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	:	

On July 24, 2018, [redacted], a Retired NFL Player and Class Member under the Amended Class Action Settlement Agreement, filed a claim for benefits under that Agreement. As he was provided a Qualifying Diagnosis outside of the Baseline Assessment Program (the "BAP"), it was his burden to submit "evaluation and evidence generally consistent with the diagnostic criteria" specified in Exhibit A(1) of the Settlement.[1]

After an extended process, the Claims Administrator concluded that Mr. [redacted] had failed to meet that burden. Mr. [redacted] appeals. The issues are vigorously contested. Because Mr. [redacted] has established by clear and convincing evidence that the Claims Administrator's decision incorrectly discounted his clinician's judgment,[2] I will remand this case to the Claims Administrator for further review.

FACTUAL AND PROCEDURAL BACKGROUND

Mr. [redacted] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on July 9, 2018, from Dr. [redacted], a Qualified MAF Physician. Doc. 180383. Licensed neuropsychologist Dr. [redacted] assisted in making the Qualifying Diagnosis. *Id.*

The claim was submitted for auditing pursuant to §10.3 of the Settlement Agreement. Doc. 181192. On November 6, 2018, Claims Administrator, completing the audit process, made no adverse inference. Doc. 189990.

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[1] The parties to the Settlement 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 Portal, *Frequently Asked Questions,* FAQ #101.

[2] *See* Settlement Agreement, Section 9.8. The Special Masters must decide an appeal of a Monetary Award based on a showing by the appellant of clear and convincing evidence that the determination of the Claims Administrator was incorrect. *See* 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.'").

An AAP physician recommended that the Claims Administrator deny the claim, which it did on August 8, 2019. Doc. 212529. Mr. [redacted] timely appealed. Doc. 214505; Doc. 213937. Special Master Pritchett requested AAP review of the claim package in light of rules newly agreed upon by Class and NFL Counsel. That review concluded with another recommendation to deny Mr. [redacted] appeal, and the issues are now ripe for review. Doc. 221525.

DISCUSSION

Mr. [redacted] burden is simply put: to come forward with a "diagnosis . . . based on evaluation and evidence generally consistent with the diagnostic criteria set forth in subsection 1(a)(i)-(iv)" of Exhibit A of the Settlement Agreement, made by a "Qualified MAF Physician or a board-certified or otherwise qualified neurologist . . . ." The parties to the Settlement 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 Portal, *Frequently Asked Questions,* FAQ #101.

Dr. [redacted] is a Qualified MAF Physician. Further, Mr. [redacted] has met his burden under criterion (i), *i.e.*, there is concern for a "severe decline in cognitive function."

The parties (and class counsel) have spent most of their energy disputing the second criterion, and their briefing has raised important issues in the appropriate interpretation of the Settlement Agreement. Here, it is Mr. [redacted] burden to offer evidence generally consistent with:

> "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, in two or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-spatial), provided one of the cognitive domains is (a) executive function, (b) learning and memory, or (c) complex attention." Settlement Agreement, Ex. A(1)(a)(ii).

The Settlement Agreement lists a carefully negotiated battery of tests, contained in Exhibit A(2), to assess this criterion. Because the criterion requires a *decline* in cognition, the Settlement requires the physician to "estimate premorbid intellectual functioning in order to use the criteria for impairment set out in this document." Settlement Agreement, Ex. 2, Section 3.

Exhibit 2, Section 1, mandates that clinicians use the ACS Test of Premorbid Functioning (TOPF) to estimate premorbid functioning. The TOPF is a short (5-10 minute) test that asks the patient to "read up to 70 phonetically irregular words." The clinician scores the patient's ability to correctly recognize those words, and subjects the resulting raw score to a statistical norming process. *See generally* James A. Holdnack, Mike R. Schoenberg, Rael T. Lange & Grant L. Iverson, *Predicting Premorbid Ability for WAIS-IV, WMS-IV and WASI-II, WAIS-IV*, *in* WMS-IV, AND ACS: ADVANCED CLINICAL INTERPRETATION 235 (Holdnack et al. eds., 2013). There are various equations the clinician can use to accomplish that norming process, as Section 3 of Exhibit 2 explains:

> "The Test of Premorbid Functioning (TOPF) provides three models for predicting premorbid functioning: (a) demographics only, (b) TOPF only, and (c) combined demographics and TOPF prediction equations. For each model using demographic data, a simple and complex prediction equation can be selected. In the simple model, only sex,

race/ethnicity, and education, are used in predicting premorbid ability. In the complex model, developmental, personal, and more specific demographic data is incorporated into the equations. The clinician should select a model based on the patient's background and his or her current level of reading or language impairment."

As the Settlement Agreement thus makes clear, the selection between models is a matter of fine clinical judgment. The textbook from which the exhibit language above is quoted continues:

> "In most cases, using the TOPF, either alone or with simple demographic data, can likely provide a satisfactory estimation of premorbid abilities. Simple demographic data are easier to verify than the background information in the complex model and the level of prediction is generally the same as the complex model. The complex model may be selected in cases where elements of the simple model do not seem sufficient for capturing the nature of the patient's background. For example, ethnicity may not reflect issues of reduced access to education, healthcare, or other resources as well as those individual variables; or that an individual who is very active and fit, comes from a wealthy family, and whose parents have a high degree of education, may be better represented by the complex demographics. Moreover, the simple demographic model may not best represent an individual coming from very poor or disadvantaged backgrounds. The clinician must evaluate each patient to determine the most appropriate model for that individual. The clinician may decide not to use demographic data when there is concern regarding the fidelity of that information, or when the clinician believes that the demographic data may not be representative of the patient's actual premorbid ability." Holdnack et al., *supra*, at 236-37.

Dr. [redacted] used one of the three permitted tests—the combined demographics and TOPF prediction equation—and estimated Mr. [redacted] premorbid IQ to be 91. Doc. 180384. Dr. [redacted] evidently selected the combined demographics and TOPF model based on his review of the patient's background and past medical examinations, both of which he became intimately familiar with through the course of the full exam. A 91 reflects an average score for estimated premorbid ability. Dr. [redacted] then estimated Mr. [redacted] current Full-Scale IQ to be 85.

The AAP Reviewer and AAPC concluded that Dr. [redacted] should have used the TOPF-only model, leading to an estimated pre-morbid IQ of 84. Doc. 220083; Doc. 220084; Doc. 221525. This position finds support in guidance from the textbook, which cautions against reliance on the demographic models when they produce discrepant results. Holdnack et al., *supra*, at 237-38. But it also reflects a long-standing position of the AAP. Multiple reviewers have argued that when there are discrepancies between the models, use of the demographics-linked models in this population will inflate pre-morbid IQ, because they (in effect) inappropriately boost scores given (nominal) educational attainment.

As one AAPC put it reviewing this file, the "TOPF is preferred to a 'demographic formula' for estimating premorbid intellect for athletes because the rules for passing college courses and accumulating credits are clearly different for them. 'Years of schooling' often overestimates their intellect." Doc. 220083. Another argued that "in these players, years of college gained directly as a result of their athletic skills tends to inflate the overall TOPF formula outcomes and their reading carry somewhat more weight (in my opinion). In this player's case, reading is 84 and overall score is 91, barely in the average range. If below average standards were used the player would again fall at the level 1.0 neurocognitive level for the neuropsychological. Repeatedly this is the level most generally consistent [*sic*] the preponderance of his data." *Id.* The original denial relied on

those reviews in stating (without further analysis) that "the premorbid IQ as determined using the TOPF was determined to be 84 and the current full scale IQ was determined to be 85. . . ." Doc. 212529. A more recent review concluded that Dr. [redacted] TOPF choice was "not appropriate" given the above-quoted AAPC commentary. Doc. 221525.

There is no provision in the Settlement Agreement providing for a standard of review by which the Claims Administrator can overrule the choice of a qualified MAF physician as between the three permitted TOPF models. The Exhibit affirmatively seems to vest discretion in the clinician, who "should *select* a model based on the patient's background and his or her current level of reading or language impairment." (Emphasis added). True, the Settlement, at Section 8.6(b), provides that the Claims Administrator will have the "discretion to undertake or cause to be undertaken further verification and investigation, including into the nature and sufficiency of any Claim Package or Derivative Claim Package documentation." Moreover, Section 9.8, which details the standard of review that governs this Appeal, empowers the Appeals Advisory Panel and Consultants to "take all steps necessary to provide sound advice with respect to medical aspects of the Class Action Settlement." But neither set of language illuminates under what circumstances the Claims Administrator may, in a case proceeding under the generally consistent standard and subject to a clear and convincing standard of review, set aside a diagnosis when the Agreement itself appears to explicitly vest the choice between estimating models in the clinician.

The Claims Administrator, seeking clarity, asked the parties to state their views. By correspondence dated February 5, 2020, the parties jointly responded:

> "The Parties agree that it is permissible for the examining neuropsychologist to select any of the three models set forth in the Settlement Agreement for estimating premorbid function. In certain limited circumstances, an AAPC may question the examining neuropsychologist's selection of one of the three permissible models in a particular claim only if the AAPC determines that the selection was medically unsound under the particular facts presented. If an AAPC makes such a determination, the AAPC must explain this conclusion in sufficient detail to permit Claimant and the Parties to consider the conclusion in connection with potential appeal."

The Parties negotiated the Agreement and are intimately familiar with its terms; their stipulated view of its meaning is entitled to deference. Here, the phrases "certain limited circumstances" and "medically unsound under the particular facts presented" indicate that questioning the TOPF model choice must rest on the singular facts of an appeal. Arguments that are general to all or most claimants will not meet this extremely high standard.

The Claims Administrator did not conclude that Dr. [redacted] choice was "medically unsound," *i.e.,* without any articulable medical rationale. Rather, the AAPC reviewers of Mr. [redacted] appeal (and consequently the AAP member and the Claims Administrator relying on those reviews) have articulated a general view of the value of college education to football players. That perspective was explicitly adopted to discount the appropriateness of using the complex demographic adjustment for this particular player. Nothing about the reviewers' judgment was particular to Mr. [redacted] course of undergraduate education, nor is there clearly expressed concern regarding the fidelity of his particular demographic information as reported by the clinician.

I do not discount the reviewers' medical expertise. In the context of this subject population, choosing the demographically adjusted TOPF model may permit too many degrees of freedom,

leading to possible overestimation of pre-morbid IQ. The state of the art might thus counsel against Dr. [redacted] approach.

However, where the Settlement Agreement explicitly vests the choice between statistical models with the clinician, it is erroneous to override that discretion based on arguments that would, in effect, privilege one estimation method over another for most of the members of the Class. If the Parties agree that it is inappropriate to demographically weigh for education in the TOPF, a remedy would be to modify the qualifying diagnosis provision, as provided in the Agreement at Section 6.6(a). Alternatively, the Claims Administrator may change its training materials to persuade physicians as to the appropriate use of their discretion. But neither course would make Dr. [redacted] reliance on the combined demographics and TOPF model "medically unsound" given the particular facts of this Appeal.

Given the parties' stipulation, and the plain language of the Settlement Agreement, I must conclude that the Claims Administrator's decision to override Dr. [redacted] selection of the TOPF plus demographic model, and to conclude that Mr. [redacted] premorbid IQ was 85, not 91, was clearly erroneous.

As a biproduct of their disagreement on the test for premorbid IQ, the parties identified distinct ranges for Mr. [redacted] premorbid intellectual functioning. After concluding that Mr. [redacted] estimated premorbid IQ was 91, Dr. [redacted] placed his premorbid intellectual functioning in the average range. Doc. 180384. The AAP and AAPC members believe that this was an error. *See* Doc. 220084 ("Additionally, there was an error in scoring the testing by Dr. [redacted] who used an average premorbid IQ to determine the scores when a *below average* premorbid IQ should have been used,"); Doc. 220083 ("When the player's test scores are evaluated against impairment criteria for persons of *below average* premorbid intellect, the player meets Level 1 criteria in Learning and Memory and Executive Function, and no impairment in the other three domains."). The range of premorbid functioning matters because "[i]t is necessary to estimate premorbid intellectual functioning in order to use the criteria for impairment set out in this document." Settlement Agreement, Ex. 2, at 4.

This disagreement over average versus below-average premorbid functioning does have a practical impact under the testing protocol for the Learning and Memory domain, but not for the Executive Function domain. For Executive Function, both levels of premorbid functioning require either: (a) 3 or more scores below a T score of 35; or (b) 2 or more scores below a T score of 35 and 1 score below a T score of 30. While the respective scores (30, 42, 60, 30) do not strictly meet these criteria, Dr. [redacted] found Level 1.5 Impairment in this domain and provided the following sufficient explanation: "Claimant missed meeting BAP criteria for Level 1.5 impairment by only one raw score point on an executive function." Doc. 180384, at 18. As Special Master Pritchett has previously found in a similar case, that choice is generally consistent with the diagnosing criteria.[3]

[3] The diagnostic criteria for a diagnosis made outside the BAP need not be identical to the diagnostic criteria for a diagnosis made in the BAP, so long as the Qualified MAF Physician and/or Examining Neuropsychologist provides a sufficient explanation. *See* Settlement Agreement, Section 6.4(b); Rules Governing Qualified MAF Physicians, Rule 20. The Special Master has previously found a single raw score point difference between Level 2.0 Impairment and Level 1.5 Impairment to be a sufficient explanation by an examining neuropsychologist. *See* Special Master Opinion Regarding Appeal of Settlement Class Member [redacted] (I.D. # 100014405).

For Learning and Memory, there are relevant differences based on the estimated level of premorbid functioning. *Compare* Below Average (3 or more T Scores below a score of 35 and *2 scores below* a T score of 30), *with* Average (3 or more T Scores below a score of 35 and *1 score below* a T score of 30). *See* Settlement Agreement, Ex. A(2), at 6-7. Here, the respective T Scores were 29, 33, 46, 50, 40, and 33. Doc. 180384. I have found that Dr. [redacted] appropriately assigned Mr. [redacted] to average premorbid functioning. Therefore, Mr. [redacted] has offered evidence generally consistent with criterion (ii).

Just as I have concluded that the Settlement Agreement requires the Claims Administrator to defer to choices explicitly left to front-line clinicians, so too is my review circumscribed. I may only set aside the judgment if Mr. [redacted] offers "clear and convincing" evidence that it was wrong, a standard of review between "preponderance of the evidence" and "reasonable doubt." The Rules Governing Appeals of Claim Determinations further define the standard as a "high degree of probability that the determination of the Claims Administrator being appealed was wrong." Mr. [redacted] has satisfied this burden for the Claims Administrator's decision on criterion (ii).

That conclusion does not resolve this appeal, because the Claims Administrator also decided that Mr. [redacted] did not offer evidence generally consistent with satisfying criterion (iii), and there are indications in the file that there are concerns about criterion (iv). Considering those criteria, and their relative weight, presents fact-intensive questions and would benefit from a fresh and more focused look in light of my decision about criterion (ii) and the new evidence offered during this appeal. On remand, the Claims Administrator may come to a different view about criterion (iii), its weighing of the total balance of factors, or again deny the claim. In any event, it should also clearly indicate if it agrees that Mr. [redacted] has satisfied criterion (iv).

If an appeal from either party results from the decision that follows this remand, it would proceed with clearer factual predicates than those present on this record.

CONCLUSION

The administration of this Settlement is made both more efficient and more fair by faithful adherence to its terms, including its injunction to defer where possible to the appropriate decisionmaker. That deference always requires as complete and reasoned analysis as possible, even at the cost of some slight delay.

Given these considerations, the better approach is to follow Rule 24 and to remand to the Claims Administrator for further review in light of this decision.

Date: May 1, 2020

David A. Hoffman, Special Master