

IN RE: NATIONAL FOOTBALL LEAGUE
PLAYERS' CONCUSSION INJURY
LITIGATION

MDL No. 2323

Hon. Anita B. Brody

INTRODUCTION

Mr. [REDACTED] filed a second Claim on December 12, 2019, again asserting Level 2 Neurocognitive Impairment. Doc. 218332. Dr. [REDACTED], who made the Diagnosis on October 8, 2019, determined that performing neuropsychological testing to support the Diagnosis was medically unnecessary because of the severity of Mr. [REDACTED] impairment. Doc. 218333. Dr. [REDACTED] in both considering the neuropsychological tests that Dr. [REDACTED] administered as well as conducting his own preliminary assessment, explained:

Neuropsych[ological testing was] done “years ago.” He saw [a] Neuropsych[ologist] in 2016 [and] showed moderate dementia; impaired in 5+ domains. On testing [the patient] was disoriented [and] had short & long term recall. This is based on my assessment also that shows 1) Severe decline in cognitive function; (2) Decline in personal care, home & hobbies, community affairs, in absence of delirium. He is incontinent, wets bed, [is] depressed [with] anger issues, & change[s] personality.

Id. (cleaned up).

On March 12, 2020, the Claims Administrator issued a Notice of Preliminary Review, requiring Mr. [REDACTED] to submit more information about his functional impairment, while asking Dr. [REDACTED] to further explain how he isolated the causes of Mr. [REDACTED] functional impairment and why he concluded that testing was medically unnecessary. Doc. 221610. When prompted about a discrepancy between reports of Mr. [REDACTED] driving and employment and the CDR scoring, as well as about his rationale for finding that testing was not appropriate, Dr. [REDACTED] responded:

[Y]our history is different than mine. I got that the patient did not work or drive. That is in my note. He cannot recall more than a day ago. He sleeps a lot, is sad and those are features of depression. He is totally disabled. Re neuropsych, I believe I saw enough as a neurologist to diagnose as level 2. Please remember that those are categories invented by the NFL and not true categories that we use in practice. He had poor performance in 2016 which can be attributable to a lot of things including intentional lack of effort, lack of understanding of task, depression or others. However, please send for neuropsych if you feel differently or want another set of eyes.

Doc. 224378 (cleaned up).

Relying on an Appeals Advisory Panel Consultant’s analysis, the Claims Administrator denied the Claim on December 30, 2020, explaining:

The Qualifying Diagnosis of Level 2.0 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria. The Diagnosing Physician, Dr. [REDACTED], evaluated the Player on 3/11/2019 and 4/24/2019, and provided an additional explanation dated 4/15/2020. There is also a neuropsychological evaluation that was performed by Dr. [REDACTED] with a report date of 2/17/2016 and a CDR worksheet. The Qualifying Diagnosis of Level 2.0 Neurocognitive Impairment requires fulfilling four criteria.

Criterion (i) requires documentation of concern for a severe decline in cognitive function and this is fulfilled by the Diagnosing Physician’s note which reports memory loss for around 10 years, no longer working (although helping his wife in

her event planning company), depression, misplacing items, getting lost while driving, not being fully oriented, and anger/agitation issues.

Criterion (ii) requires evidence of severe cognitive decline in accordance with the standardized neuropsychological testing protocol. The Diagnosing Physician indicates on the Certification Form that neuropsychological testing is not medically necessary based on the Player having already undergone a neuropsychological evaluation in 2016 that showed impairment in five plus domains, as well as based on his own assessment which showed disorientation, impaired memory, a decline in functioning, incontinence, depression, and a change in personality.

The neuropsychological evaluation that was performed in 2016 was reviewed by the AAP Consultant who determined the testing did not support the Qualifying Diagnosis for several reasons. The examining neuropsychologist, Dr. [REDACTED] is not board-certified and did not administer the BAP battery. The testing was also determined to be invalid due to failure of multiple performance validity measures and the Player was described as falling asleep multiple times during the evaluations which were conducted over three days. There were also additional Slick Criteria issues with the performance being discrepant with accepted models of CNS dysfunction, and discrepancy between test behavior and observed behavior as well. The AAPC also noted that Dr. [REDACTED] reported a MoCA score of 11/30 only 8 months after an MMSE of 26/30 which suggests either invalidity or an acute process such as overmedication which would invalidate the findings. Consequently, the results of the neuropsychological evaluation by Dr. [REDACTED] do not support the Qualifying Diagnosis and should not be used by the Diagnosing Physician to justify why a new neuropsychological evaluation is not medically necessary. Consequently criterion (ii) is not fulfilled.

Criterion (iii) requires documentation of functional impairment generally consistent with scores of 2.0 for the three relevant CDR categories. There were some initial discrepancies noted between the Diagnosing Physician's note which indicated the Player was able to work by helping in his wife's business and would get lost while driving which seemed to indicate the Player was able to drive although with some problems. The Diagnosing Physician later clarified that in his opinion the Player was not able to work or drive. Additionally, the information in the CDR worksheet would be generally consistent with scores of 2.0 for the CDR categories of Community Affairs, Home/Hobbies, and Personal Care, so criterion (iii) is fulfilled.

Criterion (iv) requires that the cognitive deficits do not occur exclusively in the context of a delirium, acute substance abuse, or as a result of medication side effects. As noted above, the AAP Consultant review indicated that the acute worsening in performance on the evaluation by Dr. [REDACTED] could suggest an acute issue such as effects from medications; however, there are no other indications that

the cognitive deficits occur exclusively in the context of these conditions and so criterion (iv) is fulfilled.

The AAP determined criteria (i), (iii), and (iv) are fulfilled based on the documentation provided. While it is clear that the Player has cognitive and functional deficits, the decision by the Diagnosing Physician that a new neuropsychological assessment is not medically necessary is not reasonable and is not adequately supported by the evidence because the Diagnosing Physician based this decision in part on the flawed neuropsychological evaluation from 2016. The Qualifying Diagnosis of Level 2.0 or Level 1.5 Neurocognitive Impairment is not generally consistent with the Settlement criteria until the Player obtains a new and valid neuropsychological evaluation.

Doc. 231488 (cleaned up and paragraph breaks added). On February 5, 2021, Mr. [REDACTED] appealed the Denial. Doc. 232637.

DISCUSSION

The Denial rests on the correctness of the conclusion that criterion (ii) of the Injury Definition for Level 2 Neurocognitive Impairment was not fulfilled.¹

On appeal, Mr. [REDACTED] first argues that the Claims Administrator's emphasis on the validity of previous neuropsychological testing was erroneous given that Dr. [REDACTED] also found, based on his own assessment that was separate from this prior testing, that *any* testing was medically unnecessary. I agree that while Dr. [REDACTED] appears to have considered Mr. [REDACTED] prior testing to some extent, he also made clear that he examined Mr. [REDACTED] and made a distinct determination.

That said, even were I to agree that the invalidity findings in the prior testing were irrelevant, Dr. [REDACTED] conclusion based on his own assessment must have been reasonably determined. As FAQ #363 explains:

Generally, deference is given to the determinations made by a diagnosing Qualified MAF Physician because of the doctor's eminence and training, as well as his or her personal evaluation of the Player. However, if the Qualified MAF Physician indicates that neuropsychological testing is medically unnecessary because of the severity of the Player's dementia, the Claims Administrator has the obligation to determine if that conclusion was "reasonably determined." In this context, the Qualified MAF Physician's conclusion is "reasonably determined" if the doctor's conclusion can be identified as an application of the Settlement's narrow exception to the testing requirement. In other words, it was reasonable for the doctor to

¹ More precisely, the question is whether Mr. [REDACTED] can show by clear and convincing evidence that this conclusion was in error. See *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.'").

conclude that the testing would not generate valid results (note: stating that a task or test will be difficult for a Player is not the same as saying the testing would not generate valid results).

Enforcing the Settlement Agreement, I have applied two factors when determining whether the “reasonably determined” standard was met:

Under the Settlement, particularly Section 8.6(b), the Claims Administrator has the authority to verify the sufficiency of both prongs of that reasonableness inquiry: How *severe* was the impairment; and, Why does the impairment’s severity make the testing *unnecessary*? That is not the same as saying that the Claims Administrator’s supervisory authority is plenary. The Parties have interpreted the agreement to mean that the Claims Administrator cannot disagree with the clinician’s Certification merely because it would have made a different choice. The clinician’s articulated reasons for certifying must be *unreasonable*. But the Claims Administrator possesses ample authority to require a complete explanation, and to ensure it is internally consistent.²

Dr. [REDACTED] explained in his MAF Diagnosing Physician Certification Form that testing Mr. [REDACTED] was medically unnecessary because of his apparently severe decline in cognitive function, and because of his bed wetting, anger issues, and personality changes. I requested that a member of the AAP review this conclusion given the “reasonably determined” standard. One of the Program’s independent medical experts evaluated the cognitive screening tests and other evidence that Dr. [REDACTED] alluded to in determining that further neuropsychological testing was unnecessary. Ultimately, the Reviewer made the following recommendation:

The question from the Special Master indicates there are two prongs to the reasonableness of the Diagnosing Physician’s determination that a neuropsychological evaluation is not medically necessary: the first prong is the severity of the impairment, and the second prong is why does the severity of the impairment make the testing unnecessary.

Regarding the first prong, on examination the Diagnosing Physician reports scores for Mental Status testing, including most of the components of the MMSE (8/10 for orientation, 3/3 for registration, 1/3 for recall, 4/5 for spelling the word “WORLD” backwards, 2/2 for naming, 6/6 not repeat a sentence with functors, comprehend a two-part command given orally, able to read, perform a command, and write a sentence). The performance on the portions of the MMSE described by the Diagnosing Physician (24/29 points on an abbreviated MMSE) could be consistent with either minor neurocognitive disorder or a mild dementia but would not seem to indicate either a moderate or severe dementia.

² Special Master Ruling on Qualified MAF Physician’s Certification that Testing is Medically Unnecessary, at 3–4 (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_certification_testing_sm.pdf (emphasis in original).

Regarding the second prong, the severity of the impairment reported by the Diagnosing Physician's mental status testing (24/29 points on an abbreviated MMSE) would not seem to indicate a level of impairment that would cause a neuropsychological evaluation to be unable to be completed and would not seem to indicate a level of impairment so severe that a neuropsychological evaluation would not be necessary to more accurately determine the severity of the dementia. Consequently, in my opinion the Diagnosing Physician's determination that neuropsychological testing was medically unnecessary is not reasonable based on the information documented by the Diagnosing Physician in the evaluation note. Therefore criterion (ii) is not fulfilled.

Doc. 237631 (cleaned up and paragraph breaks added).³

Applying the appropriate and deferential standard, one of the Settlement's independent medical experts nevertheless concluded that Mr. [REDACTED] cognitive screening test results did not indicate a severity of impairment that would lead a diagnosing physician to reasonably conclude that further testing was medically unnecessary. I defer to this judgment. As such, Mr. [REDACTED] has not provided clear and convincing evidence of error in the Claims Administrator's Denial.

CONCLUSION

On appeal, Mr. [REDACTED] was required to provide clear and convincing evidence that the Claims Administrator's determination—particularly, that his Claim failed for lack of neuropsychological testing—was wrong. Mr. [REDACTED] did not meet that burden and I therefore deny his Appeal.

Date: September 23, 2021



David A. Hoffman, Special Master

³ As I have recently written, "reliance on [screening tests] in determining whether neuropsychological testing is unnecessary is appropriate when accompanied by other considerations of a Retired Player's cognitive impairment." Special Master Ruling on Functional Impairment/Cognitive Decline, at 7 n. 3 (Sept. 7, 2021), https://www.nflconcussionsettlement.com/Docs/functional_impairment_sm_5.pdf. Just as it is appropriate for an MAF Physician to use these screening tests, such as the Montreal Cognitive Assessment (MoCA), the Short Test of Mental Status (STMS), and the Mini-Mental State Exam (MMSE), to determine whether neuropsychological testing is medically necessary, it is also appropriate for the AAP to evaluate whether the conclusions that physicians reach based on these tests are reasonably determined.