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 **Hon. Anita B. Brody**
THIS DOCUMENT RELATES TO: APPEAL OF SETTLEMENT CLASS MEMBER [redacted] REGARDING DENIAL OF MONETARY AWARD	

INTRODUCTION

[redacted], a Retired NFL Football Player and Class Member under the Amended Class Action Settlement Agreement, filed a Claim for benefits based on a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. The Claims Administrator denied the Claim. Since Mr. [redacted] has not presented clear and convincing evidence that the Claims Administrator was wrong, the Appeal is denied.[1]

PROCEDURAL HISTORY

In January 2018, [redacted] submitted a Claim for Level 2 Neurocognitive Impairment. Doc. 152909. Dr. [redacted] provided Mr. [redacted] with a neuropsychological assessment on August 10, 2017, and then-MAF neurologist Dr. [redacted] certified the Diagnosis on December 20 of that year. *Id.*; Doc. 152856; Doc. 152855.

An audit followed, focusing on the practices of seven neuropsychologists. As I described in a recent Opinion, the investigation resulted in the disqualification of neuropsychologist Dr. [redacted] and further AAP review of Dr. [redacted] records.[2] The Claims Administrator finished

[1] *See In re Fosamax Alendronate Sodium Prods. Liab. Litig.*, 852 F.3d 268, 285-86 (3d Cir. 2017) ("Black's Law Dictionary defines clear and convincing evidence as 'evidence indicating that the thing to be proved is highly probable or reasonably certain.'").

[2] *See* Special Master Opinion on Validity Testing and Functional Impairment (Feb. 16, 2021), https://www.nflconcussionsettlement.com/Docs/validity_testing_3_sm.pdf; Claims Administrator's Rule 19 Summary Audit Report: Neuropsychological Doctors Using a Common Medical Record Template 1 (Mar. 27, 2018).

auditing Dr. [redacted] in January 2019 and Mr. [redacted] Claim emerged from audit without an adverse finding. Pursuant to the Special Masters' decision in a related Audit, in October 2019, an AAP Consultant reviewed and recommend denial of the Claim, and the Claims Administrator did so in January 2020. Doc. 219560. The Notice of Denial states:

> There is documentation of concern for cognitive decline, including report of memory problems for 20 years, progression of memory problems over 10 years, severe deterioration of memory problems over one year, as well as being anxious, irritable, and depressed. However, the Player's functional abilities indicate a higher level of functioning than would be generally consistent with the Settlement criteria for Level 2 Neurocognitive Impairment. These activities include continuing to be able to work and drive, being able to shop online, and only needing prompting (rather than actual assistance) for Personal Care activities like dressing, showering, and eating. Additionally, there is no mention of the Player needing to be accompanied to the evaluations, which also suggests a higher level of functioning.
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> The neuropsychological testing performed by Dr. [redacted] on 7/29/2017 does not support a Level 2 Neurocognitive Impairment diagnosis. Issues include discrepancies between the neuropsychological performance and reported history, such as the Player being able to travel from his home in Georgia to California for the evaluations, without mention of needing to be accompanied, being able to drive, his ability to provide clear histories during the evaluations, and being described as having normal speech and language functioning, which is not consistent with the Level 2 impairment identified in the Language domain. The score on the BDAE Complex Ideational Material test represents chance performance, and there were scores above the 99.9th percentile on three validity scales in the MMPI-2-RF, indicating gross over-reporting by the Player. Lastly, Dr. [redacted] concluded the Player had mild neurocognitive disorder, which is a condition less severe than dementia. Based on the above, the diagnosis made by Dr. [redacted] is not generally consistent with the Settlement criteria for the Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

Having asked for, and been granted, an extended time to file an appeal, Mr. [redacted] did so in June 2020. Doc. 225784. Class counsel filed a supportive brief, and counsel for the NFL and Mr. [redacted] both responded. After those briefs were ripe for review, the Claims Administrator inquired about Mr. [redacted] functional impairment, to which he responded. Doc. 230049; Doc. 230313; Doc. 230884. I then asked for additional AAP Review, which followed in the form of a report from a member of the AAP, who wrote memoranda both before (Doc. 231441) and after (Doc. 233546) a Consultant provided input (Doc. 232436).

DISCUSSION

The briefing and reports in this case are extensive, and sometimes indignant, but the live issues on appeal are simple. The Denial rests on two grounds: retained functional impairment that

"indicate[s] a higher level of functioning than would be generally consistent with the Settlement criteria for Level 2 Neurocognitive Impairment," and invalid neuropsychological testing. The Claims Administrator found that Mr. [redacted] medical records did not support his Diagnosis on both grounds. It was his burden to come forward to show clear and convincing evidence of error in that judgment.

To receive a Qualifying Diagnosis of Level 2 Neurocognitive Impairment, the Settlement Agreement requires evidence of functional impairment generally consistent with a CDR rating of 2 in Community Affairs, Home & Hobbies, and Personal Care. The Denial noted inconsistent functional abilities for each of these areas: Mr. [redacted] continued ability to work, shop (online), needing only prompting in personal care, and a *lack* of evidence that he needed help to arrive at his evaluations. Mr. [redacted] counsel submitted an email from Mr. [redacted] to establish his dependency on this last ground, which I agree satisfies his burden on appeal. Mr. [redacted] counsel also points to a Third-Party Affidavit which states that Mr. [redacted] "needs substantial assistance getting dressed" does not cook, and "no longer eats on a regular basis." This, along a contextualized understanding of his work and driving, at least arguably supports an overall CDR score of 1, though not 2.

But the AAP Reviewer, reading the file on Appeal, was critical of the processes by which Mr. [redacted] clinicians reached their judgments. Dr. [redacted] did not offer CDR domain scores with justification in the three categories, but rather a composite rating. And, significantly, neither Dr. [redacted] nor Dr. [redacted] interviewed a person knowledgeable with Mr. [redacted] situation, such as a spouse or a caregiver. The absence of that structured conversation created a fundamental gap in Mr. [redacted] diagnostic records. As the AAP Reviewer explains:

> The Appeal fails to consider the proper conduct of the CDR as clearly defined in publications and on-line by Washington University. In this case, the CDR was based on interviews of the Player alone and reading of a third party affidavit. According to the official instructions from Washington University on how to score the CDR[…,] "[t]he necessary information to make each rating is obtained through a semi-structured interview of the patient and a reliable informant or collateral source (e.g., family member)." In this case, no such interview was conducted that would could have enabled the physician to clarify and justify his CDR ratings and minimize the discrepant interpretations of the functional level of the Player that arose between the MAF examiners and the AAP and AAPC. Overall, the absence of a reliable informant interview for determining the CDR prevents me from concluding either Level 1.5 or Level 2 Neurocognitive Impairment according the Concussion Settlement Injury Definition in section iii.
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> According to the official instructions from Washington University on how to score the CDR, it should also be noted that impairment is rated "as decline from the person's usual level due to cognitive loss alone, not impairment due to other factors, such as physical handicap or depression." In this case there was severe untreated depression with suicidal ideation and psychosis with hallucinations clearly documented and diagnosed by the neuropsychologist, as well as a statement

> in the affidavit that at least some of the Player's behavioral changes were due to depression, yet the diagnosing physician failed to consider this in making his determination of CDR 2 and Level 2 Neurocognitive Impairment. It is reasonable to think that the Player would be socially withdrawing and having difficulties at work if he was so depressed that he was actively thinking of suicide and hearing voices telling him to kill himself. In situations such as this, where potentially reversible factors like depression are identified, good clinical practice dictates a course of effective treatment for such reversible factors followed by neuropsychological reassessment. If the player is retested in the future, I agree with both MAF examiners that treatment of his major depression disorder is recommended during the interim, then a reliable CDR determination may be possible based upon assessment of the degree of functional change that is due to cognitive impairment alone rather than depression.

Doc. 231441. As this explanation clarifies, interviewing both the player and a knowledgeable informant is good practice. Information gleaned from these discussions should then be corroborated by documentary evidence or a third-party sworn affidavit from a person familiar with the Retired NFL Football Player's condition.[3] The importance of that iterated process is reflected not only in the CDR scoring manual, but also in FAQ 113.1, which states that "[w]hen assigning a CDR score in each area, the diagnosing physician must use all reliable information available, including information from the Player's history and physical and *notes from the diagnosing physician's interviews with the player and a reliable informant*." (Emphasis added.)

Missing steps in clinical practice have particular weight here. Mr. [redacted] history of depression was well-documented: Dr. [redacted] himself recommended "additional mental health assessment" and both "psychotherapy and pharmacological intervention." And yet Dr. [redacted] report neither considered nor addressed these potentially confounding factors, though the Program's rules required him to do so "to the extent feasible."[4] While I do not read the AAP Reviewer to conclude that an informant interview is necessary in all cases, its absence here, coupled with a documented history of depression and a cursory analysis by the Diagnosing Physician, left a gap that justifies the Denial.

Ultimately, because Dr. [redacted] CDR examination did not adequately interrogate the relationship between Mr. [redacted] depression and his functional impairment, it is not possible to conclude with the requisite certainty that he satisfied his burden of offering evidence generally consistent with either a CDR of 2 in the applicable categories (required for a Level 2 Diagnosis) or 1 (required for a Level 1.5 Diagnosis). And thus, he has not offered clear and convincing evidence of error in the Claims Administrator's Denial of his claim.

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[3] FAQ 114 states: "The sworn statement must include the name of the person who is familiar with the Retired NFL Football Player's condition and describe his or her relationship to the Player… The person who signs this cannot be a member of the Player's family."

[4] FAQ 113.2 provides: "In situations where the diagnosing physician determines that a Player suffers from functional impairment that is due to both cognitive loss and emotional/psychiatric factors such as depression, anxiety, or sleep disorders (other than sleep apnea), the diagnosing physician should, to the extent feasible, then attempt to isolate the functional impairment due to cognitive loss alone and assign a CDR rating based solely on that cognitive loss."

Second, the Parties (and Class Counsel) spent significant time discussing issues of validity. This briefing preceded the release of my Opinion on that topic, which (in broad strokes, and as the AAPC has recently confirmed) established Mr. [redacted] did not fail *Slick* Criteria 1.[5] But Dr. [redacted] discussion of the remaining Slick criteria was conclusory,[6] and the AAPC found that at least three *Slick* criteria (2, 3, and 7) raised red flags. The AAP Reviewer agreed:

> I agree with the AAPC that Slick criterion #2 is a concern, as evidenced by the fact that Dr. [redacted] identified only two areas of cognitive impairment (Language and Memory) suggesting that "his issues are more isolated in nature." This observation is not generally consistent with the presence of a more global neurodegenerative disorder. One might raise the question of whether he may have had a focal brain lesion in the left hemisphere, but no brain imaging was available to support this explanation, as opposed to invalid test performance. I agree with the AAPC that Slick criterion #3 was evidenced by the clear discrepancy between chance scoring on a simple verbal test and observations of unimpaired verbal comprehension during the interview and testing. Lastly, I agree with the AAPC that Slick criterion #7 is a concern, as evidenced by Dr. [redacted] statement that "He positively reported items that are rarely reported in the general population and even reported symptoms that psychiatric patients rarely endorse. Exaggerated memory complaints were also suggested in the MMPI-2 RF validity scales."[7]

The AAP was required (at the time of the Claim's determination) to "discuss those criteria that factored into the determination of a denial."[8] It minimally satisfied that requirement in the language recorded in the Denial notice.[9] And, although I think the question is close, I do not see

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[5] Doc. 232436 ("While it is the case that the 'official' validity measures are passed (contrary to the NFL's contention) …"); Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 7 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf (establishing a safe harbor).

[6] Dr. [redacted] wrote: "An analysis of Mr. [redacted] performance on symptom validity measures indicated that he gave appropriate effort on the neuropsychological battery. Analysis of the Mr. [redacted] performances across measures, along with self-report of cognitive problems would not flag any of the considerations of the Slick et al. (2013) indications for judging possible malingered cognitive performance. As such, the patient's neuropsychological profile was judged to be valid and congruent with his current level of functioning" Doc. 152856, at 12.

[7] On the MMPI-2 RF, see Special Master Ruling on Validity Testing and Cause of Functional Impairment, at 6 (Aug. 19, 2020), https://www.nflconcussionsettlement.com/Docs/testing_impairment_sm.pdf ("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.")

[8] Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

[9] Mr. [redacted] argues that the AAP, to overturn a MAF conclusion of validity, must have evidence in support of denial that is "clear (not ephemeral) and every effort should be made to confirm whether each Slick factor supports invalid testing . . . the error should be real and demonstrable." Doc. 228408, at 5. Mr. [redacted] brief does not cite the Settlement's text in support of that exacting standard of review. But my own formulation of the appropriate standard, guided by the Settlement's text, is only modestly different:

> The AAP should defer to a clinician's *Slick*-criteria-based validity analysis when it results from reasoning completely articulated in contemporaneous reports, unless the analysis is clearly erroneous. Conversely, when clinicians fail to articulate their judgment through complete Slick

in either Mr. [redacted] or Class Counsel's briefing *clear and convincing* evidence that the Claims Administrator wrongly denied the claim on this ground. In short, I defer to the AAP's independent medical judgment that the *Slick* criteria indicated that Mr. [redacted] testing provided an invalid measure of his abilities.

Mr. [redacted] history appears consistent with some level of neurocognitive impairment that may very well qualify him for a Monetary Award. In the event that Mr. [redacted] does submit a future Claim Package, his physicians, based on their sound clinical medical judgement and a review of the documentation of functional impairment included in this current Claim, may consider whether to date a new Qualifying Diagnosis back to his 2017 evaluation.[10]

CONCLUSION

The problems in Mr. [redacted] file can be traced to inadequate documentation by his original examining clinician and physician. His Claim has, moreover, been under review for an unfortunately long period. But to prevail on Appeal, Mr. [redacted] was required to submit clear and convincing evidence of error in the Claims Administrator's decision to deny his claim. Both on the grounds of his retained function, and on the question of test validity, he failed to do so. His Appeal is therefore denied.

Date: March 19, 2021

David A. Hoffman, Special Master

analyses, the AAP may thoroughly and independently assure themselves the criteria do not indicate invalid testing.

Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf. The problem here is that Dr. [redacted] did not offer an explanation of his conclusions regarding potentially discrepant *Slick* criteria, even though his underlying report noted them.

[10] *See* Settlement Portal, Frequently Asked Questions, FAQ #101(c)(5) (explaining that "the physician making a diagnosis may conclude, in the exercise of his or her sound medical judgment, that he or she has enough information from personal examination, medical records from other healthcare providers, medical history, corroborating evidence from non-family members and other information that medical specialists rely on in their clinical practices, to form a sound medical judgment that the Player's Qualifying Diagnosis conditions existed at a date earlier than the date of a personal examination . . ."). The Qualified MAF Physician cannot rely solely on the 2017 diagnosis (because the diagnosis may not be supported under the Settlement Agreement criteria) but may rely on objective facts or evidence provided by his original (now terminated) providers in the reports from their exams. *See* FAQ #93.2 (addressing reliance on records from providers who were terminated because of questionable medical practices, as was the case with Dr. [redacted]