Alzheimer's disease from the Settlement Criteria for the diagnosis of Level 1.5 Neurocognitive Impairment which requires very specific levels of cognitive decline according to neuropsychological testing. The next part of the DSM-5 criteria for Alzheimer's disease separates off cases in which there is a clear indication that the cognitive decline could be caused by another etiology, such as clinical evidence in the form of extended plateaus in the decline or identification of mixed etiologies like the presence of stroke or another neurodegenerative disease. This is also important since the Settlement Criteria for Level 1.5 Neurocognitive Impairment are not limited by or restricted according to the causative etiology (except that the cognitive deficits do not occur exclusively in the context of a delirium, acute substance abuse, or as a result of medication side effects) and consequently mixed etiology cases could qualify under Level 1.5 Neurocognitive Impairment while they would be excluded from a diagnosis of Alzheimer's disease. In contrast, the Settlement Criteria for Level 1.5 Neurocognitive Impairment requires documentation that is much more precise than is included in the Alzheimer's disease diagnosis, including 1) concern of the Retired NFL Football Player, a knowledgeable informant, or the Qualified BAP provider for a severe decline in cognitive function, 2) evidence of a moderate to severe cognitive decline from a previous level of performance, as determined by and in accordance with the standardized neuropsychological testing protocol annexed in Exhibit 2 to the Settlement Agreement, and 3) exhibition of functional impairment generally consistent with the criteria set forth in the National Alzheimer's Coordinating Center's Clinical Dementia Rating (CDR) scale Category 1.0 (Mild) in the areas of Community Affairs, Home/Hobbies, and Personal Care.

So while the presence of dementia is necessary for both diagnoses, in and of itself it is not sufficient for either of the diagnoses. Consequently, not everyone who meets criteria for Alzheimer's disease will meet the specific requirements for Level 1.5 Neurocognitive Impairment according to the Settlement Criteria and vice versa, even though everyone who meets the criteria for either of the disorders will necessarily have dementia.

As this analysis clarifies, evidence of Alzheimer's disease is not itself indicative of an earlier Diagnosis of Level 1.5 Neurocognitive Impairment under the Settlement. Nor (for similar reasons) would a postmortem Diagnosis of CTE necessarily prove that the player earlier would have satisfied the criteria for a Level 1.5 or Level 2.0 Diagnosis under the Settlement. Because the Settlement has procedures in place for each independent Diagnosis that require distinct proof, it is a mistake to think of the various Diagnoses as an interlocked set of Venn diagrams. Contemporaneous proof of each listed Claim must be evaluated on its own terms, paying attention to the actual evidence before the diagnosing physician and the Claims Administrator.

Given those limitations, the major premise of Ms. [redacted] Appeal of the April 2018 denial of Mr. [redacted] 2017 Claim falls short. The later Diagnoses, even were they proven, do not establish an entitlement to an earlier Level 1.5 Diagnosis.

Apart from this line of reasoning, the briefing makes several additional arguments to satisfy Ms. [redacted] burden of showing that Claims Administrator was clearly wrong.

First, the Appeal states that the denial rests on the MMSE, and that it "makes no sense, and is clear error, to permit the MMSE score to overrule and supercede the extensive and thorough neuropsychological test results." Doc. 225772. However, the Parties have agreed that "cognitive screening tests and evaluations can be used as part of neurological examinations by BAP Providers or MAF Physician," though, as I have previously written, a "denial that turned entirely or substantially on the MMSE screening test would be clearly erroneous."[3] The denial neither turned entirely nor substantially on the screening test. Rather, it was a piece of evidence which (appropriately) tended to prove that Mr. [redacted] "true functional abilities for Learning/Memory may be much greater than as reported on the neuropsychological testing results." Doc. 165417.

Second, the Appeal states that the AAP failed to adequately evaluate Mr. [redacted] performance on validity measures. In particular, Ms. [redacted] argues that the "AAP was also mistaken to rely on the MMPI-2-RF as a validity measurement. The Settlement clearly notes that the MMPI-2-RF is a mental health examination and is not intended as a validity measure." Doc. 225772. But, as I recently explained:

> It is true that the MMPI-2-RF is not a performance validity test. Instead, rather than treating the MMPI-2-RF as a quantitative basis for detecting invalidity, the AAP Consultant and Reviewers alike considered the qualitative significance of [a claimant's] MMPI profile—specifically, as a measure of self-reported functioning. Slick criteria 8 and 9 require the clinician to evaluate whether the patient's self-reported symptoms comport with known patterns of brain functioning (8) and behavioral observations (9). Thus, consideration of MMPI-2-RF results and validity measures within the context of overall performance validity is consistent with the language and intent of the Settlement. An invalid MMPI-2-RF profile standing alone would not invalidate a neuropsychological test profile.[4]

The AAP's analysis (and the denial itself) comports with these guidelines. The MMPI-2-RF "strongly suggested exaggeration of symptoms and non-credible memory complaints." Doc. 165417. As the underlying AAP Consultant's analysis points out, "[o]f the MMPI-2-RF scores reported, the patient's highest T-scores (>99th percentile) are on (in)validity scales. i. RBS T=88, indicating non-credible memory complaints ii. F-r T=83, indicating many very infrequent

[3] *Special Master Decision Regarding Clinical Judgment on Generally Consistent Standard* 2 (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_judgment_sm.pdf.

[4] *Special Master Decision on Validity Testing and Cause of Functional Impairment* 6 (Aug. 19, 2020) https://www.nflconcussionsettlement.com/Docs/testing_impairment_sm.pdf.

responses." Doc. 227839. And, just as with the MMSE, the Claims Administrator did not make the MMPI the sole ground for denying Mr. [redacted] Claim.

Third, the Appeal argues that:

> The AAP made a clear mistake when it stated that Mr. [redacted] had a "borderline to failing" score on three of the validity metrics. One score was borderline, but not failing, and two scores are plainly within the normal range. *See* [Doc. 54104, Dr. [redacted] report] at 5 ("7 is considered adequate" on the digit span, and "above the 75th percentile" is more than adequate on the Visual Paired Associates II Recognition). The Logical Memory II Recognition test "ranged to within normal limits and was negatively affected by his impairments in verbal memory."

Doc. 225772. This argument merely repeats Dr. [redacted] findings, and does not illuminate. The AAP Consultant, empowered by the Settlement to advise on questions related to neuropsychological testing, concluded that "the player obtained borderline-to-failing scores on three of the five BAP-recommended measures of performance validity administered. i. Reliable Digit Span ii. WAIS-IV Logical Memory Recognition iii. WMS-IV Verbal Paired-Associate Recognition. The patient's score of 81 errors on the Booklet Category Test is also highly suspicious for lack of effort or intentional under-performance." Doc. 227839. Nothing in the Appeal indicates that this conclusion was clearly wrong.

Finally, the Appeal protests the denial's discussion of Mr. [redacted] CDR score of 1 in all domains. The denial (and the AAP report) were concerned with the discrepancy between that asserted disability and the clinician's contemporaneous observation of "an individual who arrived early for his appointment, was unaccompanied, dressed neatly, with no hygiene or grooming problems, oriented to person, place, and time, with a pleasant affect and a sense of humor, who was described as cooperative, polite, and charmingly courteous, and he was noted to have good comprehension of test instructions." Doc. 165417.

According to the Appeal, it was clear error to note this inconsistency as a part of the denial, because "the ultimate determination of the sufficiency of the evidence" must be left to the diagnosing physician. Doc. 225772. But that is not what the Settlement Agreement states. Rather, to recover for a Pre-Effective Date Diagnosis, the Player must come forward with evidence generally consistent with each of the criteria listed in Exhibit 1. For functional impairment, the Settlement provides: "Such functional impairment shall be corroborated by documentary evidence (e.g., medical records, employment records), the sufficiency of which will be determined by the physician making the Qualifying Diagnosis."[5]

That the diagnosing physician can exercise judgment in determining the sufficiency of the documentary record's *corroboration* of functional impairment is not the same as saying that he or she ultimately has plenary authority to determine the player's functional impairment. The Settlement Agreement does not confer such unreviewable authority to diagnosing physicians.

[5] Settlement Agreement, Exhibit 1(1)(a)(iii).

Indeed, in cases like these—Pre-Effective Date Diagnoses by non-MAF physicians (like Drs. [redacted] and [redacted]—it explicitly mandates an independent AAP Review).[6]

The Claims Administrator, in other words, was within its authority to note the discrepancy between Mr. [redacted] self-presentation and functioning with his neuropsychological test scores.

Conclusion

As Ms. [redacted] has not established that the Claims Administrator clearly erred in denying Mr. [redacted] premortem Level 1.5 Neurocognitive Impairment Diagnosis, this Appeal is denied.

Date: September 5, 2020

David A. Hoffman, Special Master

[6] Section 6.4(b) of the Settlement Agreement provides: "The Appeals Advisory Panel member shall review the Qualifying Diagnosis based on principles generally consistent with the diagnostic criteria set forth in Exhibit 1 (Injury Definitions), including consideration of, without limitation, the qualifications of the diagnosing physician, the supporting medical records and the year and state of medicine in which the Qualifying Diagnosis was made."