

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

flag any of the other considerations of the Slick . . . indications of malingering.” *Id.* He further asserted that Mr. ██████ “current cognitive deficits are not better explained by emotional disturbance or psychopathology.” *Id.*

Mr. ██████ received a Pre-Effective Date Diagnosis of Level 2 Neurocognitive Impairment from Dr. ██████, a board-certified neurologist, on August 18, 2016. Doc. 72188. Dr. ██████ performed a neurological evaluation and reviewed Mr. ██████ medical and social history. *Id.* Drawing support from the neuropsychological testing results obtained by Dr. ██████ Dr. ██████ concluded that Mr. ██████ demonstrated functional impairment consistent with the Settlement requirements for a Level 2 Qualifying Diagnosis. *Id.*

Multiple documents were filed in support of the Qualifying Diagnosis *after* August 18, 2016. On May 22, 2017, Dr. ██████ provided an addendum to his evaluation elaborating Mr. ██████ behavior in relation to the relevant Clinical Dementia Rating scale categories. Doc. 81903. On June 21, 2017, Dr. ██████ provided a “Supplemental Certification of Qualifying Diagnosis,” which consisted of “documents I [Dr. ██████ received after August 18, 2016, that upon review further support my diagnosis,” and his summary of the “supportive facts” contained in those documents. Doc. 81902.

In December 2017, Mr. ██████ filed a report written by Dr. ██████, a neuropsychologist, detailing the results of a neuropsychological evaluation that Mr. ██████ underwent in 2013 to support an application for disability benefits. Doc. 146228. The cover page of the document states that the report was not available to or considered by Dr. ██████ but instead “is being uploaded to support his findings.” *Id.* (capitalizations omitted).

Because Mr. ██████ Diagnosis predated the Settlement Effective Date, the Appeals Advisory Panel automatically reviewed the claim. An AAP Consultant reviewed both the neuropsychological evaluation conducted by Dr. ██████ in 2016, and the one Dr. ██████ conducted in 2013. Doc. 227475. The Consultant first explained that the 2013 evaluation report “does not provide documentation to support Level 2.0 Neurocognitive Impairment,” highlighting validity issues as well as evidence of significant psychiatric concerns. *Id.* Next, the Consultant determined that the 2016 neuropsychological evaluation of Mr. ██████ also did not support the purported Qualifying Diagnosis based upon “paramount” concerns about validity, failure of Dr. ██████ to consider Mr. ██████ emotional and learning issues, and other noted inconsistencies in the evaluation report. *Id.*

On March 1, 2018, the Claims Administrator denied Mr. ██████ claim. Doc. 159870. Quoting an AAP Reviewer, the Claims Administrator explained the basis for the denial:

The neuropsychological testing performance is questionable because of evidence of over-reporting (memory and psychological symptoms) and a dramatic decline over 3 years that is not typical of neurodegenerative diseases, especially in a younger individual. In addition, Dr. ██████ office notes show an MMSE 26/30 which is not consistent with Level 2 Neurocognitive impairment. CDR functional ratings of

2 are not clearly indicating lack of activities at home and in the community due to cognitive impairment. His comments and the comments of Ms. [REDACTED] imply that depression, anger, and mood issues are the reason for his lack of engagement (such as "sleeping for days on end and isolating himself from any contact", "dramatic mood swings" and acting out in public). Ms. [REDACTED] commented that he "chooses to stay home" and that "people are against him and mean him harm". His lack of housekeeping and inability [sic] "to even pick up things off the floor" also suggests mood driven rather than cognitive impairment. An individual with Level 2 impairment could still pick up things off the floor.

Id.

On March 28, 2018, the claim was selected for audit. Doc. 164107. In April 2019, the Claims Administrator concluded the audit without finding of misrepresentation, omission, or concealment of material fact. Doc. 205683. The Claims Administrator subsequently reissued a (nearly) identical Notice of Denial on July 12, 2019. Doc. 210918.

Mr. [REDACTED] represented by new counsel (as of December 24, 2019), appealed on December 31, 2019. Doc. 219068.

As part of their response to the Appeal, the NFL Parties submitted video surveillance footage of Mr. [REDACTED] Doc. 220499; Doc. 220501; Doc. 220502. The footage was obtained over the course of two days in January 2020, during which Mr. [REDACTED] was observed "driving himself to and attending church, shopping at a grocery store, and refueling his truck at a gas station." Doc. 220381. Mr. [REDACTED] filed a response brief "strenuously" objecting to the admission of this new evidence. Doc. 225610.

In May 2020, an AAP Reviewer assessed the claim in light of the new evidence submitted by the NFL. Doc. 224443. The Reviewer discussed numerous concerns with both Dr. [REDACTED] neuropsychological report as well as Dr. [REDACTED] neurological evaluation. *Id.* The noted issues included validity, "significant symptom exaggeration," and failure of the clinicians to account for critical information—such as the impact of physical pain and mental health on Mr. [REDACTED] functional impairment. *Id.* The Reviewer additionally noted that the surveillance footage supplied by the NFL, which shows Mr. [REDACTED] operating a motor vehicle three years after the date of Diagnosis, is "grossly inconsistent with the severity of dementia claimed by the player." *Id.*

On August 2, 2020, a member of the AAP provided additional expert input on specific issues that arise in this claim. Doc. 227059. The Reviewer clarified the role of the MMPI-2-RF profile in assessing validity; weighed in on issues surrounding satisfaction of the *Slick* criteria; addressed the role of non-cognitive factors contributing to Mr. [REDACTED] impairment; and offered insight on whether there are reasonable grounds for finding that the records support a lesser Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. *Id.*

DISCUSSION

Living Retired NFL Football Players who obtain a Pre-Effective Date Diagnosis, like Mr. [REDACTED] must provide evidence generally consistent with the criteria specified in the Settlement injury definitions. There are four diagnostic criteria that must be satisfied for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. The two at issue here are criterion (ii) (“evidence of a severe cognitive decline . . . as determined by and in accordance with the standardized neuropsychological testing protocol annexed in Exhibit 2 to the Settlement Agreement”) and criterion (iii) (“functional impairment generally consistent with the criteria set forth in . . . Clinical Dementia Rating (CDR) scale Category 2.0 (Moderate) in the areas of Community Affairs, Home & Hobbies, and Personal Care.”).

The Claims Administrator denied Mr. [REDACTED] claim based on concerns regarding performance validity on his neuropsychological testing, as well as inconsistencies between his reported level of functioning and the Qualifying Diagnosis. I will address these topics sequentially.

I. Validity of Neuropsychological Test Results

The Settlement explicitly addresses performance validity in two ways.¹

First, clinicians must include performance validity tests—both embedded and standalone—in the neuropsychological test battery. These tests aim to provide a *quantitative* basis for detecting suboptimal effort or deliberate underperformance.

Second, clinicians must evaluate performance validity by completing the *Slick et al.* checklist of validity criteria.² Eight of the nine *Slick* criteria require the clinician to *qualitatively* assess the Player’s performance. This involves, for instance, consideration of whether there are discrepancies between the Player’s scores and his observed behavior, collateral reports, and documented background history. Furthermore, the clinician must evaluate the reliability of the Player’s *self-reported* history and symptoms, analyzing whether they are discrepant with known patterns of brain functioning, the Player’s observed behavior, and information obtained from other informants.

As these are independent requirements, passing at least two of the performance validity tests included in the neuropsychological test battery does not end the validity analysis. In other words, as is evident from the *Slick* criteria, there are instances in which a patient will obtain “passing” scores across all performance validity tests, but the clinician might nonetheless determine that his neuropsychological test results are invalid.

Mr. [REDACTED] has submitted results from two neuropsychological evaluations: one conducted by Dr. [REDACTED] in 2013, and another by Dr. [REDACTED] in 2016. Doc. 146228; Doc. 72189. The 2013 evaluation resulted in a finding of “average to mild[]” impairment; Dr. [REDACTED] concluded that

¹ Settlement Agreement, Exhibit A-2, Section 1-2.

² See Settlement Agreement, Exhibit A-2, Section 2, for a complete list of the nine *Slick* criteria.

“[m]ore debilitating than neurocognitive functions is Mr. ██████ psychiatric status.” Doc. 146228. Although Mr. ██████ filed the 2013 report by Dr. ██████ “to support” his claim, only the report from his 2016 neuropsychological evaluation conducted by Dr. ██████ was considered by the diagnosing neurologist, Dr. ██████ in making the Qualifying Diagnosis. Doc. 72188.

During the testing conducted by Dr. ██████ Mr. ██████ obtained scores exhibiting severe cognitive decline in the domains of Executive Function and Language. Doc. 72189. Dr. ██████ determined that Mr. ██████ test results were valid because he obtained passing scores on all of the administered performance validity tests. *Id.* As Dr. ██████ wrote, Mr. ██████ “performance on symptom validity measures suggested that he maintained adequate effort throughout the evaluation,” and further, “his self-report of cognitive problems and history would not flag any of the other considerations of the Slick . . . indications of malingering.” *Id.* at 9.

Regarding the MMPI-2-RF—a measure of “emotional/behavioral functioning”—Dr. ██████ acknowledged that “In looking at the performance validity measures [], Mr. ██████ endorsements on this test instrument have some evidence of over-reporting. The degree of over reporting is sufficient to raise concern in the interpretation of this test.” *Id.* at 6. “However,” Dr. ██████ continued, “any indication of over-reporting or exaggeration of emotional distress is not an indication of exaggeration of cognitive difficulties on tests of neuropsychological functioning.” *Id.* Because Dr. ██████ considered the issue of validity on the *cognitive* tests to be distinct from validity on the MMPI-2-RF assessment of mental health, he ultimately found Mr. ██████ “neuropsychological profile” to be valid. *Id.*

An AAP Consultant—reviewing the claim based on the Pre-Effective Date Diagnosis—came to a different conclusion, writing:

Validity is also of paramount concern with this [] evaluation. For example, Mr. ██████ failed multiple validity scales on the MMPI-2-RF. . . . Clearly the MMPI test profile of Mr. ██████ is not valid and Dr. ██████ states, “The degree of over-reporting is sufficient to raise concern in the interpretation of this test.” This over-reporting and endorsing of symptoms is improbable in number, pattern, and severity, indicating concern for performance validity (Slick criteria 7). In addition, the apparent sudden decline in cognitive functioning within a short three-year time span between the two neuropsychological evaluations is highly suspect given that there is no reported acute event such as a stroke. This sudden decline in cognitive ability without any acute neurological event is highly unusual and markedly discrepant from currently accepted models of normal and abnormal central nervous system (CNS) function (Slick Criteria 2).

Doc. 227475. Given the conflicting opinions between Dr. ██████ and the AAP Consultant, I sought additional, independent input from the AAP.

A second AAP Reviewer, independently reviewing the claim and addressing specific inquiries that I raised, expressed explicit agreement with the excerpt quoted above from the first

AAP Consultant's report. Doc. 227059. The second Reviewer noted, regarding Mr. ██████ MMPI profile, that Mr. ██████ demonstrated a pattern of obtaining significantly invalid results on this particular test: of note, "similar elevations of scores were identified by Dr. ██████ in 2013 who stated that the MMPI-2-RF profile was 'invalid and uninterpretable,' and 'this level of infrequent responding is uncommon even in individuals with genuine, severe psychopathology.'" *Id.* (emphasis omitted).

Mr. ██████ counsel argues that a Player's scores on the MMPI-2-RF—a test included in the BAP test battery as a measure of mental health—cannot be used as a basis to infer invalid performance on the neuropsychological test profile as a whole. He asserts that "[t]he MMPI-2-RF is a psychiatric measure with built-in SVT [symptom validity test] indices; it is not a PVT [performance validity test] and should not be used to ascertain the validity of *cognitive* functioning." Doc. 219068, at 2.

It is true that the MMPI-2-RF is not a performance validity test. Instead, rather than treating the MMPI-2-RF as a *quantitative* basis for detecting invalidity, the AAP Consultant and Reviewers alike considered the *qualitative* significance of Mr. ██████ MMPI profile—specifically, as a measure of self-reported functioning. *Slick* criteria 8 and 9 require the clinician to evaluate whether the patient's *self-reported symptoms* comport with known patterns of brain functioning (7) and behavioral observations (8). Thus, consideration of MMPI-2-RF results and validity measures within the context of overall performance validity is consistent with the language and intent of the Settlement.

An invalid MMPI-2-RF profile standing alone would not invalidate a neuropsychological test profile.³ Importantly, none of the AAP experts (including Consultants and Reviewers) who have reviewed Mr. ██████ claim have focused solely on these results. The second AAP Reviewer, building upon the report of the Consultant, highlighted a variety of reasons that the totality of the circumstances triggers significant *Slick* criteria concerns, writing:

Prior AAP review has also identified that Slick Criterion 3 in the BAP Clinician's Interpretaton [sic] Guide (i.e., "Discrepancy between test data and observed behavior") was manifest. Dr. ██████ reported that no aphasia was present. Dr. ██████ reported that the player had "intact expressive and receptive language skills, as he responded to questions using full sentences and he was capable of understanding the directional sets of the administered tests. The rate and volume of his speech were low." Research findings identified that individuals achieving the same T scores as the player on the Boston Naming and Complex ideation tests in the absence of clinical evident aphasia demonstrate a near-certainty of malingered deficits.⁴

³ The AAPC Panel has not—to its knowledge—seen a case in which the MMPI-2-RF validity scales were the sole factor in determining neuropsychological test results to be invalid. However, they have seen many cases in which the results provided evidence that the clinician used as a factor in evaluating the *Slick* criteria.

⁴ An AAP Reviewer emphasized a similar point, writing:

Taken together, these features indicate that the player is not a reliable reporter of his physical, cognitive, and functional state. *Given failure on three Slick criteria, there is a very high probability that the observed neuropsychological performance is not a valid representation of his actual abilities.*

Doc. 227059 (internal footnotes omitted) (emphasis added).

The Claims Administrator is charged with evaluating the “nature and sufficiency of any Claim Package or Derivative Claim Package documentation”⁵ and may rely on the Appeals Advisory Panel and Consultants’ “sound advice with respect to medical aspects of the Class Action Settlement.”⁶ Given that authority, it was not clearly erroneous for the Claims Administrator to adopt the well-reasoned conclusion of the AAP that, due to failure on multiple *Slick* criteria, Mr. [REDACTED] neuropsychological testing performance did not support his Diagnosis.

II. Cause of Functional Impairment

Level 2 Neurocognitive Impairment requires evidence of “moderate” functional impairment based on the Clinical Dementia Rating (CDR) scale in the areas of Community Affairs, Home & Hobbies, and Personal Care. Furthermore, the impairment must result from cognitive loss. FAQ #113 provides the following:

The CDR scale also requires the diagnosing physician to determine whether the functional decline in a Player from a previous usual level was due to cognitive loss, and not due to other factors. For example, if 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.

In situations where the diagnosing physician determines that a Player suffers from functional impairment that is due to both cognitive loss and emotional/psychiatric factors . . . the diagnosing physician should, to the extent feasible, then attempt to isolate the functional impairment due to cognitive loss alone and assign a CDR rating based solely on that cognitive loss.

[N]either Dr. [REDACTED] nor Dr. [REDACTED] appropriately address the significant mismatch between a player described as having basically normal language-based interactions with the providers and severe deficits on language testing. Research findings (Erdodi et al 2017, 2018) identified that individuals achieving the same T scores as the player on the Boston Naming and Complex ideation tests in the absence of clinical evident aphasia demonstrate a near-certainty of malingered deficits. This should have been discussed in relation to the *Slick* criteria.

Doc. 224443.

⁵ Settlement Agreement, Section 8.6(b).

⁶ Settlement Agreement, Section 9.8(a)(iii).

Issues of chronic pain and psychiatric dysfunction have consistently been at the forefront of Mr. ██████ medical records. Both of these factors are explicitly mentioned in FAQ #113 as possible “other” causes that can contribute to functional decline.

Mr. ██████ neuropsychological evaluation with Dr. ██████ was highly indicative of psychopathology. Doc. 72189. Furthermore, Dr. ██████ noted that Mr. ██████ “reported notable physical pain. He rated his physical pain as being 9 out of 10. He added that he is on Total and Permanent Disability.” *Id.* Despite the presence of these concerns during the evaluation, Dr. ██████ did not consider them in light of Mr. ██████ test performance. As the most recent AAP Reviewer wrote, “in his analysis, Dr. ██████ omits mention of both the psychiatric disorder and the pain as contributors to impaired performance.” Doc. 227059. In particular, the Reviewer highlighted that “the player’s experiences of severe pain (8-9/10 headache and 9/10 physical pain) are likely to have worsened his test performance, as these are both known contributors to impaired attention and executive function.” *Id.* Dr. ██████ failed to even acknowledge this as a possibility.

Dr. ██████ adopted Dr. ██████ findings and conclusions without any further explanation. In his neurological examination of Mr. ██████ Dr. ██████ independently identified the same concerns about chronic pain and psychopathology that arose in Dr. ██████ examination. Doc. 72188. He noted that Mr. ██████ experienced “frequent severe headaches 3-4 times per week” and “constant, severe, generalized aching in his body.” *Id.* He also reported that Mr. ██████ suffered from emotional difficulties including “depression, anxiety, paranoia, ‘dramatic mood swings’ and anger or irritability. He can sleep for days isolating himself without any social contact. He will start arguments for no apparent reason.” *Id.* Yet Dr. ██████ offered *no* explanation about the bearing these factors have on Mr. ██████ functional impairment. His report contains a single, unsupported sentence (drawing from the language of the injury definitions) on this topic: “Mr. ██████ Neurocognitive Impairment is not result of delirium, substance abuse, the result of medications or any psychopathy.” Doc. 72188.

Mr. ██████ counsel asserts that “the Settlement Agreement did not require Dr. ██████ to find a ‘clear indication’ of functional impairment caused by cognitive impairment. Instead, it only requires Dr. ██████ to do what is feasible to determine the scope of Mr. ██████ functional impairment.” Doc. 219068. He argues that because “Dr. ██████ concluded that Mr. ██████ impairment was not a ‘result of ... psychopathology,’” the AAP’s position that “there could be another reason for some of Mr. ██████ functional impairment” is unsupported. *Id.*

But, as FAQ #113 states, “if the Player’s functional impairment resulted from . . . other causes other than cognitive loss, the Player cannot be found to have a Level 1.5 or Level 2 Qualifying Diagnosis.” Furthermore, in the event that multiple factors might contribute to a Player’s impairment, the diagnosing physician is responsible for “isolat[ing] the functional impairment due to cognitive loss alone” to the extent feasible.

Despite a pattern of Mr. ██████ reporting significant physical pain and exhibiting clear psychiatric symptomology, neither clinician at all addressed the possibility that these nontrivial “other” causes could be contributing to Mr. ██████ impairment. It follows that Dr. ██████ did

not isolate Mr. [REDACTED] functional impairment due to cognitive loss alone to the extent feasible. Indeed, he did not—based on the reports provided—isolate it at all.

The Claims Administrator determined that Mr. [REDACTED] functional impairments were more likely to be mood-driven than due to cognitive loss, and there is nothing in the record that counters (or even addresses) that determination. The finding was not clearly erroneous. Thus, the available evidence of Mr. [REDACTED] functional impairment does not support a Level 2 Qualifying Diagnosis.⁷

CONCLUSION

Mr. [REDACTED] has failed to satisfy his burden to show that the Claims Administrator's decision was clearly erroneous. His Appeal is therefore denied.

Date: August 19, 2020



David A. Hoffman, Special Master

⁷ The NFL Parties submitted new evidence—namely, video surveillance footage of Mr. [REDACTED] obtained in January 2020—in support of their opposition to this Appeal. But, as I explained in a recent opinion, the Appellate value of evidence out of temporal joint with the Diagnosis will typically be low. My focus with any claim is on the record of behavior “*contemporaneous with the examination that led to the diagnosis.*” See Special Master Ruling on Pre-Diagnosis Evidence (July 2, 2020) https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_sm.pdf; see also Special Master Ruling on Post- Diagnosis Evidence (June 8, 2020) https://www.nflconcussionsettlement.com/Docs/post_diagnosis_evidence_sm.pdf. Given the other grounds for affirming the Denial, further discussion of this evidence is not necessary.