

**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 REPRESENTATIVE
CLAIMANT ██████████
REGARDING DENIAL OF MONETARY
AWARD

INTRODUCTION

██████████, a Retired NFL Player and Class Member under the Amended Class Action Settlement Agreement, filed for benefits associated with a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. In the absence of a *Slick* validity checklist and evidence that Mr. ██████████ reduced daily functioning was the result of cognitive decline, the Claims Administrator determined that his Claim did not qualify for the Settlement's benefits. Since Mr. ██████████ has not presented clear and convincing evidence that the Claims Administrator's determination was incorrect, his Appeal is denied.¹

PROCEDURAL HISTORY

On June 25, 2018, Mr. ██████████ filed for benefits based on a Level 2 Qualifying Diagnosis. Doc. 177198. Dr. ██████████ served as Mr. ██████████ MAF neurologist, and relied on a neuropsychological assessment that Dr. ██████████ provided on April 20, 2018. Doc. 176736; Doc. 179454. On November 18, 2019, after reviewing Mr. ██████████ Claim, the Claims Administrator determined that he was not eligible for the Settlement Agreement's benefits, noting "significant inconsistencies between medical records, neuropsychological testing and reports of the Player's function in daily life. There are also serious concerns regarding the validity of the Player's poor performance on neuropsychological testing as a reflection of a neurocognitive disorder, as well as the accuracy of the Player's symptom reporting." Doc. 217292. On January 20, 2020, Mr. ██████████ appealed, and the Special Master remanded his Claim for re-review. Doc. 219726; Doc. 220124.

¹ 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.") (cleaned up).

On April 8, 2020, Mr. ██████ Claim was placed into audit, with the Claims Administrator requesting further documentation regarding his health and employment history. Doc. 223209. After the audit process failed to find a misrepresentation, omission, or concealment of a material fact, the AAP weighed in on Mr. ██████ Claim. After concluding that the MMPI-2-RF protocol was invalid, the AAP addressed the *Slick* checklist:

Dr. ██████ did not address any of the problems with *Slick validity criteria*, which were outlined in the initial AAPC review. Dr. ██████ neuropsychological report and other documentation show multiple discrepancies in terms of Slick validity criteria. As previously pointed out, the retired player was able to attend the neuropsychological evaluation without requiring anyone to accompany him. In addition, there are inconsistencies in documentation for his ability to continue drive. The neurological examination by ██████ (07/17/2017) states that the player was continuing to drive and that he could shop independently. Similarly, there are inconsistencies concerning employment. For example, Dr. ██████ (07/18/2017) reported that the player was “currently looking for work.” Another inconsistency pertains to memory functioning. Documentation (multiple neurological examinations, two affidavits, and numerous neuropsychological evaluations) described memory as the retired player’s primary cognitive problem and most significant functional impairment. However, Dr. ██████ formal testing shows that memory as a relative strength on most measures of learning/memory (5 scores range from 12-58%, 1 score is at 5%).

In conclusion, symptom validity and Slick validity criteria continue to be a serious flaw and limiting factor for Dr. ██████ 04/20/2018 neuropsychological evaluation. Therefore, the evaluation cannot support the diagnosis of a major neurocognitive disorder, and do not satisfy the NFL Concussion Settlement Program’s Criteria for Level 2.0 Neurocognitive Impairment.

Doc. 228729 (emphasis in original).

The Claims Administrator denied Mr. ██████ Claim on January 12, 2021, concluding:

Based on such AAP input, the Settlement Class Member does not qualify for a Monetary Award for the following reason(s): There are four diagnostic criteria for a Qualifying Diagnosis of Level 2 Neurocognitive impairment; here, the AAP determined that criteria (ii) (“evidence of moderate to severe cognitive decline . . . in two or more cognitive domains”) and (iii) (“functional impairment”) were not generally consistent with the Settlement criteria.

The AAP member reviewed the entire file and noted the following history:

Dr. ██████ certified a Qualifying Diagnosis of Level 2 Neurocognitive Impairment on 6/22/2018. At that time the Player stated worsening memory since 2010 with

misplacing things and forgetting names, appointments and chores. The Player was no longer driving, with a previous accident and getting lost, and his wife paid the bills since he had missed payments. He was no longer working as a physical education teacher and coach since he was unable to pass the certification test in 2015. The Player scored 21 out of 30 on the MMSE but was oriented with intact speech and language. He was given a CDR of 2.0 for Community Affairs, Home and Hobbies, and Personal Care. This rating is accompanied by a CDR score sheet completed by the Player and his wife noting that he rarely or never carried out activities outside his home, was able to do some simple tasks, but usually did not complete chores. Difficulties in Personal Care listed, however, were only difficulty with dressing and needing prompted for washing and grooming, with ratings on this domain of 2,1,0, and 0. The diagnosis is supported by affidavits from friends dated 8/27/2017 and 8/29/2017, noting the Player's difficulties with memory, less fluent speech, and difficulty with finances, frustration and irritability, but with few comments regarding the relevant domains of the CDR.

The Player had neuropsychological (NP) testing on 4/20/2018 by Dr. [REDACTED] noting Level 2 impairment in the domains of Complex Attention, Language, and Visual/Perceptual Function, but without significant impairment in Learning and Memory or Executive Function. Dr. [REDACTED] considered the Player's performance to be valid.

In the prior Denial of this claim, the AAP member found the medical records and other material supporting the Player's level of cognitive impairment to be inconsistent, with highly variable performance for the cognitive domains affected on three sets of NP testing over 16 months included with the claim. These earlier NP reports also expressed concerns regarding validity of testing and the Player's effort, with interfering factors such as depression and chronic pain.

An AAP Consultant (AAPC) reviewed Dr. [REDACTED] neuropsychological evaluation and additional documentation submitted on 1/20/2020, including a letter from the Player's representative and a letter from Dr. [REDACTED] dated 1/7/2020. The AAPC found that it did not adequately support the Qualifying Diagnosis, for the following reasons: (1) invalid performance on the MMPI-2-RF, raising concern regarding over-reporting of symptoms in the Player's reports of difficulties in daily life (in that the MMPI-2-RF protocol was invalid and the T-score for a scale particularly relevant to the Player's complaint of memory difficulty was omitted, raising the strong possibility that the Player's reported symptoms were exaggerated); (2) a pattern of performance on Dr. [REDACTED] evaluation compared to previous NP testing with improvement on several subtests along with greater than expected worsening of performance on other subtests that is inconsistent with the diagnosis of a dementing illness; and (3) the functional significance of the Player's performance on Dr. [REDACTED] NP testing is questionable since testing by Dr. [REDACTED] showed intact verbal and visual memory,

while all affidavits and historical information emphasize the impact of the Player's poor memory.

The AAP member shared the AAPC's opinion that serious concerns remain regarding the overall conclusion of the Player's assessment and found that the Player's poor performance for Dr. [REDACTED] was inconsistent with several aspects of his functioning in daily life and observed behavior so as to represent a failure in Slick criteria. These inconsistencies include the domain of Language, where the description by Dr. [REDACTED] of intact speech and language is inconsistent with the poor performance on NP testing and support an opinion that the NP testing by Dr. [REDACTED] does not represent an accurate reflection of the Player's cognitive abilities, which are likely less severe than that seen in patients with a Level 2 Neurocognitive Impairment. Thus criterion (ii) is not fulfilled.

Regarding criterion (iii), concerns also remain regarding the claimed impact of the Player's cognitive difficulties on his functioning in daily life, including the accuracy of the Player's CDR scores (particularly in the area Personal Care). Not only is there a significant possibility of the Player's over reporting of symptoms, but new information obtained in the audit calls into question the role of cognitive difficulties in the Player's overall functioning. [T]he Player states that his socialization is limited by anxiety, headaches, a sense of restlessness and difficulty standing. Similar comments are made regarding why he rarely attends church. These comments support a conclusion that the influence of the Player's cognitive difficulties alone on the Player's function in daily life is also not at a level of severity seen in patients with moderate dementia and that the medical records are not generally consistent with the Settlement Criteria for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

Doc. 231820 (cleaned up). Mr. [REDACTED] timely appealed. Doc. 233725.

DISCUSSION

Mr. [REDACTED] bears the burden on appeal of offering clear and convincing evidence of error in the Claims Administrator's Denial. In considering if he has met that burden, I will focus first on the validity of his neuropsychological testing.² Doc. 233723. Unfortunately, Dr. [REDACTED] 2018 report does not reflect an articulated judgment about the *Slick* criteria. He wrote:

No clear indicators of performance invalidity are present, nor was there a clear discrepancy between his test performance and his observed behavior. Behaviorally,

² In responsive briefing, the NFL Parties refer briefly to Mr. [REDACTED] arrest and indictment for submitting fraudulent health reimbursement claims to the [REDACTED] between 2017 and 2018. They argue that the arrest is "potentially relevant information in considering the validity and veracity of Mr. [REDACTED] neuropsychological testing and self-reporting." Doc. 234808, n.2. Not fully understanding how to weigh the fact of this arrest, or the chain of logic which would make it clearly relevant, I did not consider it in reaching this decision.

Mr. [REDACTED] was noted to work diligently [a]cross the evaluation. Classification of performance validity is optimal and the current evaluation is considered to be a valid representation of Mr. [REDACTED] abilities.

Doc. 179454. This assessment falls well short of “a thorough consideration of a claim’s inconsistencies and instances of potential invalidity, and [the] use [of] the clinician’s best articulated medical judgement to resolve any inconsistencies and dispel suggestions of invalidity.”³ As Settlement FAQ # 372 clearly explains:

The Claims Administrator will evaluate a submitted claim and determine whether it satisfies the Settlement requirements, including by assessing the thoroughness and accuracy of any explanations about performance validity, with input from the AAP and/or its Consultants where necessary. 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. When clinicians fail to articulate their judgment through complete Slick analyses, the AAP and/or its Consultants may thoroughly and independently assure themselves the criteria do not indicate invalid testing.⁴

Members of the AAP, in reviewing the Claim, highlighted multiple inconsistencies between Mr. [REDACTED] testing and his retained function: e.g., Mr. [REDACTED] was able to attend his evaluation unaccompanied, prior medical reports from 2017 indicating that he was able to drive and shop,⁵ and the inconsistency between his scores with his reported struggles with memory. In the AAP’s judgment, those inconsistencies rendered Mr. [REDACTED] test scores unreliable.⁶

Dr. [REDACTED] in this Appeals process, wrote a letter questioning the relevance of the discrepancies the AAP had identified:

[T]he AAP believes Mr. [REDACTED] should have demonstrated memory problems on my testing because memory problems were specifically reported by the Player and collateral informants in the record. This is, in my opinion, a weak argument. First, it overestimates the knowledge of Mr. [REDACTED] collateral informants. Do we really

³ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 9 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

⁴ See *id.* at 10.

⁵ I agree with Mr. [REDACTED] counsel that the Claims Administrator and AAP should only consider the neuropsychological evaluations on which the Claim rests in determining whether Mr. [REDACTED] and other Class Members meet the Settlement’s requirements for Criterion (ii) of a Qualifying Diagnosis. Settlement Agreement, Exhibit A-1 (2)(a)(ii). However, *Slick* criterion 5 requires clinicians to consider “[d]iscrepancies between test data and documented background history. Improbably poor performance on two or more standardized tests of cognitive function within a specific domain (e.g., memory) that is inconsistent with documented neurological or psychiatric history.” Settlement Agreement, Exhibit A-2, Section 2. As such, it was not improper for the AAP to consider Mr. [REDACTED] current neurological and neuropsychological assessment results in the context of reliable data about his function that was part of his file.

⁶ The Claims Administrator’s determination is also not in error given Mr. [REDACTED] invalid performance on the MMPI-2-RF.

expect a lay collateral informant to untangle the complicated reason why Mr. [REDACTED] forgets information? It could be because he wasn't paying attention, or was slow to process relevant information, or had difficulty organizing the incoming information for remembering later. A lay person just knows he forgot something and it is unfair to expect them to know why. Second, the AAP underappreciates the role of processing speed and attention on memory. [REDACTED], one of the most respected leaders in the field of cognitive aging, has written extensively on the role of processing speed as the most important underlying cognitive factor that supports all other fluid processes. There are many medical conditions in which the patient reports memory problems, but a careful examination would reveal that their functional memory impairment is due to slowed processing speed (e.g., multiple sclerosis). Mr. [REDACTED] was exceptionally slow and it took considerable effort and careful observation to repeat instructions while administering memory tests to him.

Doc. 233723.

This may be a plausible analysis, but it is not what Dr. [REDACTED] wrote at the time. And it is incomplete. There remains no explanation for Mr. [REDACTED] lack of impairment in the Learning and Memory test domains. And, Dr. [REDACTED] report includes numerous mentions of Mr. [REDACTED] reported memory issues. For example, he wrote:

Mr. [REDACTED] reported experiencing cognitive decline since approximately 2009. He shared that he no longer feels like himself and that he “needs to be babysat” by his family because of his problems with his memory. Examples of his memory decline include: frequently forgetting conversations and events; poor recall of dates, timelines, and anniversaries; and misplacing his personal belongings.

Doc. 179454. But few pages later in his report, Dr. [REDACTED] wrote that Mr. [REDACTED] “[l]evel of impairment in [the Learning and Memory] domain is classified as 0.” *Id.* Therefore, Dr. [REDACTED] was required by the terms of the Settlement Agreement to complete the *Slick* checklist regarding *Slick* criterion 4, which implicates any “[d]iscrepancy between test data and reliable collateral reports,” as well as *Slick* criterion 5, which implicates any “[d]iscrepancy between test data and documented background history.”⁷

Overall, I cannot conclude that Mr. [REDACTED] has offered clear and convincing evidence of error in the Claims Administrator’s decision. Rather, at most he has suggested the existence of a good-faith dispute between two sets of doctors, both offering explanations long after the critical examination in question. “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.”⁸ That review is just what the AAP accomplished here—and the Claims Administrator in turn relied upon.

⁷ Settlement Agreement, Exhibit A-2, Section 2.

⁸ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, *supra* note 3, at 10.

Even had he established that the Denial was wrong about the reliability of his scores, Mr. [REDACTED] also must show that he would have satisfied Criterion (iii). Dr. [REDACTED] assessment includes no detailed information regarding Mr. [REDACTED] CDR scoring, save for checked boxes, circled numbers, and twelve illegible, handwritten words describing his activity. Although Dr. [REDACTED] included final scores for each of the CDR Categories, he provided virtually no accompanying information to support those determinations. Doc. 176735.⁹

This cursory report is insufficient in at least one critical respect: the extent to which Mr. [REDACTED] functional impairment was due to cognitive loss, and not to other factors. Of course, Dr. [REDACTED] was not required to establish that Mr. [REDACTED] functional loss was *caused* by his cognitive decline. Rather, the Settlement requires that when—as here—emotional/psychiatric factors potentially relate to the Claimant’s functional impairment, the physician “to the extent feasible,” must “attempt to isolate the functional impairment due to cognitive loss alone and assign a CDR rating based solely on that cognitive loss.”¹⁰ This Dr. [REDACTED] failed to do.

Mr. [REDACTED] audit questionnaire illustrates the importance and materiality of Dr. [REDACTED] missing discussion. For example, Mr. [REDACTED] explained that he “rarely engage[s] in social activities” because he is “not able to withstand the crowds due to bouts of anxiety.” Doc. 224483. He added that “because of [his] anxiety, [his] headaches and [his] ability to stand for long periods of time” he no longer engages in back-to-school events and speaking engagements. *Id.* He further stated that he no longer attends church because he becomes “edgy and restless due to sitting for long periods of time” and he cannot “tolerate the loud noises which bring about [his] headaches.” *Id.* These responses provide the only substantive information regarding Mr. [REDACTED] daily cognitive functioning since he filed this Claim, and, as the Denial Notice states, they do not tend to support his entitlement to relief. Here, too, Mr. [REDACTED] has not offered clear and convincing evidence that the Claims Administrator erred.

CONCLUSION

Mr. [REDACTED] Claim was denied on multiple grounds, including unaddressed *Slick* validity criteria, as well as an unclear and underdeveloped record regarding his daily cognitive functioning. He has not offered clear and convincing evidence of error in that Denial. His Appeal is therefore denied.

Date: July 1, 2021



David A. Hoffman, Special Master

⁹ Notably, Dr. [REDACTED] indicated that Mr. [REDACTED] needs prompting—but not another’s assistance—to wash and groom himself. This is inconsistent with a Category 2.0 score in Personal Care, which requires “assistance in dressing, hygiene, [and] keeping of personal effects.” Settlement Agreement, Exhibit A-1(2)(a)(iii).

¹⁰ Settlement Agreement, FAQ # 113.