

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

THIS DOCUMENT RELATES TO:
NFL PARTIES' APPEAL OF
QUALIFYING DIAGNOSIS AND
CLAIM DETERMINATION FOR
SETTLEMENT CLASS MEMBER
[REDACTED]

Hon. Anita B. Brody

[REDACTED], a Retired NFL Player and Class Member under the Amended Class Action Settlement Agreement, filed a Claim for a Monetary Award based on a Qualifying Diagnosis of Level 2.0 Neurocognitive Impairment. The Claims Administrator determined, after an audit and correspondence with Mr. [REDACTED]'s neuropsychologist, that Mr. [REDACTED] was entitled to an Award. On Appeal, the NFL Parties argue that Mr. [REDACTED]'s neuropsychological testing was invalid.

I asked the AAPC for assistance. The Program's reviewing consultant disagreed with the examining neuropsychologist's analysis, but advised that his determinations resulted from the exercise of reasonably articulated medical judgment. I adopt the AAPC's views with respect to the medical issues in this case, and consequently deny the NFL Parties' Appeal.

CLAIM HISTORY

This is Mr. [REDACTED]'s second Claim. His first was caught up in an audit of the law firm consortium [REDACTED], and was ultimately denied. I briefly recount that history before moving onto today's Claim.

Mr. [REDACTED]'s first Claim, submitted on his behalf by [REDACTED] on July 26, 2017, asserted a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment by Dr. [REDACTED]. Docs. 96550; 96551. After receiving two tips implicating [REDACTED] and the doctors it relied on—including Dr. [REDACTED]—in potentially fraudulent practices with respect to the Settlement Program, the Claims Administrator placed Mr. [REDACTED]'s Claim in audit on March 12, 2018. Docs. 224945 at 2; 161180.

On May 29, 2020, the Claims Administrator notified Mr. [REDACTED] that while [REDACTED] “may have misrepresented, omitted, or concealed material facts,” the Claims Administrator was “unable to fully complete the Audit, as [REDACTED] refused to answer the Claims Administrator’s Audit Questions.” Doc. 224945 at 1.

The audit decision, attached to this notice, explained further:

The Claims Administrator concluded that there is a reasonable basis to support a finding that: (1) the majority of physicians relied on by [REDACTED] for its claims were the subject of adverse audit findings, or were “currently in Audit for review of suspect trends or patterns in their evaluations and diagnoses;” (2) [REDACTED] may have taken steps to defraud the Program by engaging in improper activities to induce more favorable diagnoses from doctors; (3) [REDACTED]’s claimants routinely submitted “check-box” style affidavits from third parties to support diagnoses; (4) players may have been induced to change law firms and hire [REDACTED] under the assumption that a Qualifying Diagnosis might be more likely; and (5) [REDACTED] refused to answer Audit questions, instead asserting several objections to the questions and challenging the authority of the Claims Administrator.

Id. at 2–3.

Because the “concerns raised by this Audit” were “not rebutted,” Special Master Verrier and I concluded that “[REDACTED]’s practices impugned the integrity and fair administration of the Settlement Agreement as a whole.” *Id.* at 4. Therefore, we denied all Claims submitted by [REDACTED] based on testing by—among others—Dr. [REDACTED]. *Id.* Additionally, the decision provided that “any other claims filed in the future by [REDACTED] [...] will be audited.” *Id.* at 5. Mr. [REDACTED]’s first Claim was therefore denied. *Id.* at 1.

Still represented by [REDACTED], Mr. [REDACTED] submitted a second Claim on March 23, 2023. Doc. 279474. He now sought relief for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment dated January 31, 2022. *Id.* The diagnosing physician was Dr. [REDACTED], assisted by neuropsychologist Dr. [REDACTED]. Doc. 279426. Neither have been the subject of an adverse audit proceeding in the Settlement Program.

Mr. [REDACTED]’s evaluation with Dr. [REDACTED] took place on January 31, 2022. Doc. 279461 at 2. Among other symptoms, Mr. [REDACTED] reported “significant problems” with memory, concentration, decision-making, problem-solving, and mood. *Id.* Dr. [REDACTED] noted that Mr. [REDACTED] “is very depressed about his memory and reports problems remembering his children’s names.” *Id.* Although Mr. [REDACTED] had been prescribed Adderall, he was not taking it at the time of the appointment. *Id.* at 3. He was not prescribed any other medications. *Id.*

Dr. [REDACTED] found that Mr. [REDACTED]’s test results indicated Level 2.0 impairments in the complex attention and processing speed, learning and memory, visual-perceptual processing, and language domains, and a Level 1.5 impairment in executive functioning. *Id.* at 4. He also noted

evidence consistent with CDR ratings of 2.0 for community affairs, home and hobbies, and personal care. *Id.* Regarding validity testing, Dr. [REDACTED] explained:

Mr. [REDACTED] performed below the acceptable cutoff levels on the ACS effort scores, and the TOMM (T1=27, T2=29, T3=32). Thus, he does meet criteria one of the Slick criteria for malingered neurocognitive disorder. However, he does not meet criteria two through nine of the Slick criteria.

Id.

Dr. [REDACTED] concluded the report with a detailed explanation of his thinking. *Id.* at 4–8. In part, his reasoning included the following:

In looking at the performance validity measures overall, his performance on this test instrument appears to be exaggerated or over reported. The degree of over reporting or exaggeration is sufficient to invalidate any interpretation of this test [...]

Results of this neuropsychological evaluation indicate that Mr. [REDACTED] has a 2.0 level of neurocognitive impairment. He has severe cognitive impairment in all domains, as can be seen by the table below. His poor performance on performance validity indicators is considered to be an indication of the severity of his cognitive impairment in combination with major depression. His extremely low level of neurocognitive functioning is commensurate with moderate to severe impairment in areas of community affairs, home and hobbies, and personal care. Additionally, Mr. [REDACTED] is experiencing severe psychological deterioration and has major depression. He should be considered a moderate to severe suicidal risk.

Id. at 5, 7–8.

Dr. [REDACTED] examined Mr. [REDACTED] and interviewed his wife on September 1, 2022. Doc. 279153 at 1. Relying on his personal evaluation as well as Dr. [REDACTED]'s neuropsychological testing, Dr. [REDACTED] reported:

Patient does have neuropsychological testing, history and examination consistent with an advancing dementia process likely related to multiple concussive injuries. The patient does have impairment **rating of 2.0**. There does not appear to be any other secondary related causes (e.g., toxic, metabolic, or infectious encephalopathy) based on history and records provided.

Patient may be at risk for obstructive sleep apnea, however this would not explain his profound memory impairment nor the progressive features of his illness. I do however recommend home sleep testing to asses this further. Consideration for treatment could be made pending assessment.

On today's examination mild parkinsonism was noted, not felt to be related to idiopathic Parkinson's disease however. Monitoring however in the future may be worthwhile to assess the patient begin to develop more clinical symptoms of this.

Self-reported cognitive impairment began at the end of his playing career, and should there be objective evidence related to this by physicians, I would consider date of onset adjustment for this patient. Currently I will bases date of onset from Dr. [REDACTED]'s assessment on 1/31/22.

Id. at 3 (emphasis in original) (paragraph breaks added).

On March 24, 2023, Mr. [REDACTED]'s neuropsychological test scores were updated using the New Method, revealing Level 2 impairments in the complex attention, executive functioning, and visual-perceptual processing domains, Level 1.5 impairment in the learning and memory domain, no impairment in the language domain, and Level 2 impairment overall. Doc. 279597. Pursuant to the prior audit decision of [REDACTED], Mr. [REDACTED]'s Claim was placed into audit on March 28, 2023. Doc. 279713. The Claims Administrator ultimately determined, on June 14, 2023, that there was not "a reasonable basis to conclude that there has been a misrepresentation, omission, or concealment of a material fact" and resumed processing Mr. [REDACTED]'s (second) Claim. Doc. 284335.

As a part of a regular review process, the AAPC raised concerns regarding the validity of the neuropsychological testing supporting the Qualifying Diagnosis. Doc. 284784. The AAPC agreed with Dr. [REDACTED] that *Slick* criterion one was triggered, but while Dr. [REDACTED] had concluded that all the other *Slick* criteria were absent, the AAPC opined:

This gentleman also profoundly exaggerated his emotional and behavioral impairment. Slick criterion #7 is met.

The patient drives occasionally. This is inconsistent with Level 2 neurocognitive impairment and CDR = 2 in Community Affairs. Slick criterion #5 is met.

A qualifying diagnosis of Level 2 (or Level 1.5) Neurocognitive Impairment cannot be supported.

Id.

Prompted by these concerns, the Claims Administrator requested additional information from Dr. [REDACTED] addressing "the validity issues noted by the AAPC," and providing "a detailed Slick analysis addressing the Slick criteria concerns." Doc. 286256 at 2. Dr. [REDACTED] responded on August 15, 2023 with an addendum further explaining his thinking, including the requested *Slick* checklist:

1. The retired player does meet this criterion due to failure on embedded and stand alone performance validity measures.
2. Mr. [REDACTED] pattern of neuropsychological test performance is consistent with severe neurodegenerative dementia, and thus this criterion is not met.
3. Mr. [REDACTED] exhibited a decreased level of responsiveness, moderate slowing in his thinking, and long response latencies. He walked with the assistance of a cane. He spoke in short phrases. Articulation was poor. His speech was mumbled and he stuttered. Rapport was difficult to establish with the psychometrist. His behavior during the testing session did not change when he was out of the testing environment. Therefore, he does not meet this Slick criteria.
4. There is not a discrepancy between test data and reliable collateral reports. Test data, while technically invalid, does indicate profound impairment. The interview with the patient's wife is consistent with this degree of impairment in daily functioning. This criterion is thus not met.
5. There is not a discrepancy between the test data and documented background or history. The patient's history indicates a decline in cognitive functioning and an inability to function effectively in a work or home setting. This history is consistent with severe impairment on the neuropsychological tests.
6. Self-reported history is not discrepant with documented history.
7. Mr. [REDACTED] self-reported symptoms of severe irritability, rage and depression are consistent with neurodegenerative dementia associated with repeated blows to the brain found in chronic traumatic encephalopathy. While the MMPI-2-RF are exaggerated, it is my interpretation that these results reflect a severe degree of emotional distress, which is consistent with his self-report.
8. Retired player's self-reported symptoms are entirely consistent with his behavioral observations taken during the testing.
9. Self-reported symptoms are consistent with information obtained from collateral reports. Mr. [REDACTED] and his wife report severe neurobehavioral symptoms. He completed the Neurobehavioral Symptom Inventory, and reports severe neurobehavioral symptoms that are consistent with his neuropsychological findings. His ability to verbalize these problems are limited, however.

10. The overall Slick result is that this is not a malingered neurocognitive profile due to the presence of severe neurodegenerative dementia as found in chronic traumatic encephalopathy.

Doc. 287693 at 1–2.

Dr. [REDACTED] also expanded on the CDR rating, explaining that when Mr. [REDACTED] “does try to drive, he gets lost, which has resulted in him no longer driving.” *Id.* at 1. According to Dr. [REDACTED], furthermore, Mr. [REDACTED] no longer engages in social activities, hobbies, or household chores, spending most of his days “in the living room or in bed.” *Id.* Additionally, Mr. [REDACTED] can no longer dress himself, groom or wash himself, or even feed himself without some type of assistance. *Id.* For these reasons and for those elaborated in his *Slick* checklist, Dr. [REDACTED] emphasized his “belief that while Mr. [REDACTED] clearly failed the majority of the performance validity tests, that his performance is not a result of a malingered profile, but rather a profound neurocognitive deficit such as chronic traumatic encephalopathy.” *Id.*

Reviewing this addendum, the AAPC concluded that while it still had concerns, since Dr. [REDACTED] “actually examined this former player and he explains his reasoning,” deference to Dr. [REDACTED]’s judgment was appropriate and “overall, Exhibit 2 criteria have been met.” Doc. 288172 at 2. The Claims Administrator determined that Mr. [REDACTED] was entitled to a Monetary Award on September 12, 2023. Doc. 288930.

The NFL Parties appealed this determination on November 16, 2023, arguing that Mr. [REDACTED]’s neuropsychological testing was invalid, and that Dr. [REDACTED]’s determination to the contrary “is not entitled to any deference.” Doc. 293852 at 1. Mr. [REDACTED], through his attorney, responded that the AAPC and the Claims Administrator properly deferred to Dr. [REDACTED]’s judgment under the Settlement Agreement’s “layered deference to expertise and a diagnosing physician’s articulated consideration of factors.” Doc. 297767 at 1. Class Counsel did not participate.

RESOLVING THIS APPEAL

To “determine whether the Retired NFL Football Player’s test data is a valid reflection of his optimal level of neurocognitive functioning,” the Settlement requires each neuropsychological examiner to “complete a checklist of validity criteria as set forth in *Slick et al.* 1999, and revised in 2013.”¹ Clinicians’ careful documentation of their reasoning, in turn, determines the level of deference their assessments warrant:

The AAP should defer to a clinician’s *Slick*-criteria-based validity analysis when it results from reasoning completely articulated in contemporaneous reports, unless the analysis is clearly erroneous. Conversely, when clinicians fail to articulate their

¹ Settlement Agreement, Exhibit A-2 (2).

judgment through complete *Slick* analyses, the AAP may thoroughly and independently assure themselves the criteria do not indicate invalid testing.²

Here, there is no question that Dr. ██████'s reasoning was ultimately clearly articulated. His addendum in particular lays out a thorough *Slick* checklist and explains, in detail, why he believes that Mr. ██████'s failure on validity tests indicates "a profound neurocognitive deficit" rather than a "malingered profile." Doc. 287693. This reasoning was not produced on Appeal, but rather during the claims process, at the Administrator's request. But the NFL Parties assert that despite Dr. ██████'s articulated reasoning, his determinations are "clearly erroneous" and not entitled to deference. Doc. 293852.

The "clearly erroneous" bar for overriding a clinician's articulated reasoning is—appropriately—very high. It is not enough to conclude that Dr. ██████ was mistaken or even "wrong" in his judgment.³ Rather, any flaws in Dr. ██████'s reasoning would need to be "so basic and foundational as to render his determinations unreasonable."⁴ And on Appeal, in those cases where the Claims Administrator has accepted the validity determination in question, the NFL Parties must offer clear and convincing evidence of error in that nuanced judgment.

Emphasizing this standard, I asked the AAPC to advise me with respect to whether the NFL Parties had proven that Dr. ██████'s articulated reasoning was clearly erroneous. The AAPC's assessment illustrates the Settlement's layered system of deference in operation:

If truth be told, there is merit in the arguments of both the NFL Parties and the Claimant. But *if I were to apply my own clinical judgment*, I would side with the NFL Parties and decide that there are more than enough threats to the validity of Dr. ██████'s findings to discount them [...]

However, as Special Master Hoffman has reminded us, it is not the job of the AAP Member or Consultant to substitute our own clinical judgment for that of the examining MAF clinician. Our task is to "advise the Settlement's non-medical-expert decisionmakers on whether another medical professional's articulated conclusion resulted from the exercise of a reasonably determined medical judgment." (Special Master Ruling on October 26, 2023). In applying this rule, I consider "medical" to mean "clinical," so that it applies to the examining neuropsychologist as well as the examining neurologist.

The question then becomes whether Dr. ██████'s clinical judgment is so faulty as to be considered not "reasonably determined" and therefore not worthy of deference.

² Special Master Ruling on *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

³ Special Master Ruling on Generally Consistent Standard and Deference, at 20 (Nov. 30, 2023), https://www.nflconcussionsettlement.com/Docs/generallyconsistent_deference_sm.pdf.

⁴ *Id.*

This is a high threshold and I do not believe it is reached in this case. I therefore believe that the Claims Administrator's Award Determination should stand.

Doc. 300076 at 2-3 (emphasis in original).

This is a model analysis, and I commend the Consultant for taking this difficult task on with such care. The Consultant is correct that "medical" in "medical judgment" does include the "clinical" judgment of neuropsychologists. And I adopt the AAPC's factual determination that Dr. [REDACTED]'s validity analysis resulted from a reasonably determined medical judgment. Therefore, the NFL Parties have not proven, by clear and convincing evidence, that the Claims Administrator erred in finding Mr. [REDACTED] entitled to a Monetary Award.

CONCLUSION

Because NFL Parties have not offered clear and convincing evidence of error in the Claims Administrator's decision, I deny their Appeal.

Date: February 14, 2024



David A. Hoffman, Special Master