

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

██████████, 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 1.5 Neurocognitive Impairment. The Claims Administrator rejected the Claim on multiple grounds. Because Mr. ██████████ has not presented clear and convincing evidence of error in the Claims Administrator's ultimate determination, the Appeal is denied.¹

On August 23, 2017, Mr. [REDACTED] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 176428. That Diagnosis resulted from a May 18, 2017, examination by then-MAF physician Dr. [REDACTED], and a supporting May 11, 2017, neuropsychological exam by Dr. [REDACTED]. Docs. 176429; 176430.

Shortly after Mr. [REDACTED] submitted his claim, the Claims Administrator placed it into audit. Doc. 177966. The Claim emerged without an adverse finding in May, 2019, and was then reviewed by three of the Program's independent experts, all of whom recommended denial. Doc. 214165;

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214257; 214711. On November 27, 2019, the Claims Administrator accordingly denied the Claim. Doc. 217746. That Notice read:

The Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria. In the 5/18/17 report by the diagnosing physician, Dr. [REDACTED] the player noted a four-year history of memory problems, with impact on daily functions. Anger and agitation are reported without physical violence. Sleep problems are reported, and sleep apnea has been diagnosed. The record implies the player no longer uses the CPAP. He has intermittent, but sometimes severe headaches. Dr. [REDACTED] notes that working out too hard is a trigger. The player reports handshaking, as well as multifocal body pains. Listed medications with known adverse effects on cognition include tizanidine and gabapentin. Dr. [REDACTED] notes that language and speech are intact, and that the player scored 30/30 on the MMSE. Dr. [REDACTED] reports summary CDR scores without detailing his thought processes on functional capacity.

Dr. [REDACTED] performed neuropsychological testing on 5/11/17. In his report, there was a substantial mismatch between the reports of normal observed language and severe impairments on formal language testing, and the thresholds for Level 1.5 Impairment in the domain of Complex Attention were not met. The player's reported daily activities were not consistent with the dementia syndrome indicated by a Level 1.5 diagnosis. Additionally, Dr. [REDACTED] reported the MMPI was valid, but he indicated the player may be prone to symptom overreporting and the results should "be interpreted with caution."

An extensive evaluation was conducted on 1/6/17 at the [REDACTED]. Many of the responses in the [REDACTED] records differ significantly from those identified by Dr. [REDACTED] and Dr. [REDACTED] especially in the domain of self-care. An informant in the [REDACTED] records indicates that the player has significant sleep problems and does not wake up refreshed. Tinnitus, headache, and blurry vision are reported. Poor effort on ocular pursuits and photophobia are described on the examination at [REDACTED] but are not further described or interpreted. Those observations are consistent with the player's elevated symptom reporting scales on the MMPI. Photobia has been reported as being frequently associated with patients' desires to emphasize the severity of their illness.

[REDACTED] On pages 18 and following of the [REDACTED] reports, the player's fiancée provides responses that indicate far less impairment in daily activities than is reported on the [REDACTED] form included in Dr. [REDACTED] records. For instance, independence in self-care and self-directed transportation are reported in the [REDACTED] records.

An approved disability application is included in the portal, in which the player was determined to have total and permanent disability as of 8/1/17 based on

examinations and reports of an orthopedic surgeon, Dr. [REDACTED], on 11/3/16. In the disability application, the player acknowledges his cognitive difficulties, but also limitations in daily function due to pain and reduced mobility: “Pain makes it difficult for me to move around and walk,” “I sleep very little through the night and it cause me to have low energy and stamina throughout the day.” Critically, Dr. [REDACTED] does not document consideration of “total and permanent physical disability” on orthopedic grounds, adverse and untreated sleep patterns (“I sleep very little through the night and it cause me to have low energy and stamina throughout the day”), pain limitations on performance (e.g., headaches upon working out “too hard;” “Pain makes it difficult for me to move around and walk”), or medication effects in the determination of impairments on the CDR. To be generally consistent with CDR scoring rules, functional losses must be attributed to “cognitive loss, not impairment due to other factors.”

Furthermore Dr. [REDACTED] appears to depend entirely on the questionnaire responses of a third-party rather than the interview process required to be generally consistent with the standards for CDR rating. Based on the symptom overreporting, discrepancies of observed behavior and test data, CDR rating discrepancies, and potential alternative factors not being addressed when determining the player’s functional impairment, the Qualifying Diagnosis of Level 1.5 is not generally consistent with the Settlement criteria.

This Appeal followed. As the NFL Parties submitted extrinsic evidence in their opposition, I permitted Mr. [REDACTED] the opportunity to file a reply brief. I also asked for, and received, reviews from an AAP Consultant and an AAP Member. Dr. [REDACTED] late in the process, submitted additional information, which I will discuss below.

DISCUSSION

There are four diagnostic criteria that must be satisfied for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.² Mr. [REDACTED] has offered evidence generally consistent with the first and fourth criteria. The Claims Administrator, however, denied the validity of Mr. [REDACTED] neurological testing (“symptom overreporting, discrepancies of observed behavior and test data”) and the scope of his functional impairment (“CDR rating discrepancies, and potential alternative factors not being addressed when determining the player’s functional impairment.”)

On the second criterion, the Denial Notice focuses on problems of test validity. The NFL Parties, supporting the denial, argue that “Mr. [REDACTED] neuropsychological testing is riddled with warning signs and significant concerns regarding the veracity and potential invalidity of his performance.” Some of those red flags can be traced to Dr. [REDACTED] original report, which is barren of detail. However, in July of this year, Dr. [REDACTED] submitted a supplemental document listing the

² Settlement Agreement, Exhibit A-1 (1)(a)(i)-(iv).

raw scores for Mr. █████ validity measures and his MMPI-2-RF.³ An AAPC, given the opportunity to review those raw scores, concluded that they sufficed to establish the validity of Mr. █████ testing: “While there is some evidence of symptom overreporting, the performance validity measures do not provide a basis to question the examining neuropsychologist’s validity determination in this case. I defer to the examining neuropsychologist regarding the validity determination.” Doc. 227683. As I have recently held:

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* analyses, the AAP may thoroughly and independently assure themselves the criteria do not indicate invalid testing.⁴

In this case, Dr. █████ did not offer an articulated judgment. The AAP was thus justified in interrogating the record and assuring the Program’s participants of the legitimacy of Mr. █████ scores. The latest AAPC report found that Mr. █████ testing was valid. I adopt that reconsidered view. The reason the Claims Administrator gave in denying the second criterion was clearly erroneous.⁵

³ 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.

⁴ Special Master Ruling on *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020).

⁵ The most recent AAP Review opines that notwithstanding Mr. █████ valid test scores, he did not clearly satisfy the second criterion because Dr. █████ “did not use full demographic corrections and did not provide an adequate explanation for not using full demographic corrections. Furthermore, when full demographic corrections are used the scores no longer meet criteria for level 1.5 impairments in the cognitive domains of Learning/Memory and Complex Attention/Processing Speed.” Doc. 227907. As the terminal AAPC review stated:

However, there is a different, *previously unmentioned issue* with the neuropsychological report. Dr. █████ did not appear to use full demographic corrections in this case. Nor does he provide a rationale for not doing so. Scores with full demographic corrections are listed in the table below. I would further note that this issue of using full demographic adjustments has been reviewed to the Special Master and the Settlement Parties at length and that a standard has emerged that neuropsychologists should provide a rationale in writing whenever she or he deems it appropriate to forego full demographic adjustments. I could not find such a rationale in Dr. █████ original report or any subsequent documentation provided by him. When the recommended full demographic corrections are applied the player does not meet criteria for level 1.5 impairments in Learning/Memory or Complex Attention/ Processing Speed. Doc. 227683 (emphasis added).

Were this question controlling, a possibility would be to follow the AAP’s advice and remand for further substantiation pursuant to recent guidance from the Special Masters. *See Special Master Opinion on Demographic Norm Adjustments* (Aug. 20, 2020), https://www.nflconcussionsettlement.com/Docs/demographic_norms_sm.pdf. However, as neither the Claims Administrator nor the NFL Parties raised this issue earlier, it is not obviously in dispute. More significantly, the functional impairment issue discussed in the text above is dispositive standing alone and a remand would thus merely add delay to no useful end.

Functional impairment remains a barrier to Mr. █████ recovery. The Denial notes problems in the process by which the CDR was performed, raises concerns about Mr. █████ retained function, and states that Dr. █████ failed to explore alternative bases for Mr. █████ disabilities. Mr. █████ Appeal argues that the “record is replete with evidence showing that he has a CDR of *at least* 1.0.” But his argument largely focuses on rebutting contrary evidence (from a █████ exam that occurred in early January 2017) because (he argues) it significantly predated the Diagnosis Date of August 2017. That contention would be more persuasive if the Diagnosis did not itself rest on testing from May 2017—not “nine months” after the █████ Exam’s recording of significant retained function, but rather four. “Evidence that tends to establish a pattern of behavior inconsistent with the factual predicates of a diagnosis is always probative of claims’ legitimacy, and thus welcome on appeal.”⁶ That’s particularly true when the pattern is “contemporaneous with the examination that led to the diagnosis.”⁷

Mr. █████ also argues that Dr. █████ failure to discuss the influence of pain on functional impairment should be excused because the MAF Rules which required such explicit discussion of confounding factors had not yet been promulgated when Dr. █████ wrote his report. While that may be true, in the absence of that discussion it is not possible to determine how Dr. █████ concluded that Mr. █████ functional impairments resulted from his cognitive decline instead of his well-documented history of physical disability. That history included double vision, insomnia, depression, severe sleep apnea, daily joint pain, and a diagnosis of “complete and permanent physical disability” by an orthopedic surgeon.

AAP Members, reviewing the file, have come to somewhat different conclusions as to whether Mr. █████ functional impairment met the injury definitions. Those before the denial—as I’ve discussed—focused on the process by which the CDR was conducted and the discordance with other evidence in the file. The two that reviewed those analyses post-Appeal have reached different answers. In one review, dated April 25, 2020, the AAP concluded that Mr. █████ had offered evidence generally consistent with a 1.0 in Personal Care and Home/Hobbies, though not in Community Affairs. That review concluded, without further explanation, that “taken as a whole,” Mr. █████ established the functional impairment criterion. Implicitly, that AAP member concluded that Mr. █████ functional impairment was generally consistent with the injury definitions though he did not meet the underlying criteria in one of the three CDR categories. Doc. 227907. Another analysis, dated July 7, 2020, states that:

While the reported information regarding the functional abilities including the CDR category of Community Affairs is somewhat mixed . . . the reported abilities to drive, shop, and travel independently would indicate that the Player continued to be able to function independently outside the home and the new/additional information would not affect that determination.” Doc. 226290.

⁶ See Special Master Opinion on Pre-Diagnosis Evidence (July 2, 2020), https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_sm.pdf.

⁷ *Id.*

I conclude that Mr. [REDACTED] has not met his burden on Appeal. He has not shown clear error in the Claims Administrator's analysis of his involvement in community affairs, and consequently has failed to rebut an important gap in the file. Two additional points bear emphasis.

First, the [REDACTED] testing, which was proximate to the Diagnosis in time, undermines it. As an early AAP Reviewer, summarizing those comprehensive medical records, concluded:

The available information indicates that, although cognitive losses are present, alternative noncognitive causes of the functional deficits (as is required by the CDR) were not adequately addressed by the clinicians as the origin of the deficits. These include orthopedic limitations sufficiently severe to warrant Total and Permanent disability, untreated sleep apnea with correlated symptoms of unrefreshing sleep, headaches triggered by activity, and medications with known adverse effects on cognition.

Doc. 214165.

Dr. [REDACTED] failed to discuss these issues in his report, and Mr. [REDACTED] Appeal did not convincingly rebut the relevance of these records to the Claims Administrators' Denial.⁸ It was not clearly wrong for the Claims Administrator to deny the Claim on this ground.⁹

Second, the method by which the CDR analysis was conducted was arguably inconsistent with the the CDR form's own guidelines and with the Settlement. Mr. [REDACTED] third-party affidavit was completed by his fiancé, [REDACTED], though the Settlement states that "family members" can not be a source of that attestation.¹⁰ More importantly, the CDR Worksheet should be completed through a semi-structured interview conducted by the clinician. Dr. [REDACTED] by contrast, appeared to let Ms. [REDACTED] complete the form on her own— it is completed in the first person in her handwriting. Doc. 176432. The result is that neither the form nor the affidavit can reliably provide evidence generally consistent with the requirements of the third criterion. At the very least, the Claims Administrator was not clearly in error to so find.

⁸ The NFL Parties offer external evidence of Mr. [REDACTED] retained function in 2016 (shooting at gun ranges) and the Fall of 2017 (attending concerts). Mr. [REDACTED] in response, denies attending one of the concerts and argues that they are not inconsistent with a CDR Score of 1.0 in Community Affairs. I agree with Mr. [REDACTED] counsel that the videos standing alone are not dispositive. The videos from the Fall of 2017 are, however, inconsistent with Dr. [REDACTED] general description of Mr. [REDACTED] lack of engagement in community affairs and do reinforce the correctness of the Denial.

⁹ "[I]f 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 Portal, *Frequently Asked Questions*, FAQ #113.

¹⁰ Whether a fiancé is a "family member" for the purposes of the Settlement is not settled, and this Appeal does not turn on that question given the other independent grounds on which it fails. However, FAQ #115 defines family members to include both "spouses" and "domestic partners." I would hold that, in light of that expansive guidance, to advance the purpose of the Settlement's prohibitory language, and to aid administrability, a fiancé is a "family member." The Rule's rationale is particularly evident in this case: Ms. [REDACTED] discloses a thirteen-year relationship with Mr. [REDACTED] and the two lived together after 2005. Doc. 176434. The Parties may consider revisiting this issue with the Claims Administrator.

CONCLUSION

To establish a right to relief under the Settlement, Mr. [REDACTED] was required to offer evidence generally consistent with the requirements for Level 1.5 Neurocognitive Impairment. 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.” I conclude that Mr. [REDACTED] only partly met his burden. The Claims Administrator wrongly determined that his testing was not valid, but not that his functional impairment was inconsistent with the injury definitions. The Appeal is denied.

Date: December 15, 2020



David A. Hoffman, Special Master