

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

THIS DOCUMENT RELATES TO:
APPEAL OF SETTLEMENT CLASS
MEMBER [REDACTED]
REGARDING DENIAL OF MONETARY
AWARD

Mr. ██████ received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment from Dr. ██████ —who was, at the time of Mr. ██████ assessment, a Qualified MAF Physician. Doc. 176443. Dr. ██████ performed a neurological evaluation of Mr. ██████ on May 23, 2018 and determined that Mr. ██████ demonstrated functional impairment consistent with a Clinical Dementia Rating scale score of 1 in the categories of Community Affairs, Home & Hobbies, and Personal Care. *Id.* With support from a third-party affidavit as well as the neuropsychological test results from Dr. ██████ evaluation, Dr. ██████ concluded that Mr. ██████ met the criteria for a Level 1.5 Diagnosis. *Id.*

The Claims Administrator requested input about Mr. ██████ Claim from the Appeals Advisory Panel, prompting review by two AAP Consultants. Doc. 215194; Doc. 219037. The Consultants both opined that Mr. ██████ Claim did not meet the criteria for Level 1.5 Neurocognitive Impairment. *Id.* The Claims Administrator, drawing support from the analyses provided by the AAP Consultants, denied Mr. ██████ Claim on April 9, 2020. Doc. 223259. The Notice stated (in part):

Dr. ██████ determined the Player had an average level of premorbid intellectual function and his testing was valid despite suboptimal performance on one of seven measures, and despite an invalid MMPI-2-RF protocol due to an excessive number of infrequent responses that reflect over-reporting. Dr. ██████ determined the Player had Level 2 impairment for the domains of Learning and Memory and Language, with no impairment in the other domains, even though the Player's scores in the Learning and Memory domain did not meet the strict Settlement criteria. Dr. ██████ concluded the Player had Level 2 Neurocognitive Impairment as well as major depressive disorder. Dr. ██████ noted in an addendum dated 6/21/2018 that he reviewed the NP testing and gave the Player a diagnosis of Level 1.5 Neurocognitive Impairment on the basis of all of the Player's records, including the affidavit.

AAPC review of Dr. ██████ testing determined that her estimate of the Player's premorbid intellectual functioning as "Average" on the basis of the Player's simple demographic premorbid score of 102, rather than the TOPF reading score of 82, was not justified. Instead, the estimate should have been based on the Player's reading score or the full reading plus demographic score. This would give the Player an estimated premorbid IQ in the "Below Average" range, which would result in the Player's scores not meeting the Settlement criteria for even Level 1.5 impairment. AAPC review also found issues with the validity of the Player's performance on the NP testing, noting the Player's suboptimal performance on the MSVT measure of performance validity and the invalid MMPI-2-RF profile. These results, along with the diagnosis of major depressive disorder, suggest that the NP testing may have been an overestimate of the Player's cognitive decline and raises the likelihood of overreporting of symptoms.

Based on the above, the diagnosis made by Dr. [REDACTED] is not generally consistent with Settlement criteria for the claimed Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

Mr. [REDACTED] timely appealed. Doc. 223864.

Pursuant to my request for additional expert input, the Claim was reviewed by both an AAP Reviewer and an AAP Consultant. The Consultant provided insight about whether Mr. [REDACTED] neuropsychological testing was consistent with a Level 1.5 Diagnosis (rather than a Level 2 Diagnosis, as asserted in Dr. [REDACTED] report). Doc. 227417. Ultimately, while concluding—contrary to the Denial Notice—that Mr. [REDACTED] had met the Settlement’s first, second and fourth criteria for a Level 1.5 Diagnosis, the AAP Reviewer found that the “CDR was not conducted appropriately,” and consequently the Diagnosis was not generally consistent with the Settlement’s requirements. Doc. 227682.

DISCUSSION

There are four diagnostic criteria that must be satisfied for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.¹ Mr. [REDACTED] has satisfied the first and fourth criterion.

The Claims Administrator determined that failure to satisfy criterion (ii), regarding neuropsychological testing, was a basis for its denial of Mr. [REDACTED] Claim. Doc. 223259. It found the Diagnosis lacking in its estimate of premorbid functioning and the validity of the testing performed by Dr. [REDACTED]

Dr. [REDACTED] estimated Mr. [REDACTED] premorbid functioning using a model—namely, the “demographics only” model—that is one of three explicitly endorsed in Exhibit 2 to the Settlement.² Neither the Claims Administrator, nor its underlying independent medical experts, provided a particularized factual basis as to why Dr. [REDACTED] selection was not justified.³ But, as I explained in a previous opinion, “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.”⁴

¹ Settlement Agreement, Exhibit A-1 (1)(a)(i)-(iv).

² Settlement Agreement, Exhibit A-2, Section 3.

³ One wrote: “She chose to use the demographic score and use an ‘Average’ premorbid status rather than the reading score or the full reading plus demographic score. I don’t think this is defensible. I believe the reading score should prevail in this case and have use ‘Below Average’ in my consideration of this case.” Doc. 215194. The second wrote: “Dr. [REDACTED] compared the player’s scores to those of persons of average intellect. The player’s TOPF score is a good indication that his lifelong intellect is below average. His having earned a B.A. in liberal arts inappropriately inflates I.Q. estimates that rely on ‘demographic’ characteristics, as criteria for academic promotion are much more liberal for college athletes.” Doc. 219037. This is precisely the generalized reasoning that the Settlement abjures.

⁴ *Special Master Decision on Test of Premorbid Functioning (TOPF)* (May 1, 2020), https://www.nflconcussion-settlement.com/Docs/topf_sm.pdf. See also Settlement Portal, *Frequently Asked Questions*, FAQ # 360 (codifying the May 1, 2020 decision, and providing that the Claims Administrator defer to the examining neuropsychologist’s

The latest AAPC review applied this recent guidance. Doc. 227417. The Consultant concluded:

I believe the reading score should prevail in this case and have use ‘Below Average’ in my consideration of this case. The evidence for this includes the fact that the player went through his educational experience with untreated ADHD increasing the probability on reduced educational benefit. Further evidence for this suspicion is that the player maintained a college GPA just good enough to remain eligible to play in spite of the considerable academic supports he would have been afforded at a major college football program. Nevertheless, Dr. ██████ observes that the ACS system recommends excluding the TOPF in discrepancies as observed here. This is an articulable ‘medical’ rationale so deference is given to her determination. She used appropriate norms and determined the player to have level 2.0 impairments in Learning/Memory and Language. However, technically the player does not meet the criteria for 2 scores below 30 in the Learning and Memory domain even if the “Average’ premorbid status is used. He does however meet level 1.5 impairments in this domain.

This review lays out the AAPC’s considered views, while deferring to what it called the “articulable medical rationale” offered by Dr. ██████. Relying on that assessment, I conclude that the Claims Administrator’s decision to reject Dr. ██████ selection of the “demographics only” model, absent any specific argument as to why the model was medically unsound in Mr. ██████ case, was clearly erroneous.

On validity, Exhibit 2 provides that “a Retired NFL Football Player’s failure on two or more effort tests may result in the Retired NFL Football Player’s test results being subjected to independent review.”⁵ Given the MMPI-2-RF is not an effort test,⁶ Mr. ██████ displayed suboptimal performance on *one* effort test—the MSVT—which, on its own, does not lead to an inference of overall invalidity. Furthermore, Dr. ██████ assessed Mr. ██████ mental health (in compliance with the BAP battery), discussed her findings in the report, and did not conclude that there was reason to doubt the validity of the testing as a whole.

The Claims Administrator asserted that the testing profile “may have been an overestimate of the Player’s cognitive ability.” Consequently, I requested supplemental AAP review,

choice of models, absent a detailed explanation from the AAPC about why the neuropsychologist’s choice of model was inappropriate).

⁵ See also Settlement Portal, *Frequently Asked Questions*, FAQ # 110 (for neuropsychological assessments outside of the BAP, like Mr. ██████ “the Qualified MAF Physician and/or neuropsychologist must explain to the Claims Administrator whenever . . . the Player failed two or more performance validity measures.”).

⁶ The MMPI-2-RF is a measure of mental health. While it can be considered within the scope of validity analysis, appropriate consideration of its significance should relate to a *qualitative* assessment of the Player’s behavior and self-reported functioning. In other words, an invalid MMPI-2-RF profile is not an invalid result on a performance validity test. See *Special Master Opinion on Validity Testing and Cause of Functional Impairment* (Aug. 19, 2020), https://www.nflconcussionsettlement.com/Docs/testing_impairment_sm.pdf.

specifically to address the question of whether Mr. [REDACTED] neuropsychological testing performance was generally consistent with a Level 1.5 Diagnosis. The Consultant provided a thorough analysis and concluded that “the player does appear to meet neuropsychological criteria for level 1.5 neurocognitive impairments.” Doc. 227417. I adopt this assessment and conclude that it was clearly erroneous for the Claims Administrator to find that Dr. [REDACTED] testing does not satisfy criterion (ii).

Thus, Mr. [REDACTED] has met the first, second and fourth criteria for a Level 1.5 Diagnosis. What remains is criterion (iii): functional impairment. In the Notice of Denial, the Claims Administrator described a variety of facts related to Mr. [REDACTED] impairment in the three relevant CDR categories, writing:

Dr. [REDACTED] evaluated the Player on 5/23/2018, for five years of memory problems that included misplacing things and forgetting people’s names, appointments and chores. At that time, the Player would get lost when driving but paid his bills. He was self-employed doing photography and coaching but was having difficulty with work performance because of memory difficulty. Office- based cognitive testing at that time included an MMSE with a score of 26/30, which is considered to be within the normal range.

Dr. [REDACTED] gave the Player a CDR rating of 1.0 for the domains of Community Affairs, Home and Hobbies, and Personal Care. This level of cognitive impairment in daily life is supported by an affidavit from a friend, Mr. [REDACTED] who notes that the Player was very dependent on his mother, with whom he lives and on whom he relies for many of his activities of daily living, such as shopping and prompting for personal hygiene. The Player was dependent on his friend in driving and work-related reminders. He noted that the Player commonly appeared disheveled and unkempt, despite having access to a laundry service. The Player no longer showed significant interest in photography. A CDR worksheet notes that the Player sometimes shopped independently, but rarely or never carried out activities independently outside of the home. The Player was noted to do only simple chores like washing dishes in the home, and that he needed prompting in washing and grooming. *The Player's history of Attention Deficit Disorder as well as the fact that the Player was still working and driving are complicating factors in the assignment of the CDR.*

At the time of the Neuropsychological (“NP”) testing performed by Dr. [REDACTED] on 5/24/2018, the Player noted that his mother helped him replace items he had lost and was late paying his bills. The Player also reported forgetting medications and appointments but compensated by using his phone for reminders and taking pictures. He described getting lost when driving, including getting multiple parking tickets and difficulty with cooking. There had been a recent decline in employment from that of a high school football coach to part-time coaching of individual children.

Doc. 223259 (emphasis added).

In the most recent AAP review, the Reviewer offered more specific grounds for concern: Mr. [REDACTED] (the third-party affiant) “incorrectly stated that the Player lived with his mother and admittedly didn’t know how he functions at home [which] indicates questionable reliability as an informant.” Doc. 227051. Given that flaw, as well as the evidence noted by the Claims Administrator, this AAP Reviewer recommended denying the Claim.

Section 9.1(c)(i) of the Settlement provides that “Notices of Monetary Award Claim Determination that provide an adverse determination will include a short statement regarding the reasons for the adverse determination and information regarding how the Settlement Class Member can appeal the determination.” Rule 26 of the Rules Governing Appeals of Claim Determinations further states that on appeal, “the Appellant must convince the Special Master that there is a high degree of probability that the determination of the Claims Administrator being appealed was wrong.” The Claims Administrator communicates its final determination to deny a claim through a Notice of Denial. The Notice of Denial is an “Appealable Notice,” as defined in Rule 3(d); it is the basis for a Player’s Appeal.

Thus, the Settlement requires the Claims Administrator to provide “the reasons for the adverse determination” in the Notice, and it is this Notice which the Claimant must address in arguing that the Administrator clearly erred. The goal isn’t empty formalism, but rather to ensure that the Claimant has sufficient notice to adequately pursue an appeal in the context of a process where reply briefs are constrained, and oral argument is absent. Of course, the final Notice does not stand alone: communications from the Claims Administrator received prior to the Appealable Notice are incorporated into the Appealable Notice.⁷

The Claims Administrator’s discussion of CDR in Mr. [REDACTED] Notice of Denial was descriptive rather than conclusive. The key language that might be construed as a “reason for denial” is the statement that “[t]he Player’s history of Attention Deficit Disorder as well as the fact that the Player was still working and driving are complicating factors in the assignment of the CDR.”⁸ Doc. 223259. Does that phrase sufficiently state that the CDR scoring was a “reason” for the determination that Mr. [REDACTED] was not entitled to an award?

⁷ See Settlement Agreement, Section 8.5 (“For rejected Claim Packages or Derivative Claim Packages, the Claims Administrator will send a Notice of Deficiency to the Settlement Class Member, which Notice will contain a brief explanation of the Deficiency(ies) giving rise to rejection of the Claim Package or Derivative Claim Package, and will, where necessary, request additional information and/or documentation. . . . Any Claim Package or Derivative Claim Package that continues to suffer from a Deficiency identified on the Notice of Deficiency following the submission of documentation intended to cure the Deficiency will be denied by the Claims Administrator.”). Here, the only communication from the Claims Administrator, other than Notices regarding audit, was the Notice of Denial.

⁸ The NFL Parties argue, relatedly, that “Mr. [REDACTED] also suffers from Major Depressive Disorder, Social Anxiety Disorder, headaches, stiffness in his back, and pain in his knee, shoulder, and ankles,” and “[y]et Dr. [REDACTED] medical report contains no indication that he analyzed these issues consistent with the CDR rules.” Doc. 225009. While this rationale is persuasive—as Dr. [REDACTED] report is admittedly lacking—it is not one of the reasons currently given by the Claims Administrator for denial of the Claim.

In response to my inquiry, the NFL Parties argue that the introductory and conclusory language included in the notice—“for the following reason(s)” and “[b]ased on the above”—indicate that the “complicating factors” justified the denial, though “the Notice could have been clearer on this point.” Doc. 230099. Mr. [REDACTED] counsel responds that:

[T]he Claims Administrator wrote six sentences discussing those facts that “supported” the CDR score of 1.0. It then used one sentence to note that there were certain “complicating factors” to this assessment. However, not once did the Claims Administrator advise that these “complicating factors” resulted in the CDR score not being generally consistent with the Settlement Agreement.

Doc. 230101.⁹

I conclude that the Notice of Denial is ambiguous as to whether Mr. [REDACTED] functional impairment was a reason for the adverse determination. Determining if the Denial is “based on” a “complicating factor” is problematic: a *complicating* factor may introduce doubt, or make a claim more difficult, but it does not compel a conclusion. Imagine if the Denial were stripped of its other grounds, and was phrased to state that the conflicting evidence of Mr. [REDACTED] retained function made it “hard to know” if he was entitled to an award. That phrase, which approximates the one used, would not indicate that functional impairment was a “reason” for the Adverse Determination under 9.1(c)(i), but, rather, that the real justification was a lack of substantiation. In that were the case, the Claims Administrator likely would have established a record of failing to gather supporting evidence and could be affirmed on that ground.

Here, the underlying AAPC reports contain no such indication, and the Claims Administrator never issued a Notice of Deficiency. Nor were there clear statements in those expert reports which would have fairly led Mr. [REDACTED] to challenge the apparent determination that his retained function exceeded the diagnostic criteria. And those reports certainly did not anticipate the AAP’s late-arriving view that defects in the process of conducting the CDR justifies a denial.

It is simply not obvious if the CDR scoring played a dispositive part in the Claims Administrator’s decision to deny Mr. [REDACTED] Claim. That lack of precision makes it impossible to affirm on the sole ground recommended by the AAP, since I can not be sure that the Adverse Determination stands on that footing. But, neither does the ambiguity about the scope of reasons justifying the Denial mean that Mr. [REDACTED] has established that it was clearly erroneous. “Clear and convincing evidence” of error means that it is “highly probable or reasonably certain” that there was an error.¹⁰ A necessary predicate for that determination is some clarity about what was

⁹ Class Counsel adds that neither of the AAP Consultants who reviewed the Claim prior to the denial cited functional impairment as a reason that the Claim should be denied. Doc. 230100. But the AAP Consultants do not typically address functional impairment, leaving that task to the AAP itself.

¹⁰ *In re Fosamax Alendronate Sodium Prods. Liab. Litig.*, 852 F.3d 268, 285-86 (3d Cir. 2017).

decided and why. To that end, I will remand to the Claims Administrator.¹¹ On remand, the Claims Administrator shall evaluate whether Mr. [REDACTED] has provided documentation of functional impairment that is generally consistent with a Level 1.5 Diagnosis. It may then either issue an Award, provide Mr. [REDACTED] an opportunity to remedy any deficiencies it finds, or re-issue a revised Notice of Denial of Mr. [REDACTED] Claim.

CONCLUSION

The Claims Administrator must provide notice of the deficiencies, if any, in a Claimant's Claim Package, when reaching an adverse determination. I conclude that two of the listed reasons for Mr. [REDACTED] Denial were clearly erroneous. Whether the Denial also rested on Mr. [REDACTED] lack of functional impairment is unclear. Thus, I remand this Claim to the Claims Administrator for clarification.

Date: December 4, 2020



David A. Hoffman, Special Master

¹¹ Rule 24 of the Rules Governing Appeals of Claim Determinations provides that "at any time the Special Master determines it necessary to do so, the Special Master may remand any Claim subject to an Appeal to the Claims Administrator for further processing."