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

On November 2, 2017, [redacted], a Retired NFL Player and Class Member under the Amended Class Action Settlement, filed a claim for benefits for Level 1.5 Neurocognitive Impairment under that Agreement. Having seen a MAF Physician, it was his burden to submit "evaluation and evidence generally consistent with the diagnostic criteria" specified in the Settlement.[1]

The Claims Administrator concluded that Mr. [redacted] had failed to meet that burden, and he has appealed. On appeal, Mr. [redacted] must establish by clear and convincing evidence that the Claims Administrator's determination was incorrect.[2] He has not done so, and I consequently deny this Appeal.

FACTUAL AND PROCEDURAL BACKGROUND

Mr. [redacted] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment from neurologist Dr. [redacted], a Qualified MAF Physician, on September 6, 2017, based on an evaluation conducted on August 23, 2017, a third- party affidavit, dated August 18, 2017, and neuropsychological testing conducted by Dr. [redacted], dated August 11, 2017. Doc. 156484; Doc. 123894; Doc. 125384. Dr. [redacted] supplemented his report on February 8, 2018, based on CDR-relevant information submitted by Mr. [redacted] wife. Doc. 156484.

Mr. [redacted] filed this claim on November 2, 2017. Doc. 139864. The claim went into audit on February 13, 2018 and emerged more than a year later, on April 2, 2019, with no adverse

[1] *See* Settlement Agreement, Exhibit 1(1)(b).
[2] *See* Settlement Agreement, Section 9.8.

finding.[3] Doc. 156898; Doc. 204497. The Claims Administrator denied the claim on November 14, 2019. Doc. 217198. The Denial Notice states:

> The Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria. There is report of concern for cognitive decline, including difficulty with short term memory, focus and attention; misplacing objects, going to the grocery store and forgetting what he went there to purchase, difficulty doing calculations and no longer paying the bills due to this problem, and being more easily distracted, with difficulty doing more than one thing at a time.
>
> However, there is also report of functional abilities that would not be generally consistent with the presence of dementia or CDR scores of 1.0 for the categories of Community Affairs and Personal Care. These activities include being able to shop for himself (although will forget items), being able to travel long distances independently, such as across states from Kansas to Los Angeles and Boca Raton for appointments, and being able to carry out Activities of Daily Living independently, except with some deterioration in shaving, and the Player needed assistance only in having his clothing set out for him.
>
> Additionally, the neuropsychological testing is not generally consistent with the Settlement criteria for Level 1.5 Neurocognitive Impairment. Issues included: (1) report of functioning at a higher level than usual for dementia, including being able to drive independently without mention of accidents or close calls and able to travel long distances across states independently for appointments; (2) the Trails B test was administered without first administering the Trails A test, which is inconsistent with standard procedure and invalidates the results; (3) the neuropsychologist did not apply the Heaton norms, and when correct norms were applied, there was no impairment in the cognitive domain of Executive Function; (4) the Level 2 impairment in Language function is inconsistent with the Player's ability to supply a detailed and accurate history and with his language being described as normal and without aphasia, and speech and language described as intact.
>
> There were also issues with validity in the neuropsychological testing assessment that were not adequately addressed, with multiple indicators of inadequate effort, including poor performance on the ACS Word Choice test and the TOMM, and validity scales on the MMPI-2-RF indicated over-reporting of symptoms, with scores above the 99th percentile on four validity scales. Based on the above, the diagnosis is not generally consistent with the Settlement criteria for Level 1.5 Neurocognitive Impairment. *Id.* (breaks added).

Mr. [redacted] timely appealed. Doc. 218462. In its opposition, the NFL Parties submitted (with my permission) new evidence in support of the denial. Docs. 219590-98. That evidence was presented to an AAP Reviewer, who concurred with the denial on March 22, 2020. Doc. 221903. I then granted Mr. [redacted] an opportunity to see and respond to the new evidence, which he did, and the NFL Parties then submitted a "sur-reply" brief with yet more exhibits on May 19, 2020. Docs. 224445-56; Docs. 224580-83. I denied Mr. [redacted] the opportunity to file a second responsive brief.

[3] Dr. [redacted] was himself under audit, but was later released.

The issues, vigorously contested and factually complex, are now ripe for review.

DISCUSSION

The Denial Notice focused on three areas: (1) functional abilities inconsistent with CDR scores of 1.0 for the categories of Community Affairs and Personal Care; (2) problems in neuropsychological testing; and (3) problems of validity. I will address Mr. [redacted] objections in turn.

I. CDR Scoring

For players diagnosed outside of the BAP, the Settlement requires evaluation and evidence generally consistent with the a CDR 1.0 rating in Community Affairs ("Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection"), Home & Hobbies ("Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned"), and Personal Care ("Needs prompting"). The Denial Notice focused on Mr. [redacted] ability to travel long distances unassisted and on his relatively normal ability to engage in daily life.

Dr. [redacted] original and supplemental reports supply most of the relevant evidence.[4] Doc. 123894; Doc. 156484. As the most recent AAP review concludes, and contrary to the Denial Notice, this CDR scoring is arguably generally consistent with "cognitively mediated losses in daily function in Home & Hobbies, Community Affairs, and Personal Care sufficient for scores of 1 in those domains." Doc. 221903. But the AAP Reviewer nonetheless recommended denial, on two grounds. *Id.*

First, the AAP Reviewer focused on certain pieces of new evidence, submitted by NFL Parties on appeal, which seem to undermine Dr. [redacted] original and supplemental CDR scores. That proof largely consists of public social media reports post-dating the Diagnosis which suggest that Mr. [redacted] is more involved in his community than the reclusive picture painted by the 2017 reporting. For example, according to the NFL Parties, he participated in a fundraiser, visited sick children, addressed a youth football camp, spoke to middle school children, and played golf.

Mr. [redacted] offering an affidavit (assisted by his wife), vigorously contests the import of these outings, and denies attending one. True, he may have attended the NFL Parties' youth football camp at their invitation, but, he says, he did not coach there; he appeared at a golf event

[4] In his original report, in Community Affairs Dr. [redacted] recorded that Mr. [redacted] "no longer likes to leave the house for social events," that he has "lost interest in playing golf or basketball," and that he does not like to attend social events. In his supplemental report, Dr. [redacted] added that Mr. [redacted] "rarely drives," "does not go to friend's houses," "can go to the store for only one or two items," and "is not able to work." In Home & Hobbies, Dr. [redacted] wrote that Mr. [redacted] "is able to perform minimal household tasks, but cannot reliably load a dishwasher without his wife checking for errors. He no longer will go to movies or exercise, which he formerly enjoyed" (though in Dr. [redacted] original report, he noted that Mr. [redacted] lack of exercise at least in part "seems to be due to arthritic complaints"). He continued that Mr. [redacted] "does not attend friends groups which he used to do." In Personal Care, Dr. [redacted] reports that Mr. [redacted] "needs his wife to lay out his clothes," "does not attend to grooming and has to be reminded to bath or shave." Doc. 123894, at 1.

at a Congressman's request, but did not play; he did visit a sick child, but only a day he was already visiting his own physicians at the hospital; he spoke to middle school children, but was fed his lines. Doc. 224445. The NFL Parties' sur-reply offers additional visualizations of the events in question: Mr. [redacted] wore a golfing glove, indicating that he really played; a Facebook Live interview of Mr. [redacted] purports to show that he was actually at a training camp afterparty. Doc. 224580.

Litigating such disputes so late in the day, on such a shallow evidentiary record, is suboptimal. Nor is it—at least in this Appeal—edifying. Consider: what if it were the case that Mr. [redacted] in mid- or late-2018 appeared at an occasional community event? Or played a round of golf? Or spoke to middle school students briefly? Such limited episodes would not be necessarily fatal to his diagnosis, which rests on observations made in 2017 about his functional impairment as of that date. True, the Settlement contemplates degenerative conditions, but it is common sense that humans, even sick ones with increasingly limited cognitive function, may sometimes have better and worse days. (Mr. [redacted] himself describes putting on "big boy pants" and "put[ting] on a front." Doc. 224446.)

More broadly, the CDR scoring requires careful attention to the difference between apathy (neurologically defined) and avoidance of social functions due to other factors (like embarrassment, or physical ailments). The clinical judgments resulting from that consideration ought not be undermined by later-arriving evidence that, while suggestive, fails to constitute a pattern inconsistent with a CDR 1.0 Rating—i.e., that Mr. [redacted] is "unable to function independently at these activities although [he] *may still be engaged in some*; [and he] *appears normal to casual inspection.*" (Emphasis added). Nor does this new evidence undermine the factual predicates of the scoring. It would be different had Dr. [redacted] recorded that Mr. [redacted] never went out, was unable to converse, and could no longer exhibit the pretense of social function. But that is not what his report says. The new evidence is therefore of limited probative value, even were it uncontested.

Simply put, in this Appeal, like many others, the appropriate focus is on the strength of the clinician's contemporaneously created record and the Claims Administrator's process for reviewing that record. The AAP agrees with Mr. [redacted] that the contemporaneous foundation for the diagnosis justified a CDR 1.0 rating, and nothing in the new evidence, properly put in context and weighed, suggests a pattern of behavior inconsistent with it.[5]

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[5] The Settlement Agreement does not speak directly to the question of the weight of post-diagnosis evidence. I consequently asked the advice of our AAP Leadership Council. As one Doctor cogently replied:

> "I concur that playing 'a round of golf' or 'reading a speech' at a single community event is not sufficient to exclude a CDR score of 1 in Community Affairs. The real issue is the pattern of behaviors. Is the evidence brought forward on appeal typical or atypical of the player's *usual* function? In many cases, I have seen the appeal evidence showing multiple Facebook posts or media pages indicating regular and recurring activities by the player. Similarly reading a speech is different from delivering a heartfelt unscripted motivational address at a charity event for your own foundation or football camp that operates under your name and depends on your presence. From the neurological perspective, we anticipate that repetitive head injuries would lead to static impairment or progressive decline. The gap between the player's past usual function and his *best* current days represents the severity of the neurologic injury. The gap between the player's usual current function and his best current days almost universally represents the effects of noncognitive factors including mood, anxiety, emotional distress, medications, other substances, sleep disturbances, pain, etc. …

The AAP review, while concluding that the CDR-scoring was generally consistent with Level 1.5 Neurocognitive Impairment based on Dr. [redacted] reporting, did, however, note a more intractable problem. As the AAP states: "Neither Dr. [redacted] nor Dr. [redacted] address the roles of pain, poor sleep, and medication on cognitive and functional performance. The player was on four medications with well-recognized adverse effects on cognition at the time of testing: hydroxyzine, nortriptyline, pregabalin, and tramadol." Doc. 221903. This problem, which derives from the CDR worksheet's injunction to "Score only as decline from previous usual level due to cognitive loss, not impairment due to other factors," is well explained by FAQ #111.2:

> The CDR scale also requires the diagnosing physician to determine whether the functional decline in a Player from a previous usual level was due to cognitive loss, and not due to other factors. For example, if the Player's functional impairment resulted from a physical handicap or injury, chronic pain, sleep apnea, or other causes other than cognitive loss, the Player cannot be found to have a Level 1.5 or Level 2 Qualifying Diagnosis. Settlement Website, *Frequently Asked Questions,* FAQ #111.2.

Dr. [redacted] commented on the basis for cognitive deficits, but not the role of other factors in producing functional decline: "the cognitive deficits did not appear to be related to delirium, acute substance abuse, or as a result of medication side effects." Doc. 156484. Similarly, Dr. [redacted] while intoning that "the cognitive deficits do not occur exclusively in the context of delirium, acute substance abuse, or as a result of medication side effects," does not discuss whether medical side effects or Mr. [redacted] documented issues with pain could have caused his functional impairment. Doc. 125384, at 12. Thus, the AAP accurately has captured a problem with the contemporaneous documentation.[6]

Paralleling the discussion above, the Agreement's system of review turns on deference to contemporaneously created and articulated medical judgments. Where there are medications—like the narcotic analgesic tramadol/Ultram, on which Mr. [redacted] reported a dependency[7]— with known side-effects on cognition, or evidence of pain or sleep loss that is potentially intimately related to the functional losses observed, the treating physician should ordinarily offer some explanation of the role of such factors in the diagnosis. The Claims Administrator can then, as is entirely appropriate, defer to the clinician's judgment. Here, Dr [redacted] reports were missing any discussion of the role of potential non-cognitive factors in functional loss. It was therefore not clearly erroneous for the Claims Administrator to conclude that Mr. [redacted] had not offered generally consistent evidence satisfying the CDR criterion.

> Again, following the medicine, the static effects of remote repetitive head injury would never be expected to show sustained improvement at a later date, but 'a few good days' under exceptional circumstances might be possible."

[6] The AAP also adds that there are internal inconsistencies in the file: "Dr. [redacted] reported that the player rated his pain as 5/10 at the time of the visit. The player reported that his 'pain … tends to make him depressed, angry, and moody.' There were also complaints of stiffness and excessive tiredness. Additional symptoms included balance problems, ringing in his ears, blurred vision, seeing flashes of light, and double vision. Of note, a detailed Review of Systems in Dr. [redacted] report is negative for all items, including the headaches reported in the body of his own note. The reliability of reporting to, or by, Dr. [redacted] is therefore questionable." Doc. 221903.

[7] Doc. 125384, at 5

II. Neuropsychological Testing

The Denial Notice articulated multiple separate problems with Dr. [redacted] neuropsychological testing regime:

- "[T]he Trails B test was administered without first administering the Trails A test, which is inconsistent with standard procedure and invalidates the results;"
- "[T]he neuropsychologist did not apply the Heaton norms, and when correct norms were applied, there was no impairment in the cognitive domain of Executive Function;" and
- "[T]he Level 2 impairment in Language function is inconsistent with the Player's ability to supply a detailed and accurate history and with his language being described as normal and without aphasia, and speech and language described as intact." Doc. 217198.

Mr. [redacted] appeal argues that the Claims Administrator bears the burden of defending its decision, that is, to "show by clear and convincing evidence that the characteristics that differ from the criteria are greater than the characteristics that are in common with the diagnostic criteria." Doc. 218460, at 3. This is not how the Settlement's process of claim evaluation or appeal was designed or functions. Under the Settlement's negotiated provisions, it was Mr. [redacted] initial burden to come forward with evidence generally consistent with the criteria for a diagnosis.[8] The Claims Administrator is empowered to review that evidence for its sufficiency and completeness.[9] On appeal, it is Mr. [redacted] who seeks to overturn the Claims Administrator's decision, who bears the burden of showing, by clear and convincing evidence, that it was incorrect: *i.e.,* that there is a "high degree of probability that the determination of the Claims Administrator being appealed was wrong."[10]

In pursuing this topsy-turvy attack on the Settlement's evidentiary framework, Mr. [redacted] brief states that "the AAP created issues regarding the timing of the administration of the Trails A and Trails B testing which are not supported by any evidence in the record." Doc. 218460, at 3. This too is puzzling: Dr. [redacted] own report states that he administered Trails Form B, but makes no mention of Form A. Doc. 125384. As the AAP has advised, this method of test administration is invalid and calls into question the entire battery.

Mr. [redacted] brief continues that while the denial concludes that "the Heaton Norms were not applied, however, there is no evidence of this in the record and if there were the AAP member should show what difference it would make in the scoring in his findings as opposed to a vague reference with no supporting data." Doc. 218460, at 3. But this analysis is precisely what the Claims Administrator relied on in issuing the denial. As the underlying AAPC report states, "when the Revised Comprehensive (Heaton) Norms for African American men of this player's age and

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[8] The parties to the Agreement have defined "generally consistent" to mean that the evidence has more elements or characteristics in common with the diagnostic criteria than "elements or characteristics that differ" from the criteria. *See* Settlement Website, *Frequently Asked Questions*, FAQ #101.

[9] Settlement Agreement, Section 8.6(b).

[10] Settlement Agreement, Section 9.8; *see also* Order Appointing Special Masters, at 5. "Clear and convincing evidence" is a recognized intermediate standard of proof—more demanding than preponderance of the evidence, but less demanding than proof beyond a reasonable doubt. *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.'").

education are applied, the player's T-scores rise considerably. For example, his T-score on part B of the Trail Making Test increases from 17 to 44. When demographically adjusted scores are applied, the player does not meet criteria for any impairment in Executive Function." Doc. 225402.

Finally, Mr. [redacted] neither mentions nor rebuts the Claims Administrator's concern that a Level 2 Language function finding is inconstant with his ability to provide a detailed history without aphasia.

Mr. [redacted] therefore has not met his burden of showing the incorrectness of the Claims Administrator's decision regarding the insufficiency of his neuropsychological testing.

III. Test Validity

The Denial Notice notes multiple problems with test validity: "There were also issues with validity in the neuropsychological testing assessment that were not adequately addressed, with multiple indicators of inadequate effort, including poor performance on the ACS Word Choice test and the TOMM, and validity scales on the MMPI-2-RF indicated over-reporting of symptoms, with scores above the 99th percentile on four validity scales." Doc 217198; Doc. 225402.

These validity measures are explicitly required by the Settlement, and (as the AAP Reviewer concluded), the "results indicate an exceptionally high likelihood of non-credible and exaggerated symptom reporting." Doc. 221903. Mr. [redacted] offers no argument as to why the Claims Administrator's conclusions about validity were clearly erroneous.

CONCLUSION

The Program's review of Mr. [redacted] claim has been unfortunately protracted. Today, I finally resolve the claim, though not in Mr. [redacted] favor. Based on a thorough review of the medical record, and on multiple grounds, the Claims Administrator decided that Mr. [redacted] had not offered evaluation or evidence generally consistent with a Level 1.5 Neurocognitive Impairment. That decision was not clearly erroneous. The Appeal is denied.

Date: June 8, 2020

David Hoffman, Special Master