

**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: CLAIM
DETERMINATION FOR SETTLEMENT
CLASS MEMBER [REDACTED]

INTRODUCTION

This opinion results from two 2017 medical examinations which support a Claim for Level 2 Neurocognitive Impairment by Retired NFL Player and Class Member [REDACTED]. This is Mr. [REDACTED] fourth attempt to secure an award based on those six-year-old exams. It is well past time that the Program provides him a clear and final disposition.

Over time, the Claims Administrator identified various flaws with the documentation supporting Mr. [REDACTED] application for an award. But several years into reviewing the 2017 exams, after originally concluding that Mr. [REDACTED] had not sufficiently justified his Claim on any of the grounds of demonstrated cognitive decline, valid test scores, or functional impairment, the Program's independent experts had worked through their doubts. At that point, the existence of dozens of podcasts and interviews, recorded after 2017, came to the Claims Administrator's attention. In these podcasts and interviews, Mr. [REDACTED] demonstrated cognition and self-reported function arguably inconsistent with his Diagnosis of moderate dementia. (I will call this the "Podcast Evidence.")

The Podcast Evidence created a new material impediment to Mr. [REDACTED] Claim. As one medical reviewer reacted, it "certainly provides convincing evidence of a player that does not have moderate or even mild dementia. He shows intact attention, concentration, language, memory and executive function in his responses." Doc. 238459. Mr. [REDACTED] was given the opportunity to respond to this new evidence, and several more layers of review and appeal followed. The most recent iteration of this attenuated process results from what are effectively cross-appeals filed by Mr. [REDACTED] and the NFL Parties.

Mr. [REDACTED] appeals the Claims Administrator's decision to deny his Claim for benefits on the grounds of invalid testing. The gist of his Appeal is that the claims review process cannot legitimately rely on the Podcast Evidence as it did; he argues that the record regarding neurocognitive test validity must be fixed as of the date of the tests in question. Mr. [REDACTED] builds his argument on an expert submission prepared by one of the original authors of the *Slick* criteria, on which some of the validity analysis in the Settlement turns. That expert asserts that this Program has gotten her co-authored paper all wrong. Class Counsel joins in the Appeal, although it would permit later-arriving evidence in some circumstances.

The NFL Parties, while agreeing that the Claims Administrator was correct to deny the Claim, appeal its accession to Mr. [REDACTED] asserted functional impairment. They insist that a person who golfs, travels and speaks at dozens of events, and who can lucidly expound on a variety of topics for hours, is not functionally impaired in the way that the Settlement (or the medicine) requires to substantiate the Diagnosis of Level 2 Neurocognitive Impairment.

The parties have filed excellent briefing. And I have consequently sought additional expert review from another set of independent neuropsychologists and neurologists. Because of the difficulty of the issues raised by Claimant's Appeal, I heard oral argument and permitted supplemental briefing.

Ultimately, I conclude that the NFL Parties have met their burden of demonstrating by clear and convincing evidence that Mr. [REDACTED] was not entitled to a Monetary Award for Level 2 Neurocognitive Impairment on the grounds of functional impairment. As for Mr. [REDACTED] Appeal, the question is considerably closer. Though the Settlement's claims review process typically privileges evidence contemporaneous to the diagnosis, when later arriving information establishes a pattern of behavior inconsistent with the factual predicates of a diagnosis, the Claims Administrator has a duty to consider it. It did so here. It erred in part in how it used the evidence, but that error was not material to its judgment. Whether or not the Claims Administrator had limited its analysis to the contemporaneously observed evidence, there is not clear and convincing evidence that its conclusion was incorrect.

FACTUAL AND PROCEDURAL HISTORY

Mr. [REDACTED] registered for the Settlement on March 23, 2017. Doc. 41376. He completed MAF examinations with neurologist Dr. [REDACTED] and neuropsychologist Dr. [REDACTED] on August 17 and 18, 2017, respectively. Docs. 152811; 152812. In his Claim, submitted on January 16, 2018, he asserted a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Doc. 152823.

The Claims Administrator opened the first audit of Mr. [REDACTED] Claim on February 13, 2018, and determined, on January 7, 2019, "not to issue a Report of Adverse Finding in Audit under Audit Rule 15." Docs. 156905; 194383. His Claim was concurrently reviewed by an AAPC, who raised several concerns about the doctors' documentation. The Claims Administrator summarized those concerns in its Denial on January 23, 2019:

- (1) The reported MOCA score of 25/30 (Doc ID# 152811) is not consistent with a severe cognitive decline.
- (2) The reported functional abilities, which include completing four years of college at the [REDACTED] in the midst of a progressive dementia syndrome, and needing only reminders to perform activities like brushing teeth but not requiring actual assistance, (Doc ID# 152811), reflect a level of functioning that would not be generally consistent with a severe cognitive decline or with CDR scores of 2.0 for the categories of Community Affairs and Personal Care.
- (3) The neuropsychological testing results presented the following issues:
 - a. Issues with validity were not adequately addressed, with validity scales on the MMPI-2-RF indicating over reporting of symptoms with scores above the 99th percentile on five validity scales.
 - b. The Trails B test was administered without first administering the Trails A test, which is a violation of standard procedure and invalidates the results.
 - c. Results were not correctly adjusted for demographic characteristics and when correct (Heaton) demographically adjusted norms were applied, there was no impairment in the cognitive domain of Executive Function.

Doc. 196148.

Mr. [REDACTED] appealed on May 23, 2019. Doc. 207435. In support of his Appeal, his counsel solicited a second review of his medical records from neuropsychologist Dr. [REDACTED] and neurologist Dr. [REDACTED], physicians at [REDACTED]. Doc. 207428. Drs. [REDACTED] contested each of the issues raised in Mr. [REDACTED] Denial Notice in turn. *Id.*

Special Master Pritchett remanded the Appeal and the Claims Administrator concluded, after another AAP review, that “the response from Drs. [REDACTED] does not affect the prior determination that the diagnosis of Level 2 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria.” Doc. 212650. It denied Mr. [REDACTED] Claim for a second time on August 12, 2019. *Id.*

Mr. [REDACTED] appealed that second Denial on September 11, 2019. Doc. 214064. Before the Appeal could proceed, Mr. [REDACTED] Claim was again placed in audit on October 9, 2019. Doc. 215037. A lengthy back-and-forth between Mr. [REDACTED] his counsel, and the Claims Administrator ensued; the Claims Administrator ultimately determined that it had not found “a reasonable basis to conclude that there has been a misrepresentation, omission, or concealment of a material fact.” Doc. 229455. The audit concluded on October 19, 2020. *Id.*

In late 2020, I remanded Mr. [REDACTED] Appeal for re-review by the Claims Administrator. Doc. 229457. The Claim was reviewed by a different member of the AAPC on remand, who initially concurred with the prior determination that Mr. [REDACTED] did not meet the criteria for Level 2 Neurocognitive Impairment, largely on the grounds that his T-scores were insufficient. Doc. 230493. However, in subsequent correspondence with the Claims Administrator, Dr. [REDACTED]

offered explanations for some of the issues flagged by the AAPC. Doc. 237297. The AAPC revised its conclusion based on this new information and endorsed an Award on August 1, 2021. Doc. 238459.

But then, in the final pre-Award checks, the Claims Administrator discovered external evidence relevant to Mr. [REDACTED] Claim: a weekly podcast that Mr. [REDACTED] cohosted for over seventy episodes over two years (from October 2020 through March 2022) and eight additional interviews he gave in 2021. Doc. 237598. The Claims Administrator disclosed this evidence to Mr. [REDACTED] on August 16, 2021 and offered him the opportunity to respond. Doc. 237633. The AAPC also reviewed the Podcast Evidence and, on September 3, 2021, concluded:

The publicly available media certainly provides convincing evidence of a player that does not have moderate or even mild dementia. He shows intact attention, concentration, language, memory and executive function in his responses. Regarding Slick criteria, this information would suggest the items 3, 6, 7 and 8 are triggered. It also suggests the original opinion that with appropriate adjustments, the player did not appear to have dementia was correct.

Doc. 238459.

The Claims Administrator denied Mr. [REDACTED] Claim for a third time on September 16, 2021, explaining that the external evidence and AAPC review barred the Claim from fulfilling the Settlement criterion of “evidence of severe cognitive decline . . . in two or more cognitive domains.” Doc. 238461. At the same time, the Claims Administrator concluded that Mr. [REDACTED] had offered “marginally” sufficient evidence of his functional impairment:

Criterion (iii): For the CDR category of Community Affairs, Dr. [REDACTED] documents that the Player is no longer working or driving, participates in only minimal activities outside the home, and went to a reunion but had problems due to poor memory. Additional information indicated the Player completed college during the developing dementia, however, this was clarified in the appeal response that the Player actually completed college prior to the onset of the dementia. The external evidence in Doc ID 237598 showed participation in podcasts, which shows at least the pretense of independent functioning. However, podcasts are a controlled environment and so the implication of this is somewhat uncertain. Consequently, while the information for Community Affairs is mixed, overall the information would be generally consistent with a score of 2 for the CDR category of Community Affairs. For the CDR category of Home/Hobbies, Dr. [REDACTED] documents conflict with a significant other, no longer performing chores, and forgetting to finish laundry. This would be generally consistent with a score of 2 for the CDR category of Home/Hobbies. For the CDR category of Personal Care, Dr. [REDACTED] documents needing reminders for self-care such as brushing teeth, which would be generally consistent with a score of 1 for the CDR category of Personal Care. Therefore, Criterion (iii) is marginally fulfilled.

Id.

Mr. [REDACTED] timely appealed on November 15, 2021. Doc. 240287. I remanded for the third time, writing:

The Claims Administrator should ask the Appeals Advisory Committee Leadership Council to provide insight and clarity on its recommendation that Settlement criterion (ii) was not fulfilled. The AAPLC should further justify in writing its observation that “external evidence consisting of recent podcasts and interviews with the Player...indicated intact attention, concentration, language, memory, and executive functioning, which were inconsistent with the presence of either mild or moderate dementia.” Doc. 238461. Specifically, the AAPLC should perform a detailed and comprehensive Slick Checklist that carefully considers how Mr. [REDACTED] performance in podcasts and media interviews that were taped in October 2020 and throughout 2021 impact the validity of his August 2017 neuropsychological assessment.

If the Claims Administrator again denies the Claim, after reviewing the AAPLC’s comprehensive findings regarding Mr. [REDACTED] fulfillment of criterion (ii), Mr. [REDACTED] may file new Appeal. Whether the Claim is denied or not, should the NFL Parties conclude that they disagree with Claims Administrator’s determination that Mr. [REDACTED] fulfilled criterion (iii), they too may file an Appeal under Rule 7. I would consolidate multiple appeals under Rule 19.

Doc. 243900.

The AAPC reviewed the case on May 10, 2022, writing a lengthy analysis of Mr. [REDACTED] test validity. Doc. 265508. The AAPC noted issues in the contemporaneous record with Dr. [REDACTED] validity analysis, including self-reported “severe cognitive decline” while completing a college degree, self-reports that were “extremely unusual,” an error in administering the Trails Making Test B without first administering the Trails Making Test A, and scores above the 99th percentile in the MMPI-2-Rf. *Id.* All of these issues had been previously noted in the record, and mooted, though not decided, in at least one Appeal.

But the AAPC emphasized that it was the Podcast Evidence that really undermined the finding that Mr. [REDACTED] had exerted sufficient effort in his 2017 testing. Its validity analysis follows:

- *Suboptimal scores on embedded and stand-alone performance validity measures.* The scores reported by [REDACTED] identify no suboptimal scores on PVTs.
- *Pattern of performance markedly discrepant from accepted models of CNS dysfunction.* The pattern of performance on the tests are not markedly discrepant

from accepted models of CNS dysfunction, however his pattern of real world function is markedly discrepant from accepted models of CNS dysfunction. Having been diagnosed with severe and progressive dementia in 2017, that he would be participating on media three years later with apparently intact cognitive functions in 2020 is markedly discrepant with accepted models of CNS dysfunction. Static or worsening cognitive function would be expected, not a recovery of function.

- *Discrepancy between test data and observed behavior.* The publicly available media provides convincing evidence of a player that does not have moderate or even mild dementia. He shows intact attention, concentration, language, memory and executive function in his responses. In particular, memory language and executive functions were identified areas of impairment in his test performance. However during interviews in these media sessions he shows no evidence of word finding problems or dysfluency. He can report recent events and recall facts. For instance during podcast about his relatively recent move to [REDACTED] he can name and even describe the length of walking trails near his residence. In sports interviews he shows spontaneous recall of facts like which football players were on injured reserve for a recent opponent of his former team. This level of memory and word recall is inconsistent with his test performance. In this interview he shows excellent executive functioning in alternately waiting for interviewers to call on him or in picking up and carrying the conversation when it is lagging.

- *Discrepancy between test data and reliable collateral reports.* While there is not a discrepancy between test data and affidavits filed with the claim, there is a discrepancy between test and ‘collateral’ information reflected in the judgements of various media providers that the player is able to serve as a valuable and informative guest on the various podcasts.

- *Discrepancy between test data and documented background or history.* The publicly available media provide documentation of background and history that is discrepant with the test data as enumerated above.

- *Self-reported history discrepant with documented history.* In Dr. [REDACTED] report he documents that the player “reported that he often has difficulty finding the right word to say and he described slurred speech, odd/unusual speech sounds, and sometimes being unable to speak. He stated that he tends to have trouble staying with one idea and often has difficulty understanding what others are saying.” Additionally the player reports slowed reaction time, and difficulty sustaining his train of thought. The publicly available media provide no evidence of these problems.

- *Self-reported symptoms discrepant with known patterns of brain abnormality.* As noted above the prior AAPC extensively enumerated the evidence that self-

reported symptoms reflected in MMPI2RF are inconsistent with known patterns of brain abnormality.

- *Self-reported symptoms discrepant with behavioral observations.* As enumerated above, self-reported symptoms are discrepant with behaviors observed in publicly available media.

- *Self-reported symptoms discrepant with reliable collaterals' descriptions of behavior.* Self-reported symptoms are not discrepant with affidavits filed with the claim.

The presence of these performance validity (Slick) criteria suggests the impairments measured on neuropsychological testing are not a valid indicator of dementia and the neuropsychological evaluation does not support an award.

Id.

In summary, the AAPC believed that the external evidence called five of the nine *Slick* criteria into question. The Claims Administrator cited these five implicated criteria (#3, #5, #6, #7, and #8) when it denied Mr. [REDACTED] Claim for the fourth time on June 9, 2022. Doc. 265542.

This time both Parties appealed, as I had suggested they might.

DISCUSSION

Mr. [REDACTED] Appeal asserts that the Claims Administrator erred in finding his neuropsychological test scores invalid and denying his Claim. Doc. 271764. He bears the burden of carrying that argument by clear and convincing evidence.¹ The NFL Parties' Appeal asserts that even if Mr. [REDACTED] test scores were valid, the Claims Administrator erred in finding that he met the requisite threshold of functional impairment to justify any award, let alone one for Level 2 Neurocognitive Impairment. Doc. 271794. On this issue, the NFL Parties must also offer clear and convincing evidence of error.

I will start with the NFL Parties' Appeal.

1. The NFL Parties' Appeal: Was there Sufficient Evidence of Functional Impairment?

The NFL Parties appeal the Claims Administrator's determination that Mr. [REDACTED] sufficiently demonstrated functional impairment generally consistent with a Diagnosis of Level 2 Neurocognitive Impairment. Doc. 274896. They did so under protest, arguing that the then-current version of the Rules of Appeal did not permit cross-appeals. They further stated that:

¹ Settlement Agreement, Section 9.8.

It would offend due process and the efficient administration of the Settlement Program if, on a claimant's appeal, the NFL Parties were prohibited from making arguments beyond those on which the denial notice rests. If any such rule applied (and it does not), the NFL Parties should be allowed (but currently are not) to appeal every claim denial, as a protective matter, where the denial notice does not rest on every basis the NFL Parties believe to be applicable. Instead, the NFL Parties are entitled to make such arguments if and when a claimant appeals.

Id. at 2. To address these concerns, the Special Masters recently issued a set of amendments to the Rules of Appeal explicitly stating that where, as here, a party contests a particular aspect of a Claims Administrator determination otherwise in its favor, it may do so by noting that objection in response to a primary Appeal and giving the originally appealing party the opportunity to respond.²

On to the merits. A Diagnosis of Level 2 Neurocognitive Impairment is profound. Given Exhibit A-1's injury definitions, the functional impairment required for this Diagnosis in the CDR turns on a finding of "[n]o pretense of independent function outside home;" while in the home, "[o]nly simple chores preserved" and "very restricted interests," which are "poorly maintained;" and the person "[r]equires assistance in dressing, hygiene, [and] keeping of personal effects." Arguably, that lack of function is demonstrated in the record presented to Dr. [REDACTED] as the Denial Notice Review concluded, though, it stated, "marginally." Doc. 238461.

In contrast to the validity analysis I will discuss below, no party argues that using later-arriving evidence in evaluating functional impairment violates the Settlement Agreement. Rather, Mr. [REDACTED] relies on my opinions on this topic, which have consistently urged the Claims Administrator and reviewers to focus on the contemporaneously created record. A targeted and time-limited form of review *is* ordinarily efficient, fair and medically appropriate.³ Contemporaneous evidence of function is the gold standard; later-arriving evidence is obviously and presumptively less probative. However, there has always been an exception written into those opinions: the Claims Administrator can find that a Claimant has insufficiently supported his functional impairment if non-contemporaneous external evidence demonstrates "a pattern of behavior inconsistent with the factual predicates of a diagnosis."⁴ The Podcast Evidence appears to make that precise showing.

Indeed, *both* parties have argued here that it is inconsistent to find that the Podcast Evidence undermines the Diagnosis' conclusions about validity but not functional impairment. To resolve that tension, I solicited another expert review, this time by one of the Program's senior and

² Rules Governing Appeals of Claim Determinations (amended January 19, 2023), https://www.nflconcussionsettlement.com/Docs/rules_governing_appeals_of_claim_determinations.pdf.

³ See, e.g., Special Master Ruling on Post-Diagnosis Evidence, at 4 (June 8, 2020), https://www.nflconcussionsettlement.com/Docs/post_diagnosis_evidence_sm.pdf ("[H]umans, even sick ones with increasingly limited cognitive function, may sometimes have better and worse days.").

⁴ Special Master Ruling on Pre-Diagnosis Evidence, at 4 (July 2, 2020), https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_sm.pdf ("But the use of pre-diagnosis evidence of function—even a pattern of function—to challenge a diagnosis is fraught.").

experienced independent neurologists. That neurologist offered an opinion in two parts, both adverse to Mr. ██████ Appeal. Doc. 278654.

First, the expert neurologist noted several inconsistencies in Dr. ██████ report of Mr. ██████ function (e.g., Dr. ██████ stated that Mr. ██████ rarely leaves the house, but the third-party affiant reports that Mr. ██████ goes out for every meal). But more importantly, the neurologist stressed that Dr. ██████ did not adequately attempt to isolate the decline in Mr. ██████ function due to cognitive loss.⁵

Criterion (iii) for Neurocognitive Impairment diagnoses laid out in the Injury Definitions requires declines in daily function generally consistent with CDR scores of 2 in Community Affairs, Home & Hobbies, and Personal Care.

Dr. ██████ asserted that the player “exhibits functional impairment consistent with the criteria set forth in the National Alzheimer’s Coordinating Centers Clinical Dementia Rating (CDR) scale in instrumental and basic activities of daily living. His composite rating using the categories that include community affairs, home and hobbies and personal affairs would be 2.” Based on the available documentation, this assertion was erroneous. The CDR scoring rules require that the evaluator “Score only as decline from previous usual level *due to cognitive loss, not impairment due to other factors*” (emphasis added). Dr. ██████ assertion regarding the “criteria set forth” for the CDR is therefore contradicted by statements from Dr. ██████ (“The impact of his depression on his day-to-day functioning is significant”) and the 3rd party affiant (“Most likely this is a result of depression”) as well as his statement regarding the role of pain in daily function (“pain has a significant impact on his emotions and activities”). It also conflicts with his own medical recommendations that identify multiple noncognitive contributors to the player’s condition that warrant further assessment and treatment. Those recommendations include “Consideration for starting pharmacological agents SNRI for mood elevation and treatment of depression,” “Formal sleep evaluations including for sleep disordered breathing and treatment if appropriate,” “Psychotherapy for obsessive compulsive symptoms,” “Physical therapy and pain management for arthritis.”

Doc. 278654, at 2.

The latest evaluator also took a different view of the import of the Podcast Evidence (and other evidence external to the Claims file)⁶ than did the Claims Administrator:

⁵ Cf. Special Master Ruling on Functional Impairment/Cognitive Decline, at 10 (Sept. 7, 2021), https://www.nflconcussionsettlement.com/Docs/functional_impairment_sm_5.pdf (“[T]he Settlement does not require the exclusion of psychiatric etiologies for functional loss. Rather, the FAQ asks the physician to isolate the functional impairment due to cognitive loss ‘to the extent feasible.’”).

⁶ The evidence, though external, was submitted by Mr. ██████ in the audit process, and was therefore subject to contestation and contextualization. Docs. 190752; 191376.

NFL disability applications in 2013 and 2014 do not include notation of cognitive complaints. This is discrepant from the history of 6-11 years of cognitive impairment reported in 2017.

A disability application document dated 11/7/13 explicitly states the nature of the player's impairments as "pain, limitation of motion affecting activities of daily living." This assessment is omitted from 2017 documentation and further undermines Dr. [REDACTED] assertions regarding CDR scores at the time of the claim.

The Claims Administrator received a list of hyperlinks to podcasts that include interviews and conversations with the player in 2020 and 2021. In reviewing these media appearances, the player demonstrates intact recall of recent and remote events, intact comprehension and spoken language, intact abstract reasoning, appropriate social interactions, and no consistent evidence supporting claims of persistent memory loss or other cognitive impairments that limit his function on camera. The overwhelming bulk of scientific evidence regarding the effects of repetitive head trauma indicates that late delayed resolution of neurological deficits associated with brain injury does not occur. There is no scientifically justifiable explanation of how cognitively mediated deficits in daily function consistent with the Level 2 Neurocognitive Impairment (i.e. Moderate Dementia) claimed in 2017, more 10 years after last occupational exposure and of reported 6-11 years of duration at that time, could resolve sufficiently to not be evident on multiple protracted video encounters 3-4 years later. Determination: Additional materials and appeals exhibits submitted after the original claim support, rather than reverse, the above determination [that is, those made by the most recent Reviewer] made on the 2017 documents alone.

Doc. 278654, at 3.

The NFL Parties' burden is heavy: to show by clear and convincing evidence that the Claims Administrator's (admittedly ambivalent) judgment about functional impairment was in error. Mr. [REDACTED] points out that at least some of the Program's independent reviewers have agreed with his position, even if they concluded that he had established his right to relief "marginally." Doc. 238461. But I find that the NFL Parties have met their burden for two reasons.

First, the Claims Administrator did not consider the need, under FAQ #113, to discuss the distinct role of cognitive impairment in Mr. [REDACTED] functional loss. Multiple contemporaneous and external pieces of evidence corroborated that depression, pain, and obsessive compulsion disease contributed to Mr. [REDACTED] lack of function. The CDR scoring system required Dr. [REDACTED] to explain the distinctive role of cognition in that debilitating process to the best of his ability. He was not required to show that cognitive loss was the sole cause of functional impairment. But he

had to offer some kind of isolating framework to the “extent feasible.”⁷ The only place he came close is the bare statement that “Mr. [REDACTED] evaluation demonstrates underlying neurocognitive deficits with psychological and somatic symptoms.” Doc. 152811, at 5. This is insufficient to clear even FAQ #113’s low bar. The Denial’s failure to consider this issue was an error.

Second, and independently, though I agree that Podcasts offer a controlled environment for discussion, the evidence of function that Mr. [REDACTED] himself demonstrates *and* describes is simply inconsistent with a CDR of 2.0. As the NFL Parties observe, not only did he “lucidly participate[] in numerous lengthy podcasts,” but in them he reported often golfing twice a week. Doc. 242406, at 6. While Mr. [REDACTED] reported not driving in his August 2017 evaluation by Dr. [REDACTED] he petitioned in a DWI court hearing in February 2018 for an occupational license due to “an actual and essential need . . . to operate a motor vehicle.” Docs. 227156; 277157. In audit, the Claims Administrator noted that Mr. [REDACTED] still golfs regularly, participates in charity basketball, and attends events in different states. Doc. 224567. This behavior, both recorded in the Podcast Evidence and collected during audit, is inconsistent with the profound functional impairment his Diagnosis requires.

This is a rare case where a pattern of functional behavior inconsistent with the Diagnosis is revealed by later-arriving evidence. I defer to the latest Reviewer’s neurological expertise in concluding that this external evidence, and the absence of any attempt to isolate the role of cognitive loss as opposed to other factors, materially undermines Dr. [REDACTED] conclusions about the functional impairment criterion. I simply cannot conclude that under these circumstances, Mr. [REDACTED] has sufficiently demonstrated functional loss generally consistent with justifying an award for Level 2 Neurocognitive Impairment. The Claims Administrator’s decision was in error.

2. Mr. [REDACTED] Appeal: Validity Analysis

Given my decision on the NFL Parties’ Appeal, considering Mr. [REDACTED] Appeal is not strictly necessary. However, in the interest of efficiency and to offer guidance to the Class, I will proceed.

Mr. [REDACTED] has filed an expert report authored by Dr. Elisabeth Sherman. Doc. 271764. Dr. Sherman was one of the three authors of a paper on validity whose approach was incorporated by reference into the injury definitions.⁸ As the Settlement reads:

Each neuropsychological examiner must complete a checklist of validity criteria as set forth in *Slick et al.* 1999, and revised in 2013 (see below) for every Retired NFL

⁷ *Frequently Asked Questions: FAQ #113* (How are diagnosing physicians to apply the Clinical Dementia Rating (CDR) scale to Level 1.5 and Level 2 Neurocognitive Impairment Qualifying Diagnoses?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

⁸ Daniel J. Slick, Elisabeth M.S. Sherman, & Grant L. Iverson, *Diagnostic Criteria for Malingered Neurocognitive Dysfunction: Proposed Standards for Clinical Practice and Research* 13 CLIN. NEUROPSYCH. 545, 558 (1999); Daniel J. Slick & Elisabeth M.S. Sherman, *Differential Diagnosis of Malingering*, in MILD TRAUMATIC BRAIN INJURY: SYMPTOM ASSESSMENT VALIDITY AND MALINGERING 57 (Carone and Bush, eds. 2013).

Football Player examined in order to determine whether the Retired NFL Football Player's test data is a valid reflection of his optimal level of neurocognitive functioning.⁹

She takes the reviewing AAPC to task on several grounds. Doc. 271764. Mr. [REDACTED] Appeal rests on the implicit view that Dr. Sherman, as one of the three authors of the original *Slick* paper, can speak authoritatively and dispositively about how the *Slick* criteria were intended to be used; in other words, that her analysis provides *per se* clear and convincing evidence of error in the Denial. *Id.*

Before diving into Dr. Sherman's report, I will pause to set out the Settlement's established approach to validity. In an Opinion from October 2020, I explained that "[t]he 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."¹⁰ Later, expanding on the meaning of "clearly erroneous," I wrote:

It should be obvious that a *Slick* analysis is not "clearly erroneous" simply because a member of the AAP (or the Claims Administrator) merely disagrees with the conclusions that the Retired Player's neuropsychologist made. Something more is needed—such as a basic error in computation, a material failure to consider relevant evidence or apprehend its import, or a serious departure from the standard of care. This is not an exclusive list. But I do intend to emphasize the importance of *deference* once the Claims Administrator has determined that the clinicians' explanation is reasonably articulated. The *Slick* criteria embody a professional judgment. Clinicians may reasonably disagree about that judgment's application to particular facts. But such disagreements are not themselves evidence of clear error.¹¹

More recently, I opined on how this review function ought to interact with later-arriving evidence that undermines the factual predicates of an earlier validity analysis:

Here, and elsewhere, the Settlement Program charges its advisory clinicians and physicians to exercise *their* professional judgment in answering that question, not to forecast the views of the Special Masters. The expert's fundamental role is to take "all steps necessary to provide sound advice with respect to medical aspects of the Class Action Settlement."

As I understand the AAPC's revised view, [the Examining Clinician's] judgment may have been led astray by reports of functional impairment which did not come from the Claimant himself, and which are not supported in the fully developed

⁹ Settlement Agreement, Exhibit A-2 (2).

¹⁰ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

¹¹ Special Master Ruling on *Slick* Criteria and CDR Scoring, at 7 (Apr. 27, 2021), https://www.nflconcussionsettlement.com/Docs/slick_cdr_sm.pdf.

record. The extensive evidence of [the Claimant's] post-Diagnosis functioning was relevant to assessing [the Examining Clinician's] validity analysis. And it is a good example of why "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." But importantly (and appropriately), the external evidence was not dispositive: the AAPC believed there were validity issues even in the record [the Examining Clinician] evaluated.¹²

And finally, the Settlement's validity tests are not intended to simply prevent malingering. Rather, given the stakes of the Claims process, the parties built into it a series of checks to ensure that Claimants exerted sufficient effort:

Performance validity encompasses more than a deliberate exaggeration of symptoms. . . . There are a host of reasons why a person may not provide full task engagement during neuropsychological testing; for example, if they are suffering from a mood disorder or experiencing sleep disturbances. The Settlement's performance validity requirement is primarily intended to measure task engagement, and not necessarily to screen for conscious deception.¹³

Mr. [REDACTED] has mounted a full-throated attack on this settled approach to validity through Dr. Sherman's report. I will consider his arguments in sections.

a. The Appropriate Standard of Review

To start, Dr. Sherman states that the Settlement's expert panel has adopted the wrong standard of review: rather than ask (as they do now) if external evidence was *discrepant* from observed behavior or test scores, she believes that the Program's examiners should only find *Slick* categories triggered if the evidence is "unambiguously incompatible with or directly contradicted by observed behavior during the exam or test results." Doc. 271764, at 7. Further, Dr. Sherman says that the AAPC, and derivatively the Claims Administrator, should adopt a strong presumption in favor of validity: tests must be found valid unless extraneous evidence creates a "reasonable doubt" in the examiners' mind to the contrary. *Id.* at 10.

This "reasonable doubt" language comes from a particularly evocative section of the *Slick* authors' 1999 paper:

The appropriate approach is to treat malingering in the same manner as any other "disorder": as a diagnosis to be arrived at or rejected after a comprehensive evaluation. To conclude that a person is malingering, one must rule out the alternatives. A thorough consideration of differential diagnoses is required. Careful

¹² Special Master Ruling on Validity, at 6 (Mar. 21, 2022), https://www.nflconcussionsettlement.com/Docs/validity_testing_4_sm.pdf.

¹³ Special Master Ruling on Date of Diagnosis, at 9 (Nov. 1, 2022), https://www.nflconcussionsettlement.com/Docs/diagnosis_date_sm.pdf.

consideration of the consequences of diagnostic error is also required. Clinicians need to keep well in mind the limitations of assessment methodology and the cost of false positive errors. A “reasonable doubt” strategy should always be applied to decisions about the probability that a patient is malingering.

Clinicians also need to be aware that diagnostic qualifiers such as possible or probable may be easier to use in research than clinical settings due to the difficulty of applying or conveying them in venues where discrete diagnoses are preferred (e.g., the courtroom). No criteria can be perfect, and diagnostic errors are bound to happen.¹⁴

Additionally, according to Dr. Sherman, media evidence was not mentioned in the 1999 paper. Doc. 271764. The 2013 paper (she says) explicitly included media evidence, but the authors added qualifying language—“unambiguously incompatible”—to cut back on its use. *Id.* at 7. Thus, she concludes, the program’s reviewers have systemically put a thumb on the scale against Claimants when they should have done the opposite. *Id.*

I do not read the 1999 paper to exclude media evidence: indeed, it directs the examiner to consider “all possible sources” of information.¹⁵ It also states that “significant inconsistencies or discrepancies” between the patient’s self-report and other sources of information indicate malingering.¹⁶ It is therefore unlikely that “unambiguously incompatible” is the sole standard for evaluating media evidence under *Slick*. And, as the NFL Parties point out, while the 2013 paper does counsel against findings of malingering, in high stakes settings where there are incentives, the 1999 paper states that “patient behaviors consistent with exaggeration or fabrication are most probably volitional unless the assessment turns up *convincing evidence to the contrary*.”¹⁷

I do agree with Dr. Sherman that it is likely that in practice, most clinicians will only find that a patient is malingering when they have excluded all other possibilities. And yet the setting of this Settlement’s administration makes that usual practice inapt, not least because malingering is not the only reason that neuropsychological testing would be invalid: insufficient task engagement should be one of clinicians’ concerns in this context. It would further be inconsistent with the Settlement’s plain text to seize upon one of several formulations in a scholarly article (“reasonable doubt”) which, though familiar and fraught for legal audiences, did not carry equal weight for its authoring neuropsychologists, who themselves cautioned about the “difficulty” in translating clinical judgments to binary legal outcomes.

Stepping back from these clinical weeds, the actual standard of proof that the Claims Administrator must apply is explicitly set out by the Settlement Agreement and the interpretative

¹⁴ Slick, Sherman, & Iverson, *supra* note 8, at 558 (paragraph breaks added).

¹⁵ The 1999 paper asserts its development was shaped by the need for “specific, unambiguous, and reliable criteria that cover all possible sources of evidence (i.e., test-performance, observations, and collateral data).” *Id.* at 554; *see also id.* at 555 (explaining that “[e]xpert clinical judgment is . . . based on an objective evaluation of *all obtainable data* relevant to the particular case”) (emphasis added).

¹⁶ *Id.*

¹⁷ Slick, Sherman & Iverson, *supra* note 8, at 556 (emphasis added).

documents that give it life. The Agreement does not state that Reviewers or clinicians should adopt a version of the various set of medical practices indicated by one of the *Slick* paper's three authors. Its explicit injunction is much more limited: examiners should use a "checklist of validity criteria as set forth in *Slick et al.*..."¹⁸ It then immediately directs the reader to learn more about validity from the Clinician's Interpretation Guide. That document, created by an independent expert panel, is the actual substantive source of authority for assessing evidence of validity in the unique setting of the Settlement Program.¹⁹ In relevant part, the Guide states:

After reviewing the embedded and stand-alone performance validity measures, the provider should confirm his or her conclusion by referencing the qualitative descriptions provided in the Slick Criteria, to determine if findings are *inconsistent* with known patterns of brain dysfunction, clinical observation, collateral reports, history, and/or known patterns of test performance before judging performance to be suboptimal.

Id. (emphasis added).

The overall textual charge is clear: neuropsychologists must "determine whether the Retired NFL Football Player's test data is a valid reflection of his optimal level of neurocognitive functioning."²⁰ Referring to this charge, and the Guide, I have previously urged clinicians to carefully discuss their application of the *Slick* criteria so that the Claims Administrator may defer to their views: "[w]here a particular Slick criterion is inconsistent or discrepant, or criteria point in different directions, the examiner must thoroughly explain in writing why the testing was valid."²¹ Dr. [REDACTED] did not contemporaneously accomplish this task.

In sum, the Parties agreed in the Settlement to charge the AAPC with advising the Program's clinicians about prevailing medical practice, and I defer to their expert understanding of the best way to analyze the triggers for discrepancy in conducting validity analysis, including of media evidence, under the *Slick* criteria. There was no error in the AAPC's general standard of review.

¹⁸ Settlement Agreement, Exhibit A-2 (2).

¹⁹ Retired NFL Football Players' Baseline Assessment Program: Neuropsychologists Handbook (the Clinician's Interpretation Guide), at 11. *See also* Settlement Agreement, Exhibit A-2 (2) ("Additional information relating to the evaluation of effort and performance validity will be provided in a clinician's interpretation guide.").

²⁰ Settlement Agreement, Exhibit A-2 (2).

²¹ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 8 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf. The requirement to explain results in writing comes from MAF Rule 20(d), which states that the clinician "must explain in writing, in the method prescribed by the Claims Administrator and to the satisfaction of the Claims Administrator, any deviation from the BAP diagnostic criteria." A deviation regarding validity occurs when:

The Retired NFL Football Player was assigned scores or results indicating that the player failed two or more of the embedded and/or stand-alone performance validity measures in the neuropsychological test battery and/or where the application of the clinical criteria for assessing performance validity under *Slick et al.* otherwise indicates that the test data may not be a valid reflection of his optimal level of neurocognitive functioning.

b. Use of Evidence Across Multiple Slick Categories

Dr. Sherman next criticizes the Reviewers for applying the Podcast Evidence across multiple *Slick* checklist items. She explains that the point of having a “variety of different criteria as the basis of a diagnosis is to increase the reliability of the diagnosis.” Doc. 271764, at 9. “Re-using the same evidence to fulfill multiple malingering criteria is simply incorrect and a misunderstanding of how diagnostic models work. At most, media evidence can be used to fulfill *one* specific criterion, not multiple criteria.” *Id.*

The AAPC, reviewing this file, agreed in part with Dr. Sherman’s critique:

The review by Slick criteria expert raises the inappropriateness of using the same information source across different Slick criteria. This is a point well taken. In prior analysis of Slick criteria, the publicly available media was used in consideration across several different Slick criteria.

Doc. 276005, at 1.

That said, the single use rule is not ironclad because, as the original *Slick* paper itself noted:

The proposed criteria for MND were designed to balance specificity with flexibility. In particular, we attempted to include most possible sources of relevant data, and to consider the relative and cumulative weight of specific kinds of data. Nevertheless, every case is unique, and no set of criteria can cover every possible set of data and circumstances. Thus, the proposed diagnostic criteria are not intended for use in a reflexive or inflexible manner. The clinician must use the criteria in an integrative manner, recognizing that not all patients will be easily classified, and that in some instances there may be adequate justification to disagree with a diagnosis suggested by rigid application of the criteria to the available data.²²

Since some of the reviewers did help themselves too many times from the same evidentiary pot, a practice the AAPC concedes was error, it is possible that this reuse was itself clear and convincing evidence that the Claims Administrator’s ultimate judgment was wrong. I asked that terminal Reviewer for expert advice, and they disagreed again with Dr. Sherman:

However, allowing that this was inappropriate doesn’t really change final analysis of Slick criteria. For example, the Slick expert states that publicly available media are not what was intended by ‘observed behavior’ in item 3. Rather this is to be limited to behavior observed during the neuropsychological evaluation. Still the player displays discrepancies. For instance, the examiner notes “He was oriented to person, place, day, month, year, and purpose. ...His attention was functional for

²² Slick, Sherman, & Iverson, *supra* note 8, at 558.

daily activities. His speech and language abilities were intact.” The scores he obtains in language and memory domains are discrepant with these observations.

It is reasonable in my opinion to consider the publicly available media as part of documented history in item 5. No reasonable clinical interpretation of ‘documented history’ would exclude information available from school, work, social settings, etc., and especially instances where the clinician can directly appraise cognitive performance in the documentation. The discrepancies between earlier cognitive performance and documented history in the form of the publicly observable behavior have been well enumerated by me and other AAP members so I will not elaborate them.

Limiting the publicly available media to being only part of ‘documented history’ still allows its inclusion in item 6 as well. Here the player’s assertion of his many cognitive impairments is not concordant with what can be observed in the media.

Independent of any access to the publicly available media, another AAPC had originally enumerated the ways in which the player’s self-reported improbable neurological symptoms were incongruent with known patterns of brain function (item 7). I will not reiterate those here.

Doc. 276005.

This is an important and clarifying response. That *Slick* #3 (“test data and observed behavior”) and *Slick* #7 (“self-reported symptoms discrepant with known patterns of brain abnormality”) are triggered by *contemporaneously* created evidence is an important conclusion that was not entirely clear in the earlier reviews. The Reviewer believes *Slick* #5 (“test data and documented background history”) and *Slick* #6 (“self-reported and documented history”) can be independently triggered by the same piece of documented history (i.e., by the Podcast Evidence). I will defer to this nuanced, expert advice of the appropriate use of *Slick* evidence.

The Reviewers have identified three distinct *Slick* criteria triggered by a mix of (largely) contemporaneous findings and (some) later-arriving evidence. They have also reached a holistic judgment as to whether in light of subjective review, Mr. [REDACTED] test data “is a valid reflection of his optimal level of neurocognitive functioning.”²³ Thus, although I conclude that the Claims Administrator may have erred in permitting its reviewers to use evidence repeatedly across categories, it is not probable that doing so led it to the wrong overall conclusion.

The potential inappropriateness of using the same evidence to trigger concern under multiple *Slick* criteria has not been emphasized in the Program’s trainings of AAPC reviewers, or in its trainings of MAF/BAP clinicians. I direct the Claims Administrator to remedy this concern by convening the AAP and AAPC to discuss a set of guidelines and training materials that clarify

²³ Settlement Agreement, Ex. 2, Section 2.

when, in this Program, it is permitted to use a single piece of evidence to trigger multiple *Slick* categories and thus justify a finding of invalidity.

c. Due Process and Social Media Evidence

Next, both Class Counsel and Mr. [REDACTED] caution that social media evidence might be uniquely unreliable, especially where it was not submitted by the Claimant himself. Mr. [REDACTED] latest brief suggests that the Claims Administrator’s review of such evidence should be subject to *Daubert*’s scrutiny. Had the Settlement’s drafters wished to adopt the Federal Rules of Evidence for claims adjudication, or any other set of limiting proscriptions, they could have done so. Instead, they created a program that vests discretion in the Claims Administrator, overseen by the Special Masters and the Court, to determine the sufficiency of Claim Packages. The question is whether the procedures the Claims Administrator used to evaluate the Podcast Evidence are too permissive, or whether new safeguards are needed.

Advocates have, with increasing frequency, argued in appeals like this one that they have due process rights which create entitlements to procedures not mentioned in the Settlement’s text.²⁴ As the leading treatise on class action practice teaches, “the scope of the settlement administrator’s authority is limited by the terms of the settlement, and by an obligation to perform her duties in good faith.”²⁵ The text shapes the contours of what administrative process claimants are due. But the Court’s equitable power stands in the background of claims review, and therefore how Special Masters can legally exercise their delegated, public, duties.²⁶ Here, the Settlement entrusts the gathering and evaluation of evidence to the Claims Administrator, subject to appeal. The mechanics of the Claims Administrator’s review power are, arguably, constrained by due process.²⁷

What does that mean? Due process traditionally weighs the interests affected, the risk of error in using the procedures in question, and the value of additional safeguards.²⁸ That balance will necessarily seek to effectuate the Program’s remedial purpose, filtered through the text which gives that purpose life. Due process in claims review—before formal appeals are taken—is particularly essential in the context of long-term tribunals like this one, which are often criticized for their obscurity.²⁹ But invoking due process implies neither the application of the Federal Rules of Evidence, nor *Daubert* gatekeeping: the Settlement explicitly creates the AAP as independent

²⁴ See, e.g., *supra* at pages 7–8 (the NFL Parties’ due process argument).

²⁵ WILLIAM B. RUBENSTEIN, 4 NEWBERG ON CLASS ACTIONS § 12:20 (6th ed.). The Amended Settlement Agreement is governed by New York Law, which, while defining good faith as a “promise not to act arbitrarily or irrationally” in exercising contractual discretion, cautions that “no obligation can be implied that would be inconsistent with other terms of the contractual relationship.” *Dalton v. Educ. Testing Serv.*, 663 N.E.2d 289, 291–2 (N.Y. 1995) (citation omitted).

²⁶ *Id.* at § 12:25 (describing courts’ equitable oversight).

²⁷ I have not found Third Circuit authority making this conclusion explicit, but it appears required by the uniquely public/private nature of claims administration.

²⁸ *Mathews v. Eldridge*, 424 U.S. 319 (1976).

²⁹ See Elizabeth Chamblee Burch and Margaret S. Williams, *Perceptions of Justice in Multidistrict Litigation: Voices From the Crowd*, 107 CORNELL L. REV. 1835, 1921–24 (2021) (arguing for greater opportunities to be heard inside of claims processing tribunals).

experts to advise the Special Masters and the Court on the importance of medically-relevant evidence. Creating a full-dress trial system within the review process would attenuate claims administration to the detriment of the Class. More informal processes are appropriate here.

The Settlement explicitly builds process guarantees into its claim administration, by: (1) providing a clear way to submit evidence in support of a Claim before a decision is made;³⁰ (2) ensuring that decisionmakers are fairly independent from the Parties;³¹ (3) requiring that all participants in Review act through processes which are regular and reasonably transparent;³² and (4) creating the appeals process to oversee those decisions.³³ The particular issue here is whether due process imposes additional constraints on how the Claims Administrator should handle evidence derived from *sources other than the Claimant*. The Settlement’s text does not answer that question, though (as I will detail below) Section 8.6 and 9.1 authorize the use of evidence of all kinds.³⁴

I conclude that if a piece of evidence not provided by the Claimant is identified, the Claimant must be told of its existence, and given the reasonable opportunity to respond, *before* the Claims Administrator reaches a final determination. That additional opportunity ensures external evidence’s reliability without adding excessive formality or expense. The “External Evidence” rules, adopted by the Claims Administrator in 2020, embody that required process.³⁵ The NFL Parties would “have no objection to formalizing” the Claims Administrator’s External Evidence process. This Opinion accomplishes that end. Thus, as is appropriate—indeed, as I think is *required* by due process—Mr. [REDACTED] was offered the opportunity to contextualize the Podcast Evidence, and his arguments were seen by the Reviewing panel before it made a recommendation.

What is *not* required by due process is a special set of safeguards for the Podcast Evidence, or any other social media evidence. Because the Program offers an opportunity to be heard, its factfinders are given context from which to decide whether any particular piece of evidence is sufficiently reliable.³⁶ Here, the Podcast Evidence itself is notably self-authenticating, further reducing the risk of error. It consists of dozens of hours of interviews and podcasts by the Claimant himself, who interacts with others in vigorous debates and describes both recent events and events

³⁰ See, e.g., Settlement Agreement, Section 8.2.

³¹ See, e.g., Settlement Agreement, Sections 9.8(b); 10.1(e); 10.2(f).

³² See, e.g., Settlement Agreement, Sections 5.6(a)(iii); 10.1(a)(iv); 10.2(a)(ii).

³³ Section 8 creates many of the rules governing claim submission, while Sections 9.5 through 9.8 govern appeals. The Program has additionally created FAQs which further describe the processes that it uses. Each FAQ is approved by the Special Masters after discussion amongst the Parties. These FAQs ensure that the rules of the road are equally available to all.

³⁴ And the audit process provides for the collection of various kinds of evidence. See, e.g., Settlement Agreement, Section 10.3.

³⁵ See FAQs # 357–361.

³⁶ The text above suggests why I think a *Daubert* hearing to consider the use of social media evidence in validity analysis is inapt: it is an evidentiary protection that doesn’t fit the Settlement’s overall goals of efficient resolution. Indeed, having that legalized gatekeeping in place would have prevented me from engaging, in the absence of significantly more process, with Dr. Sherman’s report. Though the Special Masters have built into the Appeals system some of the trappings of a judicial tribunal—notably, adversarial briefing and a “common law” created by opinions—it is not one, and the Program’s participants should not wish it to be otherwise.

from his distant past with seeming ease. The Reviewers have watched that material carefully, both for what he said and how he said it. They were able to observe his behavior not in snippets but over time—indeed, they spent more hours listening to Mr. ██████ speak than did his original examining clinician and physician. And they have read Mr. ██████ able advocate’s contextualization of the evidence. Such a careful review vindicated Mr. ██████ due process rights.

d. Later-Arriving Evidence When Reviewing Validity

Dr. Sherman next argues that any evidence used to determine validity must be generated concurrently with the Diagnosis. If the Claims Administrator had not considered the Podcast Evidence, Mr. ██████ believes there is a stronger case to be made that the examining clinician’s views ought to have been deferred to, as earlier reviews in this very case acknowledged. Doc. 271764. Dr. Sherman opines (and Mr. ██████ and Class Counsel emphasize) that later-arriving evidence should be categorically excluded from review of *Slick* criteria. *Id.* This perspective about how to conduct a review forms the heart of Mr. ██████ Appeal.

Dr. Sherman’s views find support in the now well-established practices of this Settlement Program, which privilege evidence contemporaneous to the diagnosis.³⁷ But Dr. Sherman and Mr. ██████ as well as Class Counsel, would go further than I have in the past by categorically excluding later-arriving evidence from review. Dr. Sherman admits that “a diagnosis may no longer apply based on new evidence,” but, she says, to know that for sure, a new evaluation would be needed, in which the clinicians carefully examined the new evidence and put it into context. Doc. 271764, at 6. In short, Dr. Sherman’s report asserts that the record must be fixed at the time of the Diagnosis, and that our expert review system cannot legitimately learn new things afterwards which would cause it to believe that the examining physician erred.

There is much that is intuitively appealing about this approach. As Special Master, I am directed to “take all steps necessary to faithfully oversee the implementation and administration of the Settlement Agreement.”³⁸ One of my most important charges is to make sure that claims administration is both fair and efficient.³⁹ Even in a complex Claim like this one, with millions of

³⁷ See, e.g., Special Master Ruling on Date of Diagnosis, at 8 (Nov. 1, 2022), https://www.nflconcussionsettlement.com/Docs/diagnosis_date_sm.pdf (“The Claims Administrator should, prudentially, defer to the contemporaneous and well-reasoned justifications of examining physicians, particularly those who have been vetted by the Program. That practice of deference follows directly from the Settlement’s text and its core purpose of efficient and fair claim resolution.”); Special Master Ruling on Stroke Definition, at 8–9 (Apr. 25, 2022), https://www.nflconcussionsettlement.com/Docs/stroke_sm_2.pdf. (“[T]his Program is grounded on a fundamental presumption that the Claims Administrator—and by extension, the AAP—should *defer to the articulated medical judgments of examining clinicians and physicians*. When the AAP provides input, it generally should not seek to substitute its own judgment for that of the examining doctor. Instead, it is to ascertain if the front-line doctor’s judgment was well-reasoned and medically sound. That is because many of the foundational decisions for Claim Awards are incapable of being reduced to numerical scores but instead result from complex medical judgments.”).

³⁸ Settlement Agreement, Section 10.1(a)(ii).

³⁹ Order Appointing Special Masters, July 13, 2016, ECF 6871, as incorporated into Order Appointing Additional Special Master, ECF 11022, March 5, 2020.

dollars at stake, a delay of six years between Diagnosis and denial post-Appeal is objectionable. The Program would adjudicate claims faster if it sealed the claim review record (like the appeals record in a court case) at the date of Diagnosis. That would still permit the use of external evidence in the audit process while seemingly leveling the Settlement's playing field. Just as players are sometimes denied payments for real diseases because they have not met formal requirements in the claims submission process,⁴⁰ so too (the argument goes) should the NFL Parties be stuck with the original factual records generated by a medical system that they themselves negotiated for and helped to build.

Stepping back, I understand Mr. ██████ argument to be one rooted in clinical practice. The question of task engagement based on the *Slick* criteria is one that requires nuanced judgment to evaluate what the patient tells the clinician, how they behave, and what is known about the "real" facts. In ordinary clinical settings, patients' diagnoses are not usually confronted by later-arriving evidence of inconsistent function, unless that evidence strongly suggests that the patient was not telling the doctor the truth about their function on the day of the neuropsychological testing.⁴¹ And in the Settlement Program, that truth-telling role for later-arriving evidence might be addressed in the audit process, where the opportunity for factual development is richer than it is using the *Slick* criteria. Here, the AAPC treats the "documentation" which the clinician is to test her observations against as infinitely supplemental (at least until the Claim is paid) but not obviously subject to careful interrogation. This seems to be a very slippery slope.

Although I see the administrative logic and rough justice of Mr. ██████ proposed rule, I must reject it.

A plain reading of the Settlement Agreement permits consideration of later-arriving evidence in the Claims Review process. Section 8.6 explicitly empowers the Claims Administrator to consider a variety of forms of evidence when deciding if the Claims submitted justify an award:

The Claims Administrator will have the discretion to undertake or cause to be undertaken further verification and investigation, including into the nature and

⁴⁰ See Special Master Ruling on Qualifying Diagnoses Criteria, at 11 (Jan. 25, 2022), https://www.nflconcussionsettlement.com/Docs/qualifying_diagnoses_criteria_sm.pdf. ("The available records demonstrate that [the player] experienced a prolonged and severe decline in his health following a prolific career as an NFL linebacker. He suffered from many real-world diagnoses, including numerous significant neurological conditions. There is documentation of progressive cognitive decline, and unrebutted evidence that he suffered from CTE at the time of his death. But those diagnoses, and the supporting medical records, do not fit into the Settlement's prescribed boxes for the claimed Qualifying Diagnosis.").

⁴¹ With respect to quantitative performance scores, the Settlement's text is clear about the contemporaneous nature of the inquiry: "at least seven performance validity metrics utilized during each assessment." Settlement Agreement, Exhibit A-2 (2). It is also clear under the Settlement that if "based on its own detection processes," the Claims Administrator had rested its denial on a finding that Mr. ██████ had omitted "material facts relating to the claim," the Claims Administrator would have had a duty to so notify Mr. ██████ the Parties, and refer the Claim to the Special Masters for determination. *Id.* at Section 10.3(j). I do not read the record to be making that finding of deliberate omission. This is not a case where anyone has charged Mr. ██████ with omission; rather, there is merely a lack of full task engagement given his documented capabilities.

sufficiency of any Claim Package or Derivative Claim Package documentation, including, without limitation, as set forth in Section 10.3.⁴²

Section 9.1 reinforces that power:

Based upon its review of the Claim Package, and the results of any investigations of the Settlement Class Member's claim, the Claims Administrator will determine whether a Settlement Class Member qualifies for a Monetary Award and the amount of any such Award.⁴³

Mr. [REDACTED] joined by Class Counsel, argues that because the Settlement's injury definitions refer to *Slick*, and because in regular practice neuropsychologists would usually not second-guess their diagnoses based on later-arriving evidence, that implied *specific* limitation curtails the Claims Administrator's general powers. This argument is reinforced by the tense used in the *Slick* criteria (in **bold**) and the underlying paper (in *italics*):

- *this is indicated by*
- **the discrepancy between test performance** [impliedly, on that day] **and observed behavior;**
- **the discrepancy between the test data** [impliedly, on that day] **and documented background history** [impliedly, extant].

I agree that the *Slick* criteria and the *Slick* paper describe how to conduct an examination and how to compare the results of that examination with outside evidence. I do not contest that in ordinary clinical practice, if a clinician learned of evidence that caused her to reconsider an earlier exam, the normal response would not be to discard those results, but rather to conduct a new examination and try to holistically understand how the later-arriving evidence informs the diagnostic evaluation. At the same time, as Dr. Sherman herself admits, a diagnosing physician learning of later-arriving evidence inconsistent with her earlier validity analysis would no longer be as certain about that diagnosis: she would be impelled to bring the patient back to resolve the discrepancy. Perhaps this is part of the reason that Dr. Sherman notably does not conclude that Mr. [REDACTED] test results are valid, nor that he is eligible for an Award.

But nothing about this Settlement Program exactly replicates the clinical office. The Diagnoses in Exhibit 2 carve novel binaries out of a progressive disease spectrum, while the stakes of that choice create incentives which potentially depress testing effort. It is routine for a Diagnosis to predate a Claim's submission by months or more, and the Administrator's review can lag for years. In this context, it makes sense that the grants of power in Sections 8.6 and 9.1 are explicit and wide-ranging, while the inferences that Mr. [REDACTED] draws from the Settlement's passing reference to *Slick* checklist are too remote to pull in a set of clinical practices built to solve a

⁴² Settlement Agreement, Section 8.6(b).

⁴³ *Id.* at Section 9.1.

different set of problems. The Settlement empowers the Claims Administrator to check for sufficiency *and* veracity: it invites a *forensic* review.⁴⁴

The plain text of Sections 8.6 and 9.1 applies such a forensic review to all aspects of the injury definitions. And yet Mr. [REDACTED] textual argument would permit later-arriving evidence for some purposes (functional impairment) but not others (validity of testing). No such distinction appears in the Settlement, and the explicit grants of authority in generating the Claims Administrator’s forensic power are unambiguous and plenary. The reading offered by Mr. [REDACTED] and Class Counsel is simply inconsistent with the text and structure of the Amended Class Action Settlement Agreement. Thus, the powers granted in Section 8.6 and 9.1 make irrelevant—as parol evidence—Dr. Sherman’s views about clinical practice, what she and her co-authors meant to include in her papers (but didn’t), and how trade usage has interpreted those papers.⁴⁵ They are not probative of how the Program is to conduct its sufficiency review.

A plain reading of the text which permits later-arriving evidence as a part of validity review is consistent with the Settlement’s purpose. Judge Brody recently offered instruction on a closely related question. In her December 27, 2022 Order responding to a Motion for Relief under Article XXVII of the Settlement Agreement, Judge Brody wrote:

Movants rely heavily on a different portion of Special Master Hoffman’s Decision, in which he writes that the AAP “should defer to the articulated medical judgments of examining [providers].”⁴⁶ . . . *But deference is not the same thing as blind and automatic acceptance. AAP review of the medical records underlying Claims Packages is*

⁴⁴ For an excellent recent review, see Tess M.S. Neal, Kristy A. Martire, Jennifer L. Johan, Elizabeth M. Mathers, and Randy K. Otto, *The Law Meets Psychological Expertise: Eight Best Practices to Improve Forensic Psychological Assessment*, 18 ANN. REV. L. SOC. SCI. 169 (2022).

⁴⁵ Neither party argues that the contract is ambiguous on its face. Under New York law, which governs, in such circumstances, admission of parol evidence is inadmissible to create ambiguity. *Donohue v. Cuomo*, 184 N.E.3d 860, 866 (N.Y. 2022) (statement of plain meaning rule); Settlement Agreement Section 27.1 (adopting New York law); Special Master Ruling on 53-Man Roster, at 5 (Dec. 4, 2017), https://www.nflconcussionsettlement.com/Docs/53manroster_SM.pdf (describing New York’s plain meaning rule and its application to the Settlement Agreement). As I understand Mr. [REDACTED] and Class Counsel’s argument, because the offered trade evidence teaches that the appropriate use of the *Slick* criteria is limited to evidence available on the date of the exam, that trade usage gives content to the *Slick* references, and then the specific limitation excludes the general power. But this is the very ambiguity-creating use of parol evidence which the plain meaning rule rejects. Nothing in the Settlement Agreement states that evaluators should follow clinical practice as later defined by the *Slick* authors; rather, the Settlement refers to the *Slick* checklist as a way of ensuring that the tested player’s scores were a “a valid reflection of his optimal level of neurocognitive functioning.” That is the goal: the checklist is one tool, and referencing it does not implicitly sweep in clinical practice as a limiting provision. If the evidence were admissible, I would still not reach the conclusions urged by Mr. [REDACTED] and Class Counsel. If the Settlement were interpreted to mean that the validity analysis follows the *Slick* authors’ implicit as well as express meaning, the testimony of one author would be probative but not dispositive of that meaning, and I would invite the NFL Parties to provide further evidence from the other *Slick* authors. And if the text were read to state that we are to replicate the clinical office’s approach to validity, the best source for whether that permits post hoc scrutiny remains the AAP and AAPC, entrusted by the Settlement itself to advise its factfinders about medical practice.

⁴⁶ Special Master Ruling on Stroke Definition, at 8 (Apr. 25, 2022), https://www.nflconcussionsettlement.com/Docs/stroke_sm_2.pdf.

integral to attaining the diagnostic accuracy administration of the Settlement requires, and is expressly provided for by the terms of the Settlement Agreement. . . .

A BAP diagnosis is not an automatic rubber stamp for a Class Member to receive a monetary award. Rather, the BAP program is distinct from the claims review process, and BAP diagnosis is simply only one component of a successful Claim Package, which must be reviewed by the Claims Administrator . . . [T]he Claims Administrator may request AAP review of the medical records underlying a Claim Package in making a determination of whether a Class Member is entitled to receive a Monetary Award, regardless of whether there are conflicting diagnoses.⁴⁷

I was corrected in this passage. Judge Brody reminds us that the Settlement is built on diagnostic accuracy. Certainly, the Claims Administrator should defer to the diagnosing physicians and the records they had in front of them whenever possible. But doing so is prudential, not required by the text. And while audit is *one* way that accuracy can be monitored, it is not the only tool available: the Claims Review process itself must always endeavor to get it right. That is because the Settlement Program ultimately awards money—over a billion dollars to date— for Claims. *It does not make medical diagnoses*. All Claims are subject to the legalized review process described in the Agreement itself.

That is, a Claim Denial signifies only that the Retired Player produced insufficient evidence to satisfy the Amended Settlement Agreement’s exacting injury definitions.⁴⁸ It does not mean that he is free from cognitive disease. The Settlement has particular boxes that must be checked and can create medical-legal processes which are not ordinary in the clinical setting.⁴⁹ But it also permits Retired Players to submit new claims after a Denial, based on fresh diagnoses, for decades to come.⁵⁰

If applied indiscriminately, post hoc review threatens to open up every claim to indefinite inspection, with pernicious systemic effects which the drafters of the Settlement did not

⁴⁷ ECF No. 11931, Explanation and Order Denying 11813 Motion for Relief (December 27, 2022) (emphasis added).

⁴⁸ And in the case of a MAF award, like this one, generally consistent with those definitions.

⁴⁹ Special Master Ruling on Qualifying Diagnosis Criteria, *supra* note 40, at 11.

⁵⁰ The *Slick* paper itself suggests differences between clinical and legal review:

One area that has not been adequately addressed to date is the establishment of a consensus in neuropsychology about which category of error (false-positive vs. false-negative) is preferable when diagnosing malingering. Reynolds (1998) points out that the answer involves “moral, social, and perhaps even constitutional values that should be the subject of policy debates,” and concludes that until such time as a consensus is reached “we should present our case for diagnosis, its basis, its philosophy (conservative or liberal), revealing any personal biases and let the litigators do their job.”

Slick, Sherman, & Iverson, *supra* note 8, at 558. In this Settlement, the parties crafted a process which contemplates ongoing review of the predicates of claims after their submission to assure their accuracy. But they balanced this potentially intrusive review with the free ability to re-submit claims in the coming decades. The Settlement’s checks on payment and permissive resubmission system imply a functional preference for false negative over false positive errors. The *Slick* authors themselves state that this a permissible way to conduct validity review.

contemplate. Dignity, finality and efficiency are values that count alongside accuracy in this Program, which exists to remedy the harms of a class of vulnerable, proud, individuals.⁵¹ Privileging perfect processes to the detriment of good-enough ones leads to repeated, invasive, inconclusive audits, and multiple trips around the claim review round-about. Six years, two audits, and four Appeals flowing from two days of testing is not what the drafters of the Amended Class Action Settlement intended, nor is it what the Class deserves.

But though backfilling the record to incorporate information learned later is and should be unusual, I cannot conclude that it was probably in error. Simply put, the Agreement charges the Claims Administrator to make sure that the Claim is sufficiently rooted in the record to justify payment—that is, to ensure that facts that the clinicians and doctors relied upon were true and complete (enough).

The expert panel concluded that no one with the level of dysfunction indicated by Mr. ████████ neuropsychological tests could retain so much cognitive and verbal fluency for years afterwards if the tests were valid: it is, in effect, a *res ipsa* determination. It interprets the checklist’s “documented history” and “documented background history” to mean what the Reviewer has in front of them at the time *they* evaluate the file, not when the clinician did. I interpret the Agreement to permit this review (which functions as a redo) of the clinician’s validity analysis.

To be clear, simply because the record is open for later-arriving evidence does not mean that it has the same probative weight as information contemporaneous with the Diagnosis. Both the Claims Administrator and the AAPC should and do have a prior belief that any later-arriving evidence will not disturb the clinical impressions formed by examining physicians.⁵² They should and do defer to those examiners especially when they have considered evidence like it—for example, having discussed with a player his podcasting and written cogently about why it does not disturb the conclusions reached. And Reviewers should and do discount the probative value of evidence gathered post-Diagnosis—without a contextualized foundation—and are rightly wary of allowing a few pieces of evidence to be determinative.

Overall, the Claims Administrator should only second-guess a Diagnosis using later-arriving evidence if it generates a substantial and material update to the contemporaneously generated prior belief. Under my authority as Special Master, I have directed the Program’s reviewers publicly and privately that singular pieces of later-derived evidence should rarely, if ever, impeach a fully-articulated diagnosis by one of the Program’s clinicians or physicians.

The Program will continue to emphasize this practice of layered deference when instructing the AAPC and AAP Reviewers. There will be occasional—I would expect *extraordinarily* rare—cases where a pattern of behavior post-Diagnosis is so discrepant with the story told to the clinician that it is fair to question if the test scores were valid estimates of functioning (and, for similar reasons, whether the claimant’s reported functional impairment is

⁵¹ Cf. Alexandra D. Lahav, *Due Process and the Future of Class Actions*, 44 LOY. U. CHI. L.J. 545, 555 (2012) (discussing the importance of dignity in defining due process rights inside of class action administration).

⁵² See Special Master Ruling on Date of Diagnosis, *supra* note 37, at 8.

accurate). In those cases, the Reviewing panel, having reasonably assured themselves that the risk of error in using this evidence does not outweigh its probative value,⁵³ will ask if the original Diagnosis, when considered in light of what we know now, got it right.

According to the Settlement's medical experts, this is such a case. The contemporaneous evidence triggers two *Slick* criteria (#3 and #7). The post-Claim evidence implicates *Slick* #5 ("the discrepancy between the test data and documented background history") and #6 ("the discrepancy between self-reported history and documented history"). The Reviewers have listened to each of the podcasts, learning from both what Mr. ██████ said (his function) and how he said it (informing the validity of the earlier scores). When combined with the other doubts arising from the contemporaneous record, they recommended a Denial. As the AAPC argued:

The publicly available media provides convincing evidence of a player that does not have moderate or even mild dementia. He shows intact attention, concentration, language, memory and executive function in his responses. In particular, memory language and executive functions were identified areas of impairment in his test performance. However during interviews in these media sessions he shows no evidence of word finding problems or dysfluency. He can report recent events and recall facts.

For instance, during podcast about his relatively recent move to ██████ he can name and even describe the length of walking trails near his residence. In sports interviews he shows spontaneous recall of facts like which football players were on injured reserve for a recent opponent of his former team. This level of memory and word recall is inconsistent with his test performance. In this interview he shows excellent executive functioning in alternately waiting for interviewers to call on him or in picking up and carrying the conversation when it is lagging.

Doc. 265508 at 2 (cleaned up).

The Amended Class Action Settlement established the AAPC and AAP to advise the Claims Administrator in moments like these. Multiple independent medical experts, reviewing the Podcast Evidence, believe it to be discrepant with the test data or self-reported history. Dr. Sherman disagrees, while carefully not opining that Mr. ██████ test results were valid. This good faith disagreement about the process is not clear and convincing evidence of error.

e. Use of the MMPI Evidence

Dr. Sherman's only remaining argument is that the AAPC Reviewers misinterpreted the MMPI evidence, particularly taking too much probative value from an elevated TRIN scale. The most recent AAPC wrote in response:

⁵³ To reiterate, this sort of reliability weighting is an aspect of due process.

The idea that the only basis for an elevated TRIN is a bias towards responding true is not well considered. The scales of the MMPI-2-RF are not fully independent. There is item overlap. TRIN can increase as a result of respondents failing to say false to infrequently endorsed items. The other SVT scales are replete with items that people typically reject. Saying true to these can contribute to elevation of ‘true responding bias’. This does not render the remainder of the SVTs uninterpretable. . . . However, even in the extreme where an examinee responds true to all items on the MMPI we are still left with evidence of poor task engagement favoring overstatement of symptoms leading to conclusion of invalid examination.

Doc. 276005, at 1.

I defer to this independent expert’s judgment.

* * *

In sum, on appeal, Mr. [REDACTED] had the burden of showing clear and convincing evidence that the Claims Administrator erred in determining that his test scores were invalid. His counsel has written a powerful brief, one of several over years of representing this Claimant, which incorporated the views of an expert with indisputable knowledge about the *Slick* criteria. But his arguments do not surmount Mr. [REDACTED] appellate burden. The Settlement’s plain text and incorporated Guide for Clinicians govern and support the Claims Administrator’s determination. Post-Diagnosis evidence can be relevant, in limited circumstances, in assessing validity, especially when in the opinion of the independent expert panel, dozens of podcasts so starkly demonstrate that the contemporaneous record was incomplete. Mr. [REDACTED] has identified errors in the original Reviewer’s *Slick* analysis, but I cannot conclude as a matter of fact that he has shown by clear and convincing evidence that the decision overall was in error.

CONCLUSION

I return to the words of Judge Brody’s recent order: “AAP review of the medical records underlying Claims Packages is integral to attaining the diagnostic accuracy administration of the Settlement requires, and is expressly provided for by the terms of the Settlement Agreement.”⁵⁴

In service of diagnostic accuracy, the Claims Administrator sought expert review to harmonize the picture of Mr. [REDACTED] generated from his 2017 medical examinations and that apparent in the dozens of podcasts he has given in the years since. That evidence, combined with a more careful scrutiny of the record, leads me to conclude that Mr. [REDACTED] has not offered clear and convincing evidence that his 2017 tests were valid, and that the NFL Parties have met their burden of showing that his functional impairment is not generally consistent with a Level 2 Award.

I deny Mr. [REDACTED] Appeal and grant that of the NFL Parties. To avoid doubt if an appeal follows, I would reach the same factual conclusion on the basis of functional impairment even if, as Mr. [REDACTED] argues, validity analysis can never be informed by later-arriving pieces of evidence.

⁵⁴ ECF No. 11931, Explanation and Order Denying 11813 Motion for Relief (December 27, 2022).

Mr. [REDACTED] remains entitled to a BAP examination, as his deadline to do so was extended due to this MAF submission. He has two years from the date of this Opinion, or the disposition of any appeal to the District Court, to request such an examination from the BAP Administrator.⁵⁵

Date: March 27, 2023



David A. Hoffman, Special Master

⁵⁵ I overrule the shorter and contrary deadline noted in Mr. [REDACTED] most recent Denial Notice.