UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION	:	No. 2:12-md-02323-AB
	:	MDL No. 2323
	:	**Hon. Anita B. Brody**
THIS DOCUMENT RELATES TO: APPEAL OF SETTLEMENT CLASS MEMBER [redacted] REGARDING DENIAL OF MONETARY AWARD	:	

INTRODUCTION

On June 19, 2018, [redacted], a Retired NFL Player and Class Member under the Amended Class Action Settlement, filed a claim for benefits for a Diagnosis of Level 1.5 Neurocognitive Impairment obtained through a MAF physician. He was required to submit "evaluation and evidence generally consistent with the diagnostic criteria" specified in the Settlement.[1]

The Claims Administrator concluded that Mr. [redacted] had failed to meet his burden. I will remand to allow the Claims Administrator to make a decision on a more complete record.

FACTUAL AND PROCEDURAL BACKGROUND

Mr. [redacted] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on April 16, 2018, effective as of February 20, 2017, after examination by MAF neurologist Dr. [redacted] and neuropsychologist Dr. [redacted]. Doc.175993; Doc. 175988. The claim was placed into audit on June 29, 2018, and emerged on May 10, 2019, with no adverse findings. Doc. 177750; Doc. 206685.

On January 6, 2020, relying on a report from a member of the Appeals Advisory Panel Leadership Council, the Claims Administrator denied the claim, primarily based on Dr. [redacted] failure to justify departure from the Settlement criteria:

> "There is documentation of concern for cognitive decline, including trouble with memory for ten years, misplacing items, forgetting names, forgetting appointments, forgetting chores, getting lost while driving, and his wife now manages the household finances.

[1] *See* Settlement Agreement, Exhibit 1(1)(b).

> However, the diagnosing physician, Dr. [redacted] also reports an MMSE score of 28/30, which would not typically indicate the presence of dementia or a significant cognitive decline. Furthermore, the scores from the neuropsychological testing performed by Dr. [redacted] on 4/16/18 meet the Settlement criteria for Level 1 Neurocognitive Impairment only, and there is not adequate justification as to why these scores should be considered generally consistent with a diagnosis of Level 1.5 Neurocognitive Impairment. Consequently, the diagnosis is not generally consistent with the Settlement criteria for Level 1.5 Neurocognitive Impairment." Doc. 219174.

Mr. [redacted] timely appealed the denial on February 5, 2020. Doc. 220412. The parties, including class counsel, have filed excellent and clarifying briefs.

DISCUSSION

Mr. [redacted] satisfied criteria (i) and (iv). Despite a footnote in the NFL Parties' brief, there is no real dispute that he also satisfied criteria (iii). As the AAPC memo concluded: "The CDR reports level 2.0 impairments in Community Affairs, Home and Hobbies, and Personal Cares. An affidavit from a friend documents social and personal cares deterioration. I believe this documentation shows level 2.0 neurocognitive impairments in this case." Doc. 212072. Turning to criteria (ii), the denial notice lists two infirmities.

First, the notice states that the MMSE score of 28/30 "would not typically indicate the presence of dementia or a significant cognitive decline." The MMSE is not listed in the Settlement Agreement, Exhibit 2, nor included in the BAP Clinician's Guide, and is consequently not a part of the BAP diagnostic criteria. When prompted about the relevance of this test, the parties jointly (on February 20, 2020) wrote the Claims Administrator:

> "The Parties agree that cognitive screening tests and evaluations can be used as part of neurological examinations by BAP Providers or MAF Physicians. The Parties do not believe it is necessary to legislate how much weight, if any, such cognitive screening tests should be given in connection with the approval or denial of any particular claim."

As Class Counsel correctly argues, while "the MMSE may serve as a preliminary screen, the MMSE should never replace the results of extensive neuropsychological testing, such as the rigorous neuropsychological test battery administered to Mr. [redacted] which is specifically designed to determine specific levels of impairment." Doc. 223302. A denial that turned entirely or substantially on the MMSE screening test would be problematic. But that is not this case.

Second, the denial concluded that the testing failed to meet the criteria for Level 1.5 Neurocognitive Impairment. Mr. [redacted] burden was not to replicate the BAP criteria but rather to offer evaluation and evidence "generally consistent" with them. Mr. [redacted] scores met the BAP cutoffs in only one domain—Visual-Perceptual.[2] For Executive Function, his T-scores were 33 and 30, and in Complex Attention they were 31 and 30. As Class Counsel summarizes, "Mr. [redacted] had one score well below 35 for both domains (33 and 31) and scores of exactly 30 in both

[2] Mr. [redacted] T-scores for the Visual-Perceptual Functioning domain were 36, 35, and 32 (three scores below 37 and one below 35).

domains. So, if either of Mr. [redacted] scores of 30 had been one point less, he would have satisfied the BAP criteria, which is not even required since he was diagnosed outside of the BAP."

Generally consistent does not mean the same, and Class Counsel's counterfactual argument resonates. And yet, it would be a perverse result if every player diagnosed outside of the BAP received an award based on results which would have rendered him ineligible within it: the exercise cannot be a mechanical one, where all ties go to the runner. If that were what the Parties had intended, the Agreement would not have said "generally consistent:" it would have explicitly directed that non-BAP diagnoses may meet a *lower*, not a *different*, standard. What's called for instead is the exercise of reasoned, individualized, clinical judgment.

In concluding that Mr. [redacted] satisfied Level 1.5, rather than Level 1.0, Dr. [redacted] offered very little by way of justification. Indeed, the entirety of the relevant commentary appears to be:

> **Executive Function**: "Level of impairment in this domain is classified as 1.5. Level of impairment in this domain is classified as 1.5 as he approximates the criteria by having two T scores less than 35 with one of those T scores at 30 (i.e., 2 standard deviations below the mean)." Doc. 175988.
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> **Complex Attention**: "Level of impairment in this domain is classified as 1.5 as he approximates the criteria by having two T scores less than 35 with one of those T scores at a 30 (i.e., 2 standard deviations below the mean)." *Id.*

The parties agree that a qualified MAF physician can use diagnostic criteria that differ from the BAP's, so long as they are generally consistent with it. Here, the MAF physician used the BAP test battery itself, and under the rules governing MAF physicians, where the results "do not meet the thresholds necessary to support the qualifying diagnosis," the physician "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 and must obtain information from the Examining Neuropsychologist as is necessary to provide a complete explanation."[3]

Requiring a written explanation makes sense, as reasons tend to justify, enabling the Claims Administrator to defer to the judgment of the treating physician. That deference in turn promotes the Settlement's global concern for speedy and equitable administration. The clinician need not offer—in the words of an AAPC report not repeated in the denial notice—a "compelling argument." Doc. 212072. Rather, it must be merely an *explanation,* i.e., an *accounting* of why the clinician believed that the deviation was appropriate. It does need to satisfy the Claims Administrator, both as to its rationale and its completeness. Considering the Claims Administrator's careful selection and training of MAF Physicians, and the Program's desire to avoid excessive re-litigation of clinical choices, such satisfaction is, and should be, the customary response to *articulated* medical judgments.

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[3] *See* Rules Governing MAF Physicians, at 20; *see also* FAQ 109: "Are Qualified MAF Physicians required to follow the strict BAP criteria when making a diagnosis of Level 1.5 or Level 2 Neurocognitive Impairment? No. However, the Qualified MAF Physician and/or neuropsychologist must explain to the Claims Administrator whenever: The full BAP test battery is used but the resulting test scores do not support a Level 1.5 or Level 2 Qualifying Diagnosis under the BAP criteria"

The problem here is that Dr. [redacted] did *not* articulate the basis for his judgment, merely writing that Mr. [redacted] "approximates the criteria." "Approximates" described the closeness of numerical fit; it did not explain the deviation's relationship to the Diagnosis. There are multiple, plausible, reasons why Dr. [redacted] could have deviated from the BAP score cutoffs given Mr. [redacted] medical history. Or so Mr. [redacted] advocates contend. But adjudicating these post-hoc explanations now would distort the Settlement's structure, which seeks to defer to contemporaneous, corroborated, clinical judgments and to avoid excessive appeals. It also wrongly enlarges my role, which here focuses on the Claims Administrator's evaluation of the sufficiency of the contemporaneous record,[4] not to fashion the best possible case for the Diagnosis and to then evaluate the Claims Administrator's decision against that hypothetical.

The Claims Administrator's denial of the sufficiency of Dr. [redacted] explanation under Rule 20 was not clearly erroneous. However, the Claims Administrator's decision might have rested on an inappropriately high standard (a "compelling argument"), which this opinion has clarified. Given the strength of Mr. [redacted] overall claim for an award, I will remand to the Claims Administrator, who should offer Dr. [redacted] the opportunity to write a supplemental deviation explanation, and then make a fresh determination as to whether it suffices.

CONCLUSION

Under Rule 24 of the Rules Governing Appeals of Claim Determinations, this Appeal is remanded to the Claims Administrator for further review in light of this decision.

Date: May 27, 2020

David Hoffman, Special Master

[4] The Special Masters must decide an appeal of a Monetary Award based on a showing by the appellant of clear and convincing evidence that the determination of the Claims Administrator was incorrect. *See* Order Appointing Special Masters, at 5. Claimants contesting the exercise of discretion explicitly granted by the MAF Rules thus ordinarily bear a heavy, but not insurmountable, burden. In Special Master Opinion Regarding Appeal of Settlement Class Member I.D. # 100014405, Special Master Pritchett found a one score deviation justified when, in "addition to considering the breadth and depth of Claimant's Impairments, [the clinician] also explained that had Claimant finished his final semester of college, Claimant would have clearly met the BAP criteria for Level 2." The case is analogous to this one, except (crucially) that the diagnosing physician there offered a more helpful and satisfactory explanation why the BAP criteria should not apply. Similarly, in the recently decided Opinion Regarding the Appeal of Settlement Class Member I.D. # 100015394, a one-score deviation in Executive Function (given otherwise conforming testing) was generally consistent with a Diagnosis. Notably, the examining clinician in that claim offered a lengthy explanation of why a deviant score should count toward a Level 1.5 Diagnosis, including evaluation of previous testing, and concluded "Given the depth of impairment on learning/memory, two executive function measures at the 2nd percentile, poor scores in complex attention and language, his consistency in poor performances in these domains over time, and his past diagnosis of Level 1.5 Neurocognitive Impairment . . . his test scores on the present evaluation are generally consistent with Level 1.5 Neurocognitive Impairment." This articulated reasoning is far from the mere observation of approximate equivalence and recitation of the standard deviations below the mean represented by the scores that Dr. [redacted] offered.