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: APPEALS OF SETTLEMENT CLASS MEMBER [redacted] REGARDING DENIAL OF MONETARY AWARD	:	**Hon. Anita B. Brody**

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, and Mr. [redacted] now brings this Appeal. Mr. [redacted] has presented clear and convincing evidence that the Denial was wrong in part. While his neuropsychological test scores support an entitlement to relief, Mr. [redacted] retained function only entitles him to an award for Level 1.5 Neurocognitive Impairment. As a result, the Appeal is granted in part and denied in part.

PROCEDURAL HISTORY

On October 26, 2018, [redacted] initially submitted a Claim for Level 2 Neurocognitive Impairment. Doc. 189220. He later withdrew that Claim. Doc. 210588. Mr. [redacted] then submitted a second claim, which resulted from a November 15, 2019 Diagnosis of Level 2 Neurocognitive Impairment made by Qualified MAF Physician Dr. [redacted]. Doc. 217230. Dr. [redacted] April 30, 2019 neuropsychological evaluation supported Dr. [redacted] diagnosis. Doc. 214894. Dr. [redacted] originally failed to include necessary information regarding Mr. [redacted] functional impairment and Clinical Dementia Rating (CDR) scoring. Doc. 217229. Supplementing his report on December 10, 2019, Dr. [redacted] concluded that "Mr. [redacted] is functionally impaired in his day to day activities, including a substantial lack of effective function at home, due to a moderate dementia consistent with level 2.0 on the CDR chart." Doc. 219408.

On January 24, 2020, the Claims Administrator issued a Notice of Preliminary Review, requesting more information regarding Mr. [redacted] functional impairment. Doc. 220001. The Claims Administrator placed the Claim into audit on February 26, 2020. Doc. 221094.

On June 25, 2020, an AAP Consultant provided an audit review of Mr. [redacted] Claim to the Claims Administrator. The Consultant concluded that Dr. [redacted] evaluation did not support a Qualifying Diagnosis of Level 2 Neurocognitive Impairment.[1] However, the Claims

[1] The Consultant wrote:

> Validity is a serious limitation for this neuropsychological evaluation. Multiple issues with validity raise concern that the neuropsychological testing is not a valid representation of the player's cognitive abilities. The player failed both embedded and stand-alone validity measures. As Dr. [redacted] points out, the player's performance was "suboptimal" on the RDS measure. In addition, performance was suboptimal for two trials within the WMT (Free Recall, Long Delay Free Recall). Dr. [redacted] actually points out that these latter two scores are 1.5 to 2 standard deviation below normative data for individuals who have sustained severe traumatic brain injuries with brain abnormalities documented by imaging.
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> There are numerous inconsistencies and discrepancies in terms of the Slick validity criteria. There is a discrepancy between test data and observed behavior for the cognitive domain of language. According to this Slick criterion, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant with the observed level of cognitive function in a way that suggests an exaggeration or fabrication of dysfunction. This player is well educated and presents with no significant language disturbance in conversation speech or during the lengthy clinical interview with Dr. [redacted] In fact, Dr. [redacted] specially described: "No difficulties were noted in speech articulation, volume, prosody, intonation, or rhythm." And, "He did not exhibit word-finding difficulties during the interview. He demonstrated good comprehension of questions and instruction[.]" In contrast, the player performed in the severely impaired range on two language tests (BNT T = 29, Category Fluency T = 21). This severely impaired performance on formal measures of language is also inconsistent with Dr. [redacted] observation of "normal language[.]"
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> Another Slick inconsistency involves a pattern of neuropsychological test performance that is markedly discrepant from currently accepted models of normal and abnormal central nervous system (CNS) function. It is extremely unusual for a patient with moderately severe dementia to have no deficits for the domain of learning/memory. This is particularly striking for this player, since memory is his primary subjective complaint. And his wife also describes prominent memory problems. However, Dr. [redacted] characterizes his memory as "normal[.]" Dr. [redacted] also describes intact memory, noting that the player is "able to independently and fluently report details of his history and communicate in writing and speech[.]"Dr. [redacted] noted that the player is an excellent historian: "During the interview, he provided extensive detail about his football and medical history, as well as about his cognitive and emotional functioning[.]" It is also highly unusual for an individual with moderate to severe dementia to be as cognitively intact as described by Dr. [redacted] In addition to normal memory and language, Dr. [redacted] describes normal orientation, normal fund of knowledge, and normal attention/concentration.
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> There is no third-party affidavit to corroborate functional impairment. Both Dr. [redacted] and Dr. [redacted] description of functional limitations is based on the player's self-report, and on his wife's description of problems. Furthermore, Dr. [redacted] does not document cognitive or functional decline during any of his neurological examinations. He did not provide functional impairment ratings for the domains of community affairs, home and hobbies, or personal care. Documentation shows that the player functions at a level inconsistent with Level 2.0 Neurocognitive Impairment. He is independent in personal care including basic and instrumental activities of daily living (per Dr. [redacted] He completes daily living activities such as grooming, dressing, washing and eating

Administrator's audit determined that there was no reasonable basis to conclude that there was misrepresentation, omission, or concealment of a material fact. Doc. 225845.

On July 6, 2020, after also obtaining input from an AAP Member, the Claims Administrator subsequently denied the Claim. The Denial Notice states:

> The Rules Governing Qualified MAF Physicians provide the Claims Administrator with the discretion to have members of the Appeals Advisory Panel (AAP) Leadership Council review claims based on diagnoses made by Qualified MAF Physicians to determine whether the diagnoses comply with the Settlement Agreement and the Rules Governing Qualified MAF Physicians. Based on such AAP input, the Settlement Class Member does not qualify for a Monetary Award for the following reason(s): The Diagnosing Physician, Dr. [redacted], initially evaluated the Player on 4/17/2018, with follow-up evaluations on 9/25/2018 and 5/28/2019, with addendums dated 11/15/2019 and 12/10/2019. There is also a neuropsychological evaluation that was performed by Dr. [redacted] on 4/30/2019 and responses by the Player to audit questions. There is documentation of concern for cognitive decline, including cognitive symptoms that are worse since 2006, no longer working, no longer managing the household finances, erratic and violent behavior, depression, and anxiety. However, the information in Dr. [redacted] medical notes does not clearly assign a clinical diagnosis of dementia, and the scores for the three relevant CDR categories documented by Dr. [redacted] (Community Affairs – 1.0, Home/Hobbies – 2.0, and Personal Care – 1.0) indicate a higher level of functioning than would be generally consistent with the Settlement Criteria for Level 2 Neurocognitive Impairment. In an addendum dated 12/10/2019, Dr. [redacted] reports there is moderate dementia consistent with level 2.0 on the CDR, without clearly specifying scores for the CDR categories of Community Affairs, Home/Hobbies, and Personal Care. There is documentation of the Player being independent in personal care activities such as grooming, dressing, washing, and eating. For the Home/Hobbies category, the Player is also able to maintain interests (exercises three times weekly) and walk the dog without mention of getting lost or

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independently"). The player is also able maintain interests ("exercises three times weekly"). He is able to walk the dog without getting lost or requiring assistance, is able to drive alone with his children in the car, and continues to "read the news" every day. In addition, Dr. [redacted] indicated that the player continues to travel by plane, noting that within a recent 3-month time frame he had twice required Xanax because "going to the airport" made him anxious. Dr. [redacted] did not provide additional details about the player's recent travels.

For the reasons outlined above, Dr. [redacted] neuropsychological evaluation does not support a diagnosis of moderate dementia and the player does not meet the Settlement criteria for Level 2.0 Neurocognitive Impairment. Furthermore, there is no objective documentation of functional limitations caused by cognitive impairment/decline.

Doc. 225950 (cleaned up and internal punctuation marks omitted).

requiring assistance, and continues to read the news every day. These functional activities are inconsistent with moderate dementia.

Concerning the neuropsychological testing, there were also issues with validity that include failure of both embedded and standalone validity measures, such as the RDS measure and on two trials of the WMT (Free Recall and Long Delay Free Recall). There were also numerous inconsistencies and discrepancies in terms of the Slick Criteria, including a discrepancy between the test data and observed behavior for the cognitive domain of Language. According to the Slick Criteria, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant with the observed level of cognitive function in a way that suggests an exaggeration or fabrication of dysfunction. The Player is well educated and presents with no significant language disturbance in conversational speech or during the lengthy clinical interviews. In particular, Dr. [redacted] noted there were no difficulties in speech articulation, volume, prosody, intonation, or rhythm, and that the Player did not demonstrate word-finding difficulties during the interview and demonstrated good comprehension of questions and instructions. However, the Player performed in the severely impaired range on two language tests: the BNT and the Category Fluency tests. This severely impaired performance on the Language tests is also inconsistent with Dr. [redacted] description of normal language.

Another Slick Criteria inconsistency involves a pattern of neuropsychological test performance that is markedly discrepant from currently accepted models of normal and abnormal central nervous system function. It is extremely unusual for a patient with moderately severe dementia to have no deficits in the domain of Learning/Memory. This is particularly striking because memory problems are the Player's primary subjective complaint. It is also unusual for an individual with moderate dementia to be as cognitively intact as described by Dr. [redacted] who reported normal memory, language, orientation, fund of knowledge, and attention/concentration. There is also no third-party affidavit to corroborate functional impairment, and the descriptions of functional impairment are based on self-report. Consequently, based on the currently available information, the diagnosis is not generally consistent with the Settlement criteria for the Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

Doc. 226249 (cleaned up). On October 30, 2020, Mr. [redacted] appealed. Doc. 229979.

DISCUSSION

It is uncontested that Mr. [redacted] has satisfied the requirement of concern about a decline in his cognition. There is no suggestion that his testing was impacted by delirium, medication side effects, or acute substance abuse. His neurological test results fall at levels which amply support

an award at either Level 2 or Level 1.5. What's at issue—as ably argued by Mr. [redacted] counsel—is the validity of those tests, and Mr. [redacted] retained function.[2]

That is, is the record generally consistent with the Settlement's second and third diagnostic criteria for a Level 2 Award (or, failing that, for any award)? The Claims Administrator concluded that it was not. I am constrained on appeal to affirm that decision unless Mr. [redacted] offers clear and convincing evidence that the determination was incorrect.

The *Slick* Checklist and Validity of Mr. [redacted] Neuropsychological Test Results

This Settlement Program is committed to efficiently paying all valid claims. To give life to that promise, the Parties to the Settlement Agreement wisely designed a Claims Appeal process "built around a layered deference to expertise."[3] The Claims Administrator, and its independent advisory experts, seek to "police the process, not its outcomes."[4] That approach bears on questions of test validity. Thus, as I have held in a recent opinion, "[t]he 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."[5]

An AAP Consultant, initially reviewing the file, determined that Mr. [redacted] scores were "*not* a valid representation of the player's cognitive abilities." Doc. 225950. The Consultant then performed an independent analysis of the relevant *Slick* criteria. In its Denial, the Claims Administrator relied on the AAP Member's adoption of that *Slick* analysis.

On appeal, in light of the newly clarified standards of review, I asked the AAP to again consider Dr. [redacted] *Slick* analysis. In particular, I was interested in learning the AAP's views on whether (1) Dr. [redacted] analysis was sufficiently articulated; and (2) if so, whether it was otherwise clearly erroneous.

In February 2021, another AAP Consultant (different than the one who provided the audit review in June 2020) responded to that invitation:

> The above noted documents including the appeal response by the player's representative and the original neuropsychological evaluation by Dr. [redacted] were reviewed. In regards to the question as to whether the examining neuropsychologist (note not a physician) provided a sufficiently articulated discussion of the Slick criteria the plain answer is yes. The neuropsychologist carefully documented all criteria and provided an extensive detailing of her consideration of the factors favoring and disfavoring validity. Her conclusion is ultimately that it was 'more

[2] I commend both parties for their excellent briefing.

[3] Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/-Docs/pre_diagnosis_evidence_sm.pdf.

[4] Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 12 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

[5] *Id.* at 10.

> likely than not' that a valid neuropsychological evaluation was obtained. Not only do I believe that this opinion should be afforded deference but further I concur with her conclusion.

Doc. 233221 (cleaned up). The Claims Administrator, at my direction, then sought additional review from an AAP Member. That Member's report (in April 2021) disagreed with the Consultant:

> This case is reviewed in response to a request from the Special Master, with particular attention to validity and whether the examining physician provided a sufficiently articulated discussion of the Slick criteria, so that it ought to be deferred to, unless it is clearly erroneous. After reviewing the numerous files on this case, I have concerns about the validity of the results of the neuropsychological evaluation. The neuropsychologist failed to recognize that the pattern of preserved memory on neuropsychological testing is markedly discrepant from currently accepted models of normal and abnormal central nervous system function as well as being discrepant from the multiple self reports of memory impairment. Also, she recognized, but failed to address the marked discrepancy between the Player's normal behavior in language function and his scores on cognitive tests of language indicating major impairment. Therefore, I feel her assessment of multiple Slick criteria was erroneous. Also concerning, the neurologist in this case performed a cursory examination and assessment of this case, relying essentially on the report of the examining neuropsychologist. He did not assess the Slick criteria for validity concerns at all. His lack of provision of an informative MAF physician evaluation of the Player, along with very limited responses to requests for clarification and support for his diagnosis, severely undermine his diagnosis of Level 2 Neurocognitive Impairment and serve to hinder one's ability to defer to his judgment as the treating physician.

Doc. 234714. This April 2021 AAP Member then provided yet another detailed *Slick* analysis, based on a review of the documentation that Mr. [redacted] had submitted. *Id.* The AAP Member's analysis largely tracks the June 2020 AAP Consultant report.

In sum, this Appeal well-illustrates a principle I articulated last Fall:

> The *Slick* criteria thus combine objective and subjective factors, and operate to guide and standardize a professional judgment—is the patient malingering?—on which reasonable minds may sometimes disagree. As their developers made clear, there is an inherent tension when such qualified judgments are shoehorned into binary legal outcomes.[6]

Here, the "binary legal outcome" in dispute has generated disagreement among not only the parties but also independent experts within the Program.

[6] *Id.* at 6.

However, careful attention to the Settlement's rules and procedures eases that apparent conflict. The threshold question is whether Dr. [redacted] analysis "results from reasoning completely articulated in contemporaneous reports."[7] The first appeals Consultant concluded that it was. The AAP Member seemingly agreed, focusing instead on whether Dr. [redacted] views were "erroneous." I defer to these independent medical experts on the sufficiency of Dr. [redacted] reasoning. Indeed, Dr. [redacted] report is cogent and addresses each relevant factor. Where they are not apt, Dr. [redacted] did not put a check mark, but rather took the effort to write "WNL," meaning "within normal limits." She acknowledged red flags in the file—i.e., that Mr. [redacted] was "able to independently and fluently report details of his history and communicate in writing and speech." Doc. 214894, at 6. But she ultimately concluded that, in her opinion, "[b]ased on the Slick criteria checklist, performance validity was more likely than not to be intact." *Id*. This level of calibrated analysis is just what the Program expects from its clinicians. It is a far cry from an unadorned checklist, bereft of discussion, which does little to assuage a reviewer of the clinician's seriousness and application to the task.

What remains is to determine if the *Slick* analysis was "clearly erroneous."[8] It should be obvious that a *Slick* analysis is not "clearly erroneous" simply because a member of the AAP (or the Claims Administrator) merely disagrees with the conclusions that the Retired Player's neuropsychologist made. Something more is needed—such as a basic error in computation, a material failure to consider relevant evidence or apprehend its import, or a serious departure from the standard of care. This is not an exclusive list. But I do intend to emphasize the importance of *deference* once the Claims Administrator has determined that the clinicians' explanation is reasonably articulated. The *Slick* criteria embody a professional judgment. Clinicians may reasonably disagree about that judgment's application to particular facts. But such disagreements are not themselves evidence of clear error.

One of the Program's independent and trusted experts wrote that not only should Dr. [redacted] "opinion should be afforded deference but further I concur with her conclusion." Doc. 233221. That statement is itself conclusive evidence that Dr. [redacted] articulated judgment was not clearly erroneous. Thus, in concluding that Mr. [redacted] test scores did not reflect the optimal level of his functioning, the Claims Administrator erred.

Mr. [redacted] Functional Impairment and CDR Scoring

The Claims Administrator also denied Mr. [redacted] Claim on two grounds related to his retained function. It first pointed to the absence of a third-party affidavit to support his purported functional impairment. I agree that the inclusion of a third-party affidavit, which often provides colorful descriptive context regarding a Retired Player's functional impairment, both facilitates appropriate diagnoses and checks fraud. Clinicians ordinarily will seek out such sources of information. It is also true that Dr. [redacted] reports were devoid of virtually any detail about the extent of Mr. [redacted] daily activity and functioning.

[7] Settlement Portal, *Frequently Asked Questions*, FAQ #372.
[8] Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, *supra* note 4.

But a third-party affidavit is not mandatory under the text of the Settlement. It is required when "no documentary evidence of functional impairment exists or is available."[9] Although Mr. [redacted] neurological reports did not adequately explore and interrogate his daily cognitive functioning and the documentation to corroborate it, his *neuropsychological* reports did. Even more, the Claims Administrator, in conducting a Preliminary Review and audit, secured more information from Mr. [redacted] and his physician regarding the extent of his cognitive daily functioning. That additional documentary proof provides more foundation for the award. As a result, to the extent that the Denial rested on the absence of a third-party affidavit, it was in error.

Second, the Denial concluded that Mr. [redacted] proffered evidence of functional impairment was not generally consistent with a Level 2 Award. Here, the weakness of Dr. [redacted] documentation raises meaningful barriers to Mr. [redacted] recovery. Dr. [redacted] original analysis—*standing alone*—was deficient. Even his December 2019 addendum does not provide individual scores for the three CDR categories. Doc. 219408. Dr. [redacted] however, assigned Mr. [redacted] to CDR scale Category 1.0 in Community Affairs and Personal Care, and a Category 2.0 in Home and Hobbies. Doc. 214894, at 10. So, Mr. [redacted] argues, the deficiencies in his neurologist's report might be filled in by his neuropsychologist's analysis. But in reviewing this analysis, the recent AAP Consultant wrote:

> I believe the neuropsychologist erred and the neurologist, by deferring to the neuropsychologist, perpetuated this error . . . in rendering an overall CDR of 2.0. The neuropsychologist clearly scored CDR community affairs and personal cares as level 1 impairments and only home and hobbies as level 2.0. The players attorney wants to average these scores and then round up; however, this is not how the CDR works. Level 2 is associated with the notion of moderate dementia including "of no pretense of function outside the home" and the need for some amount of in person supervision. Evidence suggests episodes of independent function outside the home and the ability to be home independently for long stretches of time. This is more consistent with mil[d] (1.0 CDR) dementia. On this basis, in my opinion, the available data supports (only) a finding of level 1.5 neurocognitive impairment.

Doc. 233221.

The record evidence is more consistent with the AAP Consultant's analysis than Dr. [redacted] As part of his daily routine, Mr. [redacted] occasionally goes to the park with his family, and he "watches television, eats breakfast, walks the dog,… and reads the news." Doc. 214894; Doc. 221639. Against the advice of his physicians, he drives his daughter to and from school, though he avoids unfamiliar locations and does not drive long distances. At home, Mr. [redacted] has forgotten to turn off the gas stove, no longer cooks, "can't manage trash disposal anymore," and struggles to carry out steps to complete a task. Doc. 214894, at 2. This level of activity is generally consistent with Category 1.0 in Community Affairs as well as Home and Hobbies. Mr. [redacted] struggles to groom himself without assistance, forgets to shower, needs his wife's assistance to properly dress

[9] Settlement Agreement, Exhibit A-1, (1)(a)(iii).

himself, and has to be continuously prompted to brush his teeth and shave. This level of functioning is generally consistent with at least Category 1.0 in Personal Care.

Overall, Mr. [redacted] has failed to offer clear and convincing evidence that he was entitled to a CDR score of 2.0 (and thus an overall Level 2 Diagnosis). However, I defer to the AAP Consultant, who concluded that Mr. [redacted] has offered evidence generally consistent with a CDR of 1.0. When considering his valid test scores, he thus is eligible for an Award based on a Level 1.5 Diagnosis.

CONCLUSION

On appeal, Mr. [redacted] was required to offer clear and convincing evidence that the Claims Administrator's determination was incorrect. I conclude that the Claims Administrator inappropriately failed to defer to his clinician's *Slick* analysis, and thus wrongly concluded that his test scores were invalid. As a result, there is clear and convincing evidence that the Denial was in error. However, Dr. [redacted] and Dr. [redacted] incorrectly concluded that Mr. [redacted] level of daily cognitive functioning was generally consistent with Level 2 Neurocognitive Impairment. Instead, his CDR, along with his neuropsychological test results, indicate that he is eligible for benefits associated with a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

Therefore, the Appeal is granted in part and denied in part.

Date: April 27, 2021

David A. Hoffman, Special Master