

**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

[REDACTED], a Retired NFL Football Player and Class Member, filed a Claim for an Award based on a Qualifying Diagnosis of Alzheimer's Disease on February 6, 2023. After the Claims Administrator denied that Claim, Mr. [REDACTED] filed an appeal, which I denied on July 16, 2024. Mr. [REDACTED] objected to that decision before the District Court. The District Court has now remanded Mr. [REDACTED] Appeal for further explanation.

Today's Opinion responds to the Court's remand order and answers a novel question about the Settlement's Injury Definitions. The Amended Class Action Settlement makes awards for "a diagnosis of Major Neurocognitive Disorder due to probable Alzheimer's Disease as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)."¹ The District Court instructed me to determine if that reference to the "DSM-5" mean the current version of the DSM-5—called the "DSM-5-TR"—which includes text revisions that postdate the Settlement's formation? Or does "DSM-5" mean only those diagnostic techniques found in the precise text operative as of the Agreement's effective date, at least until the parties agree otherwise?

By way of background, the American Psychiatric Association ("APA") published the original DSM in 1952.² Sixteen years later, it issued a second edition. A third followed in 1980.³ And then, in 1987, the APA released the DSM-III-R: a revised version of III, but not sufficiently distinct to justify a new volume number.⁴ In 1994, the APA finally plunged into the DSM-IV, which

¹ Settlement Agreement, Exhibit A-1 (3).

² See *State v. Harris*, 12 N.Y.S.3d 762, 764 (N.Y. Sup. Ct. 2015) ("The Diagnostic and Statistical Manual [...] is a treatise created by the American Psychiatric Association in 1952, which, by classifying mental disorders, serves as the standard diagnostic handbook used by psychiatrists and psychologists throughout the United States.") (cleaned up).

³ AMERICAN PSYCHIATRIC ASSOCIATION, *DSM History*, <https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm/history-of-the-dsm> (last visited Jan. 10, 2025).

⁴ *Id.*

was revised into IV-TR in 2000. The APA put out the DSM-5 (and adopted Arabic numbering) in 2013.⁵ These iterations are why, though the Supreme Court referred to the DSM as “one of the basic texts used by psychiatrists and other experts,”⁶ it emphasized that “[t]he only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment.”⁷

In 2013 (and 2015, when the parties fixed the Amended Settlement’s text) the DSM-5 represented the gold standard diagnostic manual. Unsurprisingly, it was incorporated into the Settlement. And yet, while the parties could have written that diagnostic practices were to follow the “DSM-5 (2013),” they left the date off their instruction.⁸ Years passed. Then, in 2022, in response to “[m]ajor changes in the US standard ICD-10-CM classifications of Dementia (Major Neurocognitive Disorder),” requiring alignment of the “DSM-5 with the revised codes to facilitate correct classification and submission of valid codes for billing,” the APA published the *DSM-5-TR, Update (Supplement to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision)*. (Appendix A: AAPLC Report, hereinafter “App. A”). Like the DSM-III-R and DSM-IV-TR before it, the DSM-5-TR revises the DSM-5. The APA has continued to update the DSM-5-TR on a rolling basis.

One such update—approved in September 2024—immediately precipitated the District Court’s remand. The DSM-5 (2013) required that physicians making diagnoses of Major Neurocognitive Disorder due to probable Alzheimer’s Disease find “[n]o evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline).”⁹ The DSM-5-TR removed that exclusion.¹⁰ At the same time, it retains the requirement that the diagnosis of probable Alzheimer’s Disease is not “better explained by [other illness states].”¹¹

I have written repeatedly about the interaction between the “no evidence of mixed etiology” exclusion in the 2013 DSM-5 and the Settlement Agreement’s structure and text. Its elimination in the DSM-5-TR poses three related questions which this Opinion answers.

First, does the Settlement’s “DSM-5” mean the most current version of the DSM-5, *i.e.*, does “DSM-5” mean “DSM-5-TR”? I asked Mr. [REDACTED], Class Counsel, and the NFL Parties for briefing on that question. The NFL Parties argue that the Settlement’s “DSM-5” means (in

⁵ *Id.*

⁶ *Hall v. Florida*, 572 U.S. 701, 704 (2014) (cleaned up). The *Hall* opinion uses “the latest edition of the Diagnostic and Statistical Manual of Mental Disorders,” which at the time was the 2013 version of the DSM-5. *Id.* at 704–705.

⁷ *Clark v. Arizona*, 548 U.S. 735, 774 (2006) (quoting *Greenwood v. United States*, 350 U.S. 366, 375 (1956)). The *Clark* opinion cites to the then-current DSM-IV-TR and refers to it interchangeably as the “DSM” or the “DSM-IV.” *Id.* at 774–776.

⁸ Settlement Agreement, Exhibit A-1 (3).

⁹ AMERICAN PSYCHIATRIC ASSOCIATION, *DSM-5-TR® Update: Supplement to Diagnostic Manual of Mental Disorders, Fifth Edition, Text Revision*, at 10 (Sept. 2024), <https://www.psychiatry.org/getmedia/2ed086b0-ec88-42ec-aa0e-f442e4af74e6/APA-DSM5TR-Update-September-2024.pdf>.

¹⁰ *Id.* at 10–11.

¹¹ *Id.* at 11.

effect) “DSM-5 (2013)”]; Class Counsel contends that the better reading is “DSM-5-TR.” Docs. 380714; 380570. Mr. [REDACTED] agrees with Class Counsel. Doc. 380541.

I conclude that “DSM-5” in the Settlement means the most current version of the DSM-5, text revisions included.

Second, if “DSM-5” means “DSM-5-TR,” does this particular text revision require any changes to the Settlement Program’s diagnostic practices for Alzheimer’s Disease? I consulted with the AAPLC for guidance on the medical issues. It is their view, and therefore mine, that this particular text revision requires no change to the Program’s diagnostic practices. To the contrary, the edit confirms that the Program’s established approach to Alzheimer’s diagnoses aligns with the latest scientific consensus.

Third, does the September 2024 update to the DSM-5-TR provide clear and convincing evidence that the denial of Mr. [REDACTED] Claim was in error? It follows from my conclusion that the text revision requires no change to the Program’s diagnostic practices, that Mr. [REDACTED] Claim was properly denied and that no further remand is needed. I therefore deny his Appeal for a second time.

CLAIM HISTORY

I summarized the history of Mr. [REDACTED] Claim in my July 16, 2024 decision.¹² In short, the Claims Administrator deferred to the AAP’s determination that Mr. [REDACTED] Diagnosing Physician, then-MAF Neurologist Dr. [REDACTED], did not sufficiently address the evidence of mixed etiology to support his diagnosis of Alzheimer’s Disease.¹³ Initially dating his Diagnosis to 2010, Dr. [REDACTED] explained:

He has a documented history of gradually progressive functional and cognitive decline going back to 2010. He has evidence of decline in memory/learning and executive function. See above description of 2019 and 2020 neurological, psychiatric, and psychological evaluations and notation over time (dating back since 2010), and notation about decline over time. See above CDR with community affairs, home/hobbies, self-care scores of 2-2-1, and MoCA with spatial, language, memory related deficits. There is no evidence of a cerebrovascular, other neurodegenerative, systemic, or other clinical-pathological process to explain this. **There is evidence of concurrent depression, which by interview, CDR, MoCA, exam performance does not supersede or by itself explain these dysfunctions and deficits.** In my neurologic opinion, the patient’s diagnosis is Alzheimer’s Disease, with date of diagnosis Sept 17 2010, in relating to worker’s compensation evaluation/diagnosis (described above) of DSM-IV Class 4 multi-domain cognitive impairment related to brain injury.

¹² Special Master Ruling on Mixed Etiology for Alzheimer’s Disease Diagnosis (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf.

¹³ *Id.* at 4.

Doc. 276921 at 4 (emphasis added).

When the AAP asked for further clarification on the impact of depression and anxiety on Mr. [REDACTED] Alzheimer's Diagnosis, Doc. 282251, Dr. [REDACTED] responded:

[S]ee Mar-Oct 2022 neurology clinic visits with treatment with duloxetine, donepezil, escitalopram, and serial observation/examinations, CDR functional sub-scores of 2, 2, 1. Qualifying diagnosis still Alzheimer's Disease, but with date of diagnosis of Oct 20 2022.

Doc. 286234.

As the Claims Administrator's denial notice ultimately explained, the AAP member reviewed the full record and noted the following:

The Player has undergone evaluations for cognitive losses dating to at least 2010. Irritability and social withdrawal are reported to be increased since 2017. The past records and the CDR reporting identify persistent losses in function. These are noted to be associated with a loss of interest in multiple prior hobbies and activities. The records indicate that the Player depends on others for household management and related tasks. The records indicate that pain, loss of mobility, and sleep disturbance are persistently reported as contributing factors to his losses in function. For example, Dr. [REDACTED] in 2019 explicitly records 'He no longer drives to due his pain.'

Depression and anxiety are clearly noted across multiple evaluations dating back to 2010. In 2010, the Player's responses on the Beck Depression Inventory generated a score of 50 (out of 63), indicative of 'clinically relevant depression.' At that time, Dr. [REDACTED] reported that this demonstrated 'the urgency of immediate industrial psychiatric treatment.' Dr. [REDACTED]'s 2019 report specifically notes that the Player has a 'severely depressed mood' and met DSM criteria for Major Depressive Disorder.

Dr. [REDACTED]'s exam of 1/24/2022 supports the presence of depression with statements including 'decreased/constricted affect, avoidant gaze' and 'At end of exam, the claimant gets up and begins pacing and becomes very tearful.' In his summary, Dr. [REDACTED] asserted 'There is evidence of concurrent depression, which by interview, CDR, MoCA, exam performance does not supersede or by itself explain these dysfunctions and deficits.'

However, this conclusion does not fulfill the requirements for diagnosis of Probable Alzheimer's disease, which requires that 'The cognitive deficits are not better explained by another mental disorder' (DSM-5).

ICD-10 expands on this with the statement ‘In assessing the presence or absence of a dementia, special care should be taken to avoid false-positive identification: motivational or emotional factors, particularly depression, in addition to motor slowness and general physical frailty, rather than loss of intellectual capacity, may account for failure to perform.’

Additionally, under ICD-10, early onset Alzheimer’s Disease should be expected to show ‘relatively rapid deterioration, with marked multiple disorders of the higher cortical functions. Aphasia, agraphia, alexia, and apraxia occur relatively early in the course of the dementia in most cases.’ In contrast, the Player’s deficits are described in largely similar terms over the interval dating to 2010, especially from 2019 to 2022.

In correspondence submitted after the original diagnosis, Dr. [REDACTED] revised the date of diagnosis to 10/20/2022 and submitted notes documenting ongoing care from March to October 2022, during which anti-depressant medications were prescribed and beneficial responses were noted. Importantly, during that care, Dr. [REDACTED] does not identify Alzheimer’s Disease as the diagnosis. Instead, his diagnosis list includes depression, sleep disorder, and unspecified dementia.

In conclusion, the Settlement criteria for the Qualifying Diagnosis of Alzheimer’s Disease are not fulfilled either in 2010 or 2022.

Doc. 299663 (breaks and emphasis added).

Mr. [REDACTED] appealed the denial of his Claim. Doc. 303112. Noting that there was “no question that Mr. [REDACTED] is suffering from profound sadness, episodes of forgetfulness, and a loss of day-to-day function and engagement with the world,” I concluded that Mr. [REDACTED] had not shown by clear and convincing evidence that the Claims Administrator erred in denying his Claim.¹⁴ I explained:

The Settlement Agreement requires the Claims Administrator to assess asserted Qualifying Diagnoses of Alzheimer’s Disease for their sufficiency in fulfilling the ICD-9/10 or DSM-5 diagnostic criteria. Both definitions require the exclusion of ‘mixed etiology’ under the DSM-5 or ‘clinical evidence... to suggest that the mental state may be due to other systemic or brain disease which can induce a dementia’ under the ICD-10. Dr. [REDACTED] documented extensive symptoms of depression beginning on Mr. [REDACTED] initial January 24, 2022 evaluation, echoing references to depression across Mr. [REDACTED] medical history. Applying the Settlement’s explicit rules, the APP concluded that that consistent documentation of depression indicated impermissible mixed etiology under the Settlement’s criteria.

¹⁴ Special Master Ruling on Mixed Etiology for Alzheimer’s Disease Diagnosis, at 4 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf.

To be clear, the presence of depression alone cannot and does not preclude an Alzheimer's Diagnosis. How could it: Alzheimer's is a terrible, wasting disease which may be co-morbid with, or even cause, depression. For that very reason, the long form notice stated that Class Members do not 'need to exclude the possibility that the Qualifying Diagnosis was caused or contributed to... by various risk factors linked to the Qualifying Diagnosis.' But diagnosing physicians still must determine that Alzheimer's Disease, not depression or any other concurrent condition, is the predominant reason for a Player's cognitive decline, because that's what defines the disease itself. [...]

Dr. [REDACTED]'s continued documentation and treatment of Mr. [REDACTED] dementia and depression as intertwined threads did nothing to clarify which of the two is the predominant cause of his cognitive decline. Indeed, over the course of Mr. [REDACTED] visits, Dr. [REDACTED] ceased to even mention a Diagnosis of Alzheimer's Disease, instead recording 'unspecified dementia' in Mr. [REDACTED] chart. The AAPLC was left with no choice but to determine that his Diagnosis was simply inconsistent with the record evidence.¹⁵

Mr. [REDACTED] filed an objection to that decision with the District Court on August 6, 2024. Doc. 351949. On February 12, 2025, the Court remanded Mr. [REDACTED] Claim with the following instructions:

1. Obtain briefs from counsel for [REDACTED], Class Counsel, and counsel for the NFL Parties and resolve the question of whether and, if so, how the provisions of the DSM-5-TR September 2024 Update impact the Settlement's criteria for the Qualifying Diagnosis of 'Alzheimer's Disease.' This determination could include consideration of whether the Settlement Agreement's reference to 'the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)' reflects the DSM edition published in print in 2013 or whether it encompasses the most current version of the Fifth Edition of the DSM: the DSM-5-TR September 2024 Update; and
2. Determine whether it is appropriate to remand the claim to the Claims Administrator for further consideration of the claim, including consultation with the AAP, in light of the above question, new medical evidence in the claim file, or for any other reason.

Doc. 378161 at 4-5.

¹⁵ *Id.* at 5-7 (cleaned up).

Having obtained briefing from the parties and consulted with the AAP for guidance on the medical issues in this case, I now issue this Opinion responding to the Court’s remand order and denying Mr. [REDACTED] Appeal.¹⁶

RESOLVING THIS APPEAL

1. Editing the DSM

Class Counsel and the NFL Parties must have been aware that in 2013, the DSM-5 was the latest of several numbered editions and between-edition revisions, including the DSM-III-R and the DSM-IV-TR. Predictably, after the Settlement went into effect, the APA continued its longstanding revision process. But it did so aware of the digital revolution, and moved from a punctuated, versioned process to one reflecting continuous improvement.¹⁷ As the APA describes its new process:

Advances in digital publishing have paved the way to the adoption of this ‘continuous improvement’ model. This approach differs from the previous mechanism for making changes to the DSM, which was to revise the manual in its entirety at variable intervals. Although this older approach had the advantage of facilitating standardized communication among users of the classifications, it prevented the incorporation of new scientific knowledge into the manual as it emerged.

Anyone can initiate the process for consideration of a proposal for changes to the DSM via this website. Most proposals will require the submission of supportive information in a structured format including the reasons for the change, and data documenting improvements in validity, evidence of reliability and clinical utility, and consideration of potential deleterious consequences. [...] Proposals involving only minor corrections or clarifications of the diagnostic criteria or text will not require supporting data.

The revision process is overseen by a Steering Committee of experts in psychiatric nosology, research, and practice who have been vetted for conflicts of interest using the same standards as for DSM-5-TR. [...] Proposals that are determined to have sufficient evidence will be posted for public comment. The Steering Committee’s

¹⁶ Before the District Court remanded Mr. [REDACTED] Claim, I had separately asked the Parties for briefing on the DSM-5-TR question, and solicited the AAPLC’s views in December of 2024, intending to resolve that question outside of any individual claimant’s appeal. The District Court’s remand squarely presented the question for decision and I have consequently been able to instead use the AAPLC report (attached as an appendix) here.

¹⁷ See Paul S. Appelbaum, Ellen Leibenluft, & Kenneth S. Kendler, *Iterative Revision of the DSM: An Interim Report from the DSM-5 Steering Committee*, 72 PSYCHIATRIC SERVICES 1348, 1348 (2021) (“[F]ollowing the publication of its *Diagnostic and Statistical Manual, 5th edition (DSM-5)* in 2013, the American Psychiatric Association (APA) embarked on an innovative process for future revisions [...] The Web portal for proposal submissions opened in 2017.”) (cleaned up).

recommendations, along with a summary of public comments, will be forwarded to the APA Board of Trustees for approval.¹⁸

The rolling revision process began with the 2022 release of the DSM-5-TR. Then, on October 2, 2023, the DSM Steering Committee approved a proposal to correct the criteria for Major or Mild Neurocognitive Disorder Due to Alzheimer's Disease.¹⁹ The Committee explained:

When a Neurocognitive Disorder is believed to be due to more than one etiology, the DSM coding note instructs clinicians to code each of the etiologies separately, with the medical etiologies listed first and then the ICD-10-CM codes for the Neurocognitive Disorders themselves listed next. The following example can illustrate how this works:

For example, for a presentation of Major Neurocognitive Disorder, moderate, with psychotic disturbance that is judged to be due to Alzheimer's disease, cerebrovascular disease, and HIV infection, and in which heavy chronic alcohol use is judged to be a contributing factor, code the following: G30.9 Alzheimer's disease; B20 HIV infection; F02.B2 Major Neurocognitive Disorder due to Alzheimer's disease and HIV infection, with psychotic disturbance; F01.B2 Major Neurocognitive Disorder probably due to vascular disease, moderate, with psychotic disturbance; and F10.27 alcohol-induced Major Neurocognitive Disorder, non-amnestic confabulatory type, with moderate alcohol use disorder.

However, the current DSM-5-TR criteria for Major Neurocognitive Disorder due to Alzheimer's disease would not allow for cases of Major Neurocognitive Disorder due to multiple etiologies (as in the example above) in which Alzheimer's disease is one of the etiologies since criterion C.2.c (in the Major Neurocognitive Disorder component of the criteria set for Major or Mild Neurocognitive Disorder due to Alzheimer's disease) excludes other etiologies. A parallel problem exists for Mild Neurocognitive Disorder due to Alzheimer's disease. The problematic criteria currently read as follows:

Major Neurocognitive Disorder criterion C.2.c/Mild Neurocognitive Disorder criterion C.3: No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological or systemic disease or condition likely contributing to cognitive decline).

¹⁸ AMERICAN PSYCHIATRIC ASSOCIATION, *Submit Proposals for Making Changes to DSM-5-TR*, <https://www.psychiatry.org/psychiatrists/practice/dsm/submit-proposals> (last visited Jan. 10, 2025); *see also* APA DSM TEAM, *Guide to Submitting Proposals for Changes to DSM-5*, <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/DSM5-Proposal-Submissions-General-Guidance.pdf>, at 49–51 (last visited Jan. 10, 2025) (providing a detailed summary of the steps in the review and approval process once a proposal is submitted).

¹⁹ AMERICAN PSYCHIATRIC ASSOCIATION, *View and Comment on Recently Proposed Changes to DSM-5-TR*, <https://www.psychiatry.org/psychiatrists/practice/dsm/proposed-changes> (last visited Jan. 10, 2025).

To correct this inconsistency, both criterion C 2.c in Major Neurocognitive Disorder due to Alzheimer’s disease and criterion C.3 in Mild Neurocognitive Disorder due to Alzheimer’s disease should be removed.²⁰

This proposal—approved by the “DSM Steering Committee, Council on Geriatric Psychiatry, and the Serious Mental Illnesses Review Committee”—underwent a public comment period through November 17, 2023.²¹ The APA approved the proposal in September 2024. (App. A). It is unclear if the APA will publish a DSM-6.²² As the chair of the DSM Steering Committee explained in a 2022 interview, a DSM-6 is “certainly possible,” but “for now, the focus is on iterative revision of what’s there, only when there is sufficient data to support that change.”²³

The purpose of transitioning from periodic to iterative revisions mirrors the Settlement’s own: diagnostic accuracy.²⁴ That’s why the APA describes the latest DSM-5-TR as “the most comprehensive, current, and critical resource for clinical practice available to today’s mental health clinicians and researchers” and “the most definitive resource for the diagnosis and classification of mental disorders.”²⁵ And the federal government uses the DSM-5-TR in its public health, labor, public welfare, and internal revenue regulations.²⁶

²⁰ *Id.* (cleaned up).

²¹ *Id.*

²² See Paul S. Appelbaum, Ellen Leibenluft, & Kenneth S. Kendler, *Iterative Revision of the DSM: An Interim Report from the DSM-5 Steering Committee*, 72 PSYCHIATRIC SERVICES 1348, 1349 (2021) (noting that while the new iterative revision “process can yield an outcome reflecting both a rigorous assessment of the data and the views of the relevant research and clinical communities,” because the “jury is still out on whether a process that relies only on proposals from the field will be sufficiently robust and comprehensive to serve as the exclusive mechanism for updating the DSM,” the “current approach may need to be modified or augmented on the basis of additional experience”).

²³ Paul Appelbaum, *quoted in* Kristen Monaco, *DSM Chair on Predictions for the Future of Psychiatry—APA board voted to move towards an “iterative process” in updating diagnostic manual*, MEDPAGE TODAY (May 23, 2022), <https://www.medpagetoday.com/meetingcoverage/apa/98879>.

²⁴ Compare ECF No. 11931, Explanation and Order (Dec. 27, 2022), at 6 (noting that “administration of the Settlement” requires “diagnostic accuracy”), with AMERICAN PSYCHIATRIC ASSOCIATION, *Submit Proposals for Making Changes to DSM-5-TR*, <https://www.psychiatry.org/psychiatrists/practice/dsm/submit-proposals> (last visited Jan. 10, 2025) (noting that the purpose of the new “continuous improvement” model of making changes to the DSM is to “incorporat[e] new scientific knowledge into the manual as it emerge[s]”).

²⁵ AMERICAN PSYCHIATRIC ASSOCIATION PUBLISHING, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR®)*, <https://www.appi.org/products/dsm> (last visited Jan. 10, 2025).

²⁶ See 42 C.F.R. § 438.900 (2024) (using “the most current version of the DSM” to define mental health conditions and substance use disorders); 42 C.F.R. § 34.2 (2024) (using “the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders” to define drug abuse and drug addiction); 29 C.F.R. § 2590.712 (2024) (“DSM means the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. For the purpose of this definition, the most current version of the DSM as of November 22, 2024, is the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision published in March 2022. A subsequent version of the DSM published after November 22, 2024, will be considered the most current version beginning on the first day of the plan year that is one year after the date the subsequent version is published.”); 45 C.F.R. § 146.136 (2024) (same); 26 C.F.R. § 54.9812-1 (2024) (same). However, I’d note that the federal government still incorporates by reference the “Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), American Psychiatric Association (2013)” into its veterans’ benefits regulations. 38 C.F.R. § 4.125 (2024).

The AAPLC summarized the clinical state of play:

The DSM-5-TR updates and supplements are meant to be cumulative and serve as the definitive resource for supporting diagnoses under the *DSM* umbrella. In clinical practice, it would contradict the intent of the updates for a provider to revert to earlier forms of the document, or to choose which update version to use. In the clinical realm, DSM-5-TR is the DSM-5.

(App. A) (emphasis in original).

2. Does the Settlement’s “DSM-5” Mean the DSM-5-TR?

Just as the DSM-5-TR *is* the DSM-5 for clinicians, so too for the Settlement. Faithfully implementing the Settlement, as I am charged to do,²⁷ requires attention both to ordinary principles of contract law and an ongoing obligation to class members:

The Third Circuit interprets settlement agreements as contracts, including when applying New York law. And yet, because of the unique way in which ‘a court retains special responsibility to see to the administration of justice’ in a class action settlement, exclusive reliance on ‘black-letter contract law is unavailing.’ In addition to ascertaining the parties’ intent using ordinary contract law principles, the Court also retains responsibility ‘for the protection of class members’ until the settlement fund has been distributed.²⁸

The District Court has cautioned against “rigid and narrow reading[s] of the text of the Settlement Agreement,” in favor of “honorable implementation” that ensures that “justice is done to all parties to the Settlement.”²⁹ Justice requires “both the payment of meritorious claims and the detection of grounds for non-payment.”³⁰

Here, both ordinary New York contract law and fiduciary principles inherent in judicial administration point in the same direction: the Injury Definitions require applying the DSM-5-TR.

In New York, the “fundamental, neutral precept of contract interpretation is that agreements are construed in accord with the parties’ intent,” and the “best evidence of what parties to a written agreement intend is what they say in their writing.”³¹ The relevant text reads:

²⁷ See ECF No. 11022, Order that Professor David Hoffman is Appointed as an Additional Special Master (Mar. 5, 2020), at 1 (appointing me to “implement and administer the Class Action Settlement Agreement”).

²⁸ Special Master Ruling on Diagnosis of Death with CTE, at 15–16 (Oct. 7, 2023), https://www.nflconcussionsettlement.com/Docs/cte_sm_3.pdf (cleaned up) (citing and quoting *In re Cendant Corp. Prides Litig.*, 233 F.3d 188, 193 n.6, 194 (3d Cir. 2000)).

²⁹ ECF No. 10811, Explanation and Order Denying Motion to Stop Multiple Audits (Aug. 20, 2019), at 4.

³⁰ *Id.*

³¹ *Greenfield v. Phillies Records, Inc.*, 98 N.Y.2d 562, 569 (N.Y. 2002) (cleaned up). I use New York law throughout this Opinion in accordance with the Settlement’s choice of law provision. See Settlement Agreement, Section 27.1 (a) (“Notwithstanding any contrary law applicable to the underlying claims, this Settlement Agreement and the

“a diagnosis of Major Neurocognitive Disorder due to probable Alzheimer’s Disease as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5).”³² The Settlement specifies no publication date, despite the DSM’s immediate history of revision between numbered editions.

The lack of a publication date creates a latent ambiguity: even though the “agreement seems clear on its face,” the “words of the instrument refer” to an “ambiguous or obscure state of extrinsic circumstances.”³³ In such circumstances, New York courts seek the reading that “would most closely effectuate the [agreement’s] purpose.”³⁴

Thus, a New York court would choose the construction of “DSM-5” that advances the purpose of Settlement Agreement’s Injury Definitions: diagnostic accuracy.³⁵ This purpose strongly favors an interpretation of “DSM-5” to mean “the most current version of the DSM-5,” so long as that result is plausible under New York law.³⁶

It is. “Terms in common use in a business or art may acquire a definite meaning understood by those who use them in connection with that business or art.”³⁷ In such a situation, a New York court “must be informed of the meaning of the language as generally understood in that business, in the light of the customs and practices of the business.”³⁸ Therefore, agreements “made in the context of a highly technical industry [...] must be construed with reference to both the intention of the parties and the known practices within the industry.”³⁹

Releases hereunder will be interpreted and enforced in accordance with the laws of the State of New York, without regard to conflict of law principles.”).

³² Settlement Agreement, Exhibit A-1 (3).

³³ *Teig v. Suffolk Oral Surgery Assoc.*, 2 A.D.3d 836, 837 (N.Y. App. Div. 2003) (cleaned up).

³⁴ *Id.* at 838 (cleaned up).

³⁵ See ECF No. 11931, at 6 (noting that “administration of the Settlement” requires “diagnostic accuracy”).

³⁶ See Special Master Ruling on Alzheimer’s Disease Diagnosis and Biomarker Testing, at 8 n. 10 (Sept. 8, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_biomarkertesting_sm.pdf (“[D]iagnostic accuracy relates to fidelity to the Settlement’s Injury Definitions, not some abstract ideal [...] for example, there is no diagnosis of Level 1.5 or Level 2 Neurocognitive Impairment as such in the clinical office.”).

³⁷ *Fox Film Corp. v. Springer*, 273 N.Y. 434, 436 (N.Y. 1937), *quoted at length in Law Debenture Trust Co. N.Y. v. Maverick Tube Corp.*, 595 F.3d 458, 466 (2d Cir. 2010) (applying New York contract law). The Third Circuit has repeatedly used *Law Debenture* when applying New York law, albeit in non-precedential opinions. See, e.g., *Benihana of Tokyo, Inc. v. Benihana, Inc.*, No. 14-3683, 622 Fed.Appx. 169, 172–173 (3d Cir. Aug. 11, 2015); *Vazquez v. TriAd Media Solutions, Inc.*, No. 19-1124, 797 Fed.Appx. 723, 725 (3d Cir. Dec. 16, 2019); *In re Verso Corp.*, No. 19-2979, 806 Fed.Appx. 130, 132 (3d Cir. Apr. 27, 2020). So has the New York Court of Appeals. See *MAK Technology Holdings, Inc. v. Anyvision Interactive Technologies*, No. 61, 2024 WL 3055302, at *1 (N.Y. June 20, 2024) (citing *Law Debenture* for “cardinal principles of contractual interpretation”). The *MAK* decision confirms the 2018 finding of the Supreme Court of New York County that although “[c]ontemporary New York cases have rarely cited *Fox Film Corp.*,” the Second Circuit’s reliance “on the reasoning of *Fox Film Corp.*” in “*Law Debenture* is in fact consistent with, and acknowledges” relevant New York law. *Lehman Brothers International (Europe) v. AG Financial Products, Inc.*, No. 653284/2011, 110 N.Y.S.3d 218 (Table), at *10 (N.Y. Sup. Ct. July 2, 2018).

³⁸ *Fox Film Corp.*, 273 N.Y. at 437.

³⁹ *Beardslee v. Inflection Energy, LLC*, 25 N.Y.3d 150, 157 (N.Y. 2015) (cleaned up).

Since the New York Court of Appeals' 1937 decision in *Fox Film Corp.*, the state's courts have continued looking to "the known practices within the industry"⁴⁰ to interpret technical contractual provisions, including:

- the term "overage" in the "business or art of motion picture production, distribution and exhibition,"⁴¹
- the phrase "existing violations" in the real estate industry,⁴²
- the "words 'edit' and 'change' in the context of the publishing industry,"⁴³
- the term "engineer's measure" in the gravel industry,⁴⁴
- a "tax practitioner's terms of art" in "light of relevant Federal tax law,"⁴⁵
- the term "registration" in "the Internet context,"⁴⁶
- a paragraph governing "the distribution of new products" in "the soft-drink industry,"⁴⁷
- the phrase "listed on an organized securities market" in the financial industry,⁴⁸
- a "*force majeure* clause" in the oil and gas industry,⁴⁹
- and the phrase "insurable interest" in the context of applicable insurance law.⁵⁰

"[W]ithout always making an express prior finding of ambiguity," these cases hold "that undefined specialized terms may be construed in light of industry custom and usage."⁵¹

The question here turns on the meaning of a term "in the context of a highly technical industry."⁵² "DSM-5" is to psychiatry and psychology⁵³ what "engineer's measure" is to gravel,⁵⁴

⁴⁰ *Id.*

⁴¹ *Fox Film Corp.*, 273 N.Y. at 435–436.

⁴² *Horby Realty Corp. v. Yarmouth Land Corp.*, 62 N.Y.S.2d 173, 173 (N.Y. App. Div. 1946).

⁴³ *Edison v. Viva Intern., Ltd.*, 421 N.Y.S.2d 203, 205 (N.Y. App. Div. 1979).

⁴⁴ *Rose Stone & Concrete, Inc. v. Broome County*, 429 N.Y.S.2d 295, 299 (N.Y. App. Div. 1980).

⁴⁵ *Harber Philadelphia Center City Office Limited v. Tokai Bank*, 281 A.D.2d 179, 180 (N.Y. App. Div. 2001).

⁴⁶ *Zurakov v. Register.Com, Inc.*, 760 N.Y.S.2d 13, 15 (N.Y. App. Div. 2003).

⁴⁷ *Last Time Beverage Corp. v. F & V Distribution Co., LLC*, 951 N.Y.S.2d 77, 81–82 (N.Y. App. Div. 2012).

⁴⁸ *J.P. Morgan Inv. Management Inc. v. AmCash Group, LLC*, 966 N.Y.S.2d 23, 24 (N.Y. App. Div. 2013).

⁴⁹ *Beardslee*, 25 N.Y.3d at 157.

⁵⁰ *Tiffany and Company v. Lloyds of London Syndicates*, No. 651544/2023, 211 N.Y.S.3d 894 (Table), at *20 (N.Y. Sup. Ct. May 3, 2024).

⁵¹ *Lehman Brothers International*, 110 N.Y.S.3d at *10. Federal Courts applying New York law have followed this approach. See, e.g., *Utica Mutual Ins. Co. v. Munich Reinsurance America, Inc.*, 7 F.4th 50, 57 (2d Cir. 2021) ("'Covered' is a term of art that usually describes a risk that is insured [...] In this context, 'covered' refers to insured risk, and there is no reason to give the term a different meaning in the endorsement."); *In re Serta Simmons Bedding, L.L.C.*, No. 23-20181, No. 23-20450, No. 23-20363, No. 23-20451, 2024 WL 5250365, at *12 (5th Cir. Dec. 31, 2024) ("[W]hen a contract is made in the context of a particular industry or trade, New York courts will also construe contractual language, especially technical terms, in light of the custom or usage in that industry or trade.").

⁵² *Beardslee*, 25 N.Y.3d at 157.

⁵³ See *Harris*, 12 N.Y.S.3d at 764 (describing the DSM as "the standard diagnostic handbook used by psychiatrists and psychologists throughout the United States") (cleaned up).

⁵⁴ *Rose Stone & Concrete*, 429 N.Y.S.2d at 299.

“organized securities market” is to finance,⁵⁵ or “registration” is to Internet services.⁵⁶ And from a clinical perspective, “the most recent DSM-5-TR is the DSM-5.” (App. A).

But the DSM-5 isn’t just a term of art, it’s also a named document incorporated into the Settlement by reference.⁵⁷ “New York law provides that another document will be incorporated if (1) it is clearly identified in the agreement, and (2) the contract contains language that clearly communicates that the purpose of the reference is to incorporate the referenced material into the contract, rather than merely to acknowledge that the referenced material is relevant to the contract.”⁵⁸ “Required is a clear manifestation of an intent to be bound by the terms of the incorporated instrument” according to an “objective standard.”⁵⁹

Once incorporated, if the document is later updated, those updates are incorporated, too. For example, in one contract case under New York law, the parties incorporated by reference rules published by a “voluntary association of member entities [...] engaged in the electric power business in the New England region” called the “New England Power Pool (NEPOOL).”⁶⁰ Prior to the formation of the relevant contracts, the “NEPOOL Market Rules and Procedures” established “a competitive bidding process” that “determined the price of energy” on “NEPOOL’s high voltage transmission lines.”⁶¹ After formation, “NEPOOL adopted significant alterations to its rules in connection with implementation of what is known as Standard Market Design, or SMD.”⁶² Unlike the old competitive bidding model, the new SMD model priced energy with “components for both congestion costs and losses.”⁶³

NEPOOL’s adoption of the SMD congestion pricing model had enormous financial implications for the parties because the contract specified that one party, Constellation, would be “responsible for [...] *any congestion charges associated with the Load Assets and any other requirements, expenses or charges imposed by NEPOOL.*”⁶⁴ Constellation conceded “responsibility for congestion charges in the Post-SMD period, since they were expected to be, and ultimately were, associated with the Load Assets.”⁶⁵ But Constellation insisted that it was not responsible for congestion

⁵⁵ *J.P. Morgan*, 966 N.Y.S.2d at 24.

⁵⁶ *Zurakov*, 760 N.Y.S.2d at 15.

⁵⁷ Settlement Agreement, Exhibit A-1 (3).

⁵⁸ *Matter of Linn Energy, L.L.C.*, 927 F.3d 350, 353 (5th Cir. 2019) (cleaned up) (quoting *National Union Fire Ins. Co. v. Beelman Truck Co.*, 203 F.Supp.3d 312, 322 (S.D.N.Y. 2016)); see also *In re Fiber-Span, Inc.*, 40 F.4th 79, 87 n. 3 (3d Cir. 2022) (describing an “external surface temperature requirement” that was “not explicitly included” in a contract governed by New York law “but was incorporated by reference”).

⁵⁹ *Matter of Linn Energy*, 927 F.3d at 353 (cleaned up) (quoting *Federated Mut. Ins. Co. v. Woodstock ’99, LLC*, 140 F.Supp.2d 225, 228 (N.D.N.Y. 2001)); see also *Miller v. Mercuria Energy Trading, Inc.*, 291 F.Supp.3d 509, 517 (S.D.N.Y. 2018) (“To determine whether a contract has incorporated a document by reference, courts look to whether a reasonable person would understand the specific document to be incorporated by reference, in other words, an objective standard.”).

⁶⁰ *Constellation Power Source, Inc. v. Select Energy, Inc.*, 467 F.Supp.2d 187, 190–191 (D. Conn. 2006) (cleaned up).

⁶¹ *Id.* at 191, 192.

⁶² *Id.* at 192 (cleaned up).

⁶³ *Id.* at 194.

⁶⁴ *Id.* at 198. The contract also specified that “for purposes of NEPOOL, the transaction shall be deemed a Load Asset Contract.” *Id.* (cleaned up).

⁶⁵ *Id.* at 205.

charges “in the Pre-SMD period since congestion charges were never associated with the Load Assets in that time period.”⁶⁶

The District Court of Connecticut, applying New York law, disagreed. Holding Constellation liable “for pre-SMD congestion charges,”⁶⁷ the Court reasoned, in relevant part, as follows:

First, this provision of the Letter Agreement uses the broadest terms possible to describe Constellation’s obligations. Thus, it refers to *any* congestion charges, and *any other* requirements, expenses or *charges* imposed by NEPOOL [...]

Second, the Letter Agreement on its face makes no distinction between charges in the Pre-SMD and Post-SMD periods, as Constellation contends it does. It is certainly true that the parties were aware that at some point NEPOOL would adopt some form of SMD, and there are certain provisions of the Letter Agreement that appear to be designed to anticipate that eventuality [...] However, the Letter Agreement itself does not apply different rules to the Pre-SMD and Post-SMD time periods. To the contrary, the provision on congestion charges explicitly applies ‘[d]uring the Delivery Term,’ which includes the entire contract term, both what we now call the Pre-SMD period and the Post-SMD period. Had the parties intended to apply different rules in these two periods it would have been rather simple to say so explicitly. It simply makes no sense that with millions of dollars at stake, sophisticated parties would choose to differentiate between Pre-SMD and Post-SMD congestion charges in the extremely subtle and ambiguous manner that Constellation suggests [...]

Fifth, even if the Court were wrong in its interpretation of the express reference to congestion charges in the Letter Agreement, the provision in question goes on to make Constellation responsible for ‘any *other*... charges imposed by NEPOOL [...]’ The Court cannot imagine a more broadly phrased catch-all provision. It literally covers the universe of charges, and there can be no question that Pre-SMD congestion costs were ‘charges imposed by NEPOOL [...]’ Therefore, even if the express language governing congestion charges were insufficient in any way, the catch-all clause is sufficient in and of itself to impose Pre-SMD congestion charges on Constellation.⁶⁸

In holding that the contract’s reference to the NEPOOL rules encompassed subsequent revisions to those rules, *Constellation Power Source* is informative. Just as the reference to “*any* congestion charges” there was unqualified, here the phrase “DSM-5” is undated.⁶⁹ As there, here it is “certainly true that the parties were aware that at some point [the APA] would adopt some

⁶⁶ *Id.*

⁶⁷ *Id.* at 219.

⁶⁸ *Id.* at 205–208.

⁶⁹ *Id.* at 205.

form of” revisions to the DSM-5, given the APA’s history of making revisions between numbered editions.⁷⁰ There, “*other...charges*” was a “broadly phrased catch-all provision” covering “the universe of charges.”⁷¹ And so here, “DSM-5” covers the universe of DSM-5’s, particularly given the evidence that clinicians believe that using the “DSM-5” means using its most up-to-date version.

It’s true, as the NFL Parties argue, that the only way to *modify* the Injury Definitions is through a process requiring the mutual consent of them and Class Counsel, as described in Section 6.6 of the Settlement Agreement.⁷² But the Alzheimer’s definition is only modified if “DSM-5” means what the NFL Parties say it means, *i.e.*, the version of the DSM-5 published in 2013. Since the Settlement itself does not specify a date for the DSM-5, I predict that a New York court would not adopt the NFL Parties’ suggested meaning.

As in *Beardslee*, which dealt with leases “made in the context of a highly technical industry,” the Settlement’s incorporation of “distinct terminology used by those in the business” of psychiatry and psychology requires construction “with reference both to the intention of the parties and the known practices within the industry.”⁷³ Here, the known industry practice is to use the DSM-5-TR “as the definitive resource for supporting diagnoses under the *DSM* umbrella.” (App. A). The Settlement’s independent medical advisors were clear: “In clinical practice, it would contradict the intent of the updates for a provider to revert to earlier forms of the document, or to choose which version to use.” *Id.*

Moreover, Section 6.6 cuts against the NFL Parties’ preferred interpretation, because it shows that “there are certain provisions of the [Settlement] Agreement that appear to be designed to anticipate th[e] eventuality” of DSM revisions.⁷⁴ By specifying “DSM-5,” the parties unambiguously foreclosed the use of a DSM-6 or DSM-7 without their mutual consent under Section 6.6.⁷⁵ But by *not* specifying a date or edition of the DSM-5, the parties chose a “catch-all” term.⁷⁶ If the parties meant to distinguish between the 2013 DSM-5 and subsequent revisions under its title, “it would have been rather simple to say so explicitly.”⁷⁷ As in *Constellation Power Source*, “[i]t simply makes no sense that with millions of dollars at stake, sophisticated parties would choose to differentiate between” the 2013 DSM-5 and future revisions to the DSM-5 “in the extremely subtle and ambiguous manner that [the NFL Parties] suggest[.]”⁷⁸

⁷⁰ *Id.* at 206.

⁷¹ *Id.* at 208.

⁷² Settlement Agreement, Section 6.6.

⁷³ *Beardslee*, 25 N.Y.3d at 157 (cleaned up).

⁷⁴ *Constellation Power Source*, 467 F.Supp.2d at 206.

⁷⁵ See *Beardslee*, 25 N.Y.3d at 157 (“As this Court has indicated on numerous occasions, courts may not by construction add or excise terms, nor distort the meaning of those used and thereby make a new contract for the parties under the guise of interpreting the writing.”) (cleaned up).

⁷⁶ *Constellation Power Source*, 467 F.Supp.2d at 208.

⁷⁷ *Id.* at 206.

⁷⁸ *Id.*

Any remaining doubts are resolved by the District Court's command that the Settlement be implemented honorably.⁷⁹ The parties' expressed intentions control, but in a class action settlement like this one, I am instructed also to weigh the interests of the Class, particularly in case of doubt.⁸⁰ The interpretation that most effectuates the Settlement's purpose of diagnostic accuracy is the honorable one here.⁸¹ It would unnecessarily pressure the Settlement's ability to deliver timely and accurate diagnoses were neurologists and clinicians to use one version of the DSM-5 for their ordinary practice and another for Settlement Claimants.

3. The September 2024 DSM-5-TR Does Not Change the Settlement's Clinical Practice

Obviously, there could be a revision to the DSM-5 that requires changing the way that clinicians in the Settlement Program render Qualifying Diagnoses. That's the very point of the APA's new rolling editing framework.⁸² But this is not such an adjustment.

Prior to the removal of the "No evidence of mixed etiology" criterion from the DSM-5's definition of Major Neurocognitive Disorder due to Alzheimer's Disease, there existed a seeming tension between that criterion and the Settlement's assurance that Class Members do not need to exclude multiple etiologies. As I wrote:

[T]he Settlement's Long-Form Notice stated that Players 'do not need to prove' that their 'Qualifying Diagnosis was caused by playing professional football.' Nor do they 'need to exclude the possibility that the Qualifying Diagnosis was caused or contributed to. . . by various risk factors linked to the Qualifying Diagnosis,' such as [a Claimant's] depression. Thus on the one hand, the DSM-5 and the ICD-10 both call for the absence of mixed etiologies. On the other hand, the Notice stated that Players need not conclusively rule them out.

The AAP offered a sensible approach to reconciling these terms: the essential question is, was depression the 'predominant cause' of the cognitive decline? If it was, that would 'confound the clinical diagnosis of Alzheimer's disease' because it would provide evidence of mixed etiology. But if not, the mere presence of

⁷⁹ See ECF No. 10811, at 4 (noting that "a rigid and narrow reading of the text of the Settlement Agreement would hamstring the claims process, prevent both the payment of meritorious claims and the detection of grounds for non-payment, and limit this Court's ability to continue to ensure justice is done to all parties to the Settlement" and adopting an "honorable implementation" approach).

⁸⁰ See Special Master Ruling on Diagnosis of Death with CTE, at 15-16 (Oct. 7, 2023), https://www.nflconcussionsettlement.com/Docs/cte_sm_3.pdf ("In addition to ascertaining the parties' intent using ordinary contract law principles, the Court also retains responsibility for the protection of class members until the settlement fund has been distributed.") (cleaned up).

⁸¹ See ECF No. 11931, at 6 (describing the importance of "diagnostic accuracy" to the Settlement Program); see also Special Master Ruling on Alzheimer's Disease Diagnosis, at 8 (Oct. 16, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm.pdf ("Diagnostic accuracy, as the NFL Parties correctly point out, is crucial to the faithful administration of the Settlement program.").

⁸² Class Counsel raises concerns about future DSM-5-TR updates which contradict other parts of the Settlement Agreement, such as ones that might require diagnostic practices the Settlement elsewhere specifically abjures. Doc. 380570. This issue isn't ripe and there is no need to opine on it now.

depression cannot be enough to create evidence of mixed etiology, or else no cognitively impaired Player with depression would ever receive an Award. Such a result would run afoul of the Long Form Notice’s express assurance that Players do not need to exclude the possibility of other contributing causes or risk factors. I adopt the AAP’s approach.⁸³

Under the AAP’s settled approach, the examining physician “must determine that Alzheimer’s Disease, not depression or any other concurrent condition, is the predominant reason for a Player’s cognitive decline, because that’s what defines the disease itself.”⁸⁴ That is the process still required by Criterion C of the Alzheimer’s definition in the DSM-5-TR.⁸⁵ The latest DSM-5-TR thus crystalizes the Program’s diagnostic status quo, eliminating even the appearance of tension between the Long Form Notice and the Injury Definitions.

When examining physicians document the bases for their judgment that Alzheimer’s is the predominant reason for cognitive decline, the Claims Administrator will ordinarily defer to them.⁸⁶ In rare cases like Mr. [REDACTED], a particular physician’s explanation for why a Claimant’s symptoms are “not better explained by [other illness]” has been woefully deficient, and the Claim has been denied.⁸⁷ But such moments are extraordinary: the Claims Administrator approved 140 of the 149 post-effective date Qualifying Diagnoses of Alzheimer’s Disease it had reviewed on the merits as of the end of 2024.⁸⁸

The AAPLC explained that the recent DSM-5-TR revision confirms this established practice:

The Special Master’s decision of 10/16/23 cites the original DSM-5 text indicating ‘that there should be no evidence of mixed etiology (i.e. absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease condition likely contributing to the cognitive decline.’ This has been struck from the text of the DSM-5-TR. The removed criterion required a degree of specificity which no longer reflected the medicine and science regarding neurodegenerative disease.

⁸³ Special Master Ruling on Alzheimer’s Disease Diagnosis, at 7–8 (Oct. 16, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm.pdf (cleaned up).

⁸⁴ Special Master Ruling on Mixed Etiology for Alzheimer’s Disease Diagnosis, at 5 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf.

⁸⁵ See AMERICAN PSYCHIATRIC ASSOCIATION, *View and Comment on Recent Proposed Changes to DSM-5-TR*, <https://www.psychiatry.org/psychiatrists/practice/dsm/proposed-changes>, at criterion C (last visited Jan. 10, 2025) (“The disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder.”).

⁸⁶ See Special Master Ruling on Mixed Etiology for Alzheimer’s Disease Diagnosis, at 6 n. 9 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf (describing “the normal case for deference” to a clinician’s medical judgment).

⁸⁷ See *id.* at 6 (describing Dr. [REDACTED]’s “(sparse) notes,” “extraordinarily terse response” to a request for more information, and lack of “attempt to explain any of the gaps in his reasoning”).

⁸⁸ Claims Administrator Status Report No. 24, Table 3.

Notably, the same Special Master decision of 10/16/23 decision includes th[e] statement:

Thus on the one hand, the DSM-5 and the ICD-10 both call for the absence of mixed etiologies. On the other hand, the Notice stated that Players need not conclusively rule them out.

In reference to the Settlement Program, the allowance for multiple etiologies in the DSM-5-TR is medically reasonable. The Special Master’s 10/16/23 decision cites depression as an appropriate example. Additionally, traumatic brain injury is explicitly listed as a potential etiology in the DSM-5-TR and is likely present in 100% of Class Members. The exclusion of multiple etiologies, if applied in ‘rigid cookbook fashion,’ would preclude essentially all Qualifying Diagnoses of Alzheimer’s disease in the program.

The Special Master’s 10/16/23 decision reinforces the role of medical reasoning and ‘articulated judgment’ in determining a Qualifying Diagnosis. Similarly, the revised DSM-5-TR text emphasizes the importance of ‘clinical judgment’ in diagnostic decision-making. The allowance for multiple etiologies in the 2024 DSM-5-TR update thus aligns with the prior Special Master’s decision and does not alter the requirement for diagnosing physicians to document the medical reasoning required to fulfill the retained Criterion C (‘not better explained by [other illness states]’) for a Qualifying Diagnosis of Alzheimer’s Disease.

(App. A).⁸⁹

In other words, the DSM-5-TR’s recent edit recognizes that “ruling out” alternative etiologies is not sensible. Rather, the DSM-5-TR codifies what the AAPLC has sought in review and almost all MAF physicians have long been providing: documentation explaining why Alzheimer’s is the better explanation for what a doctor is seeing in cases where many potential pathologies are present. Conforming the DSM-5’s text to the best medical practice, the DSM-5-TR requires no change to our primary diagnostic systems or to what the Claims Administrator does on review.

4. The Claims Administrator Did Not Err in Denying Mr. [REDACTED] Claim

The Claims Administrator based its decision to deny Mr. [REDACTED] Claim on the AAP’s finding that Dr. [REDACTED]’s explanation failed to “fulfill the requirements for diagnosis of Probable Alzheimer’s disease, which requires that the cognitive deficits are not better explained by another mental disorder” — here, depression. Doc. 299663 (cleaned up).

⁸⁹ *Quoting* Special Master Ruling on Alzheimer’s Disease Diagnosis, at 7 (Oct. 16, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm.pdf.

As I've discussed, this requirement is unchanged in the September 2024 DSM-5-TR. While Dr. [REDACTED] was not required to rule out depression in his diagnosis of Mr. [REDACTED], he did need to explain why Alzheimer's Disease, not depression, was the better explanation for Mr. [REDACTED] symptoms. Alzheimer's Disease being the predominant reason for an individual's cognitive decline is what "defines the disease itself."⁹⁰ This is as true now as it was before the September 2024 DSM-5-TR update. The update itself is therefore not evidence of error in the denial of Mr. [REDACTED] Claim.

No additional proceedings are necessary to determine whether Mr. [REDACTED] medical records sufficiently support a Diagnosis of Alzheimer's Disease. Dr. [REDACTED] knew from Mr. [REDACTED] "extensive file that his patient had long suffered depression and suicidal ideation," yet "he stated summarily that depression could not by itself explain Mr. [REDACTED] dysfunctions and deficits."⁹¹ When asked for additional explanation, Dr. [REDACTED]'s "extraordinarily terse response summarily moved the Diagnosis date by twelve years, did not attempt to explain any of the gaps in his reasoning, pointed the AAPLC generally to a series of follow-up exams that mostly dealt with treating Mr. [REDACTED] depression, and never once discussed Alzheimer's Disease."⁹² This explanation "did nothing to clarify which of the two"—Alzheimer's or depression—"is the predominant cause of his cognitive decline."⁹³

Nor has Mr. [REDACTED] submitted any other clear and convincing evidence of error in this Appeal. Mr. [REDACTED] states that his Claim should be remanded because the now-deleted criterion of no "'evidence of mixed etiology' was the driving force behind the Claims Administrator's denial of Mr. [REDACTED] claim after consultation with the AAP." Doc. 380541 at 7. He further argues:

While granting that 'the presence of depression alone cannot and does not preclude an Alzheimer's Diagnosis,' the [Special Master] also stated in his Decision that 'diagnosing physicians still must determine that Alzheimer's Disease, not depression or any other concurrent condition, is the predominant reason for a Player's cognitive decline, because that's what defines the disease itself.' This statement is no longer correct in light of the September 2024 update to the DSM-5-criteria, Criterion D of which requires only that the patient's disturbance is not 'better explained' by another condition.

Id. at 10–11 (cleaned up).

To the contrary, the AAPLC has advised me that the September 2024 DSM-5-TR *confirms* the approach taken in Mr. [REDACTED] case. "The allowance for multiple etiologies in the 2024 DSM-5-TR update [...] does not alter the requirement for diagnosing physicians to document the medical reasoning required to fulfill the retained Criterion C ('not better explained by [other illness

⁹⁰ Special Master Ruling on Mixed Etiology for Alzheimer's Disease Diagnosis, at 5 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf.

⁹¹ *Id.* at 6 (cleaned up).

⁹² *Id.*

⁹³ *Id.*

states]’ for a Qualifying Diagnosis of Alzheimer’s Disease.” (App. A). It’s true that my July 2024 decision affirming the Claims Administrator’s denial of Mr. ██████ Claim included language from the now-deleted mixed etiology criterion.⁹⁴ But as even Mr. ██████ acknowledges, I had long applied the mixed etiology criterion in a manner consistent with the Settlement’s “express assurance that Players do not need to exclude the possibility of other contributing causes or risk factors” to obtain a Qualifying Diagnosis.⁹⁵ To require that “the patient’s disturbance is not better explained by another condition” is to require “that Alzheimer’s Disease, not depression or any other concurrent condition, is the predominant reason for a Player’s cognitive decline.” Doc. 380541 at 10–11 (cleaned up). These are two verbal formulations of the same substantive criterion.

In support of his contention that his symptoms are better explained by Alzheimer’s Disease than by depression, Mr. ██████ points to Dr. ██████’s statement that the “concurrent depression” in Mr. ██████ file “does not supersede or by itself explain these dysfunctions and deficits.” *Id.* at 11. But as I explained in my July decision, the fact that depression is not the *only* explanation for Mr. ██████ symptoms does not explain which disease is the *better* explanation for these symptoms. Dr. ██████’s Diagnosis was simply deficient.

Pointing to his rescored BAP testing showing Level 2 impairment⁹⁶—which Dr. ██████ notably did not rely upon—Mr. ██████ argues that “many doctors state that depression *cannot* cause Level 2 cognitive impairments, so that the cause of Mr. ██████ cognitive deficits must be the Alzheimer’s Disease and not the concurrent depression.” Doc. 380541 at 11. This is a lawyer’s argument, not a doctor’s justification for a Diagnosis. And even so, it overstates the authority on which it rests. Mr. ██████ cited to a page from the Alzheimer’s Association website that states: “Experts estimate that up to 40 percent of people with Alzheimer’s disease suffer from significant depression.” Doc. 303112 at 8 n. 13; Ex. O. As I wrote in July 2024, this makes sense: “Alzheimer’s is a terrible, wasting disease which may be co-morbid with, or even cause, depression.”⁹⁷ That painful reality does not mean that “many doctors state that depression *cannot* cause Level 2 cognitive impairments.” Doc. 380541 at 11.

Finally, Mr. ██████ cites to a report attached to his original appeal brief from “Dr. ██████, the Social Security clinical psychologist.” *Id.* at 11. In that 2020 report—titled a “Consultive Psychological Evaluation for Use in Disability Determination”—Dr. ██████ opined

⁹⁴ See, e.g., Special Master Ruling on Mixed Etiology for Alzheimer’s Disease Diagnosis, at 5 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf (“Applying the Settlement’s explicit rules, the AAP concluded that the consistent documentation of depression indicated impermissible mixed etiology under the Settlement’s criteria.”).

⁹⁵ *Id.* at 6 (quoting Special Master Ruling on Alzheimer’s Disease Diagnosis, at 8 (Oct. 16, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm.pdf).

⁹⁶ Mr. ██████ BAP neuropsychological testing from 2019 initially showed Level 1 impairment in Learning and Memory, Level 1.5 impairment in Complex Attention, and Level 1.5 impairment in Executive Function, for an overall impairment rating of Level 1.5. Doc. 219100. This testing, rescored under the New Method, now reveals Level 2 impairments in the Complex Attention, Learning and Memory, and Executive Functioning domains, and Level 2 impairment overall. Doc. 303112 at Ex. B. Dr. ██████ did not rely on Mr. ██████ BAP neuropsychological testing in rendering his Diagnosis. Doc. 276925.

⁹⁷ Special Master Ruling on Mixed Etiology for Alzheimer’s Disease Diagnosis, at 5 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf.

that Mr. [REDACTED] “neurocognitive decline is considered genuine and significant” and that “[d]epression, social withdrawal, possible apathy, and irritability are further believed to be behavioral disturbances associated with his TBI-related neurocognitive impairment.” Doc. 303112 at Ex. E. The report purported to diagnose Mr. [REDACTED] with “Major neurocognitive disorder due to traumatic brain injury, with behavioral disturbance.” *Id.* (cleaned up).

This report is also not probative of whether depression or Alzheimer’s Disease better explains Mr. [REDACTED] symptoms. Dr. [REDACTED] is not a physician. Her exam was not undertaken within the Settlement Program. And, significantly, Dr. [REDACTED]’s report does not even mention Alzheimer’s Disease or the DSM criteria.

CONCLUSION

For the foregoing reasons, I conclude that “DSM-5” in the Settlement’s Injury Definitions means the most current version of the DSM-5, including text revisions. This interpretation of the Settlement is a legal conclusion for the purposes of any appeal that may follow.

I also find that the text revision issued in September 2024 requires no change to the Program’s diagnostic practices, as they already had incorporated the approach to Alzheimer’s diagnosis it restates. Applying the appropriate standard, Mr. [REDACTED] has not sufficiently shown that he suffers from Alzheimer’s Disease. That determination rests on a factual conclusion about the proffered evidence.

Mr. [REDACTED], therefore, has failed to identify clear and convincing evidence of error in the Claims Administrator’s decision. I deny his Appeal.

Date: March 10, 2025



David A. Hoffman, Special Master

APPENDIX A: AAPLC REPORT

19 December 2024

Major Neurocognitive Disorder due to Alzheimer's Disease Implementation and Implications of DSM-5-TR Revisions

The Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM-5) was published in 2013 by the American Psychiatric Association (APA). APA has published progressively revised versions of the *DSM* since 1952. Major updates and restructuring of diagnostic codes have generally led to new edition designations, including the release of DSM-5 in 2013.

However, the pace of developments in the field of mental health diagnosis and treatment suggested a need for DSM updates that did not require a completely new edition. Therefore, inconsistencies and lack of clarity in DSM-III (1980) led to release of a revision, known as DSM-III-R, which defined diagnostic standards from 1987 until DSM-IV was published in 1994. A key feature of the transition to DSM-IV was increased alignment of diagnostic classifications between the *DSM* and ICD-9. The DSM-IV-TR incorporated minor changes and updated ICD-9 codes; it was released in 2000 and remained the standard until the 2013 release of DSM-5.

Major changes in the US standard ICD-10-CM classifications of Dementia (Major Neurocognitive Disorder) led to a need to align DSM-5 with the revised codes to facilitate correct classification and submission of valid codes for billing. Two proposals for changes in dementia coding were rolled into a single ICD-10-CM revision for 2021. This addressed dementia severity (mild/moderate/severe) and added specific types of behavioral disturbance to the codes (e.g., agitation, anxiety, etc.). The 2022 DSM-5-TR Update included the updated classification.

Further revisions, under the title of *DSM-5-TR, Update (Supplement to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision)* were released in September 2024. The update included a major change in the criteria for Alzheimer's disease. The stated intent of the revision was to:

correct an inconsistency in the current criteria set that would not allow for cases of Neurocognitive Disorder due to multiple etiologies in which Alzheimer's disease is one of the etiologies.

Therefore, the criterion "No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease or condition likely contributing to cognitive decline) was removed from DSM-5-TR in 2024. This change reflected the growing recognition that many individuals with Major Neurocognitive Impairment have more than one contributing pathology. (see <https://www.ninds.nih.gov/current-research/focus-disorders/alzheimers-disease-and-related-dementias/focus-multiple-etiology-dementias-med-research>). The 2022 DSM-5 text revision explicitly lists the conditions which can be co-coded with Alzheimer disease. These are:

- Frontotemporal degeneration
- Lewy body disease
- Vascular disease
- Traumatic brain injury
- Substance/medication use
- HIV infection
- Prion disease
- Parkinson's disease
- Huntington's disease
- Another medical condition
- Multiple etiologies
- Unknown etiology

(see p.11; https://psychiatryonline.org/pb-assets/dsm/update/DSM-5-TR_Neurocognitive-Disorders-Supplement_2022_APA_Publishing.pdf)

Importantly, criterion C under “Major or Mild Neurocognitive Disorder due Alzheimer’s Disease” remained unchanged in the 2024 update. It states “The disturbance is not *better explained* by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder” (emphasis added).

The 2024 TR update document also includes the explicit text:

The specific diagnostic criteria included in DSM-5-TR are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a rigid cookbook fashion.

(see p.3, <https://www.psychiatry.org/getmedia/2ed086b0-ec88-42ec-aa0e-f442e4af74e6/APA-DSM5TR-Update-September-2024.pdf#:~:text=The%20specific%20diagnostic%20criteria%20included%20in%20DSM%2D5%2DTR,%E2%80%9CThe%20ICD%2D10%2DCM%20codes%20for%20pica%20are%20F98.>)

Summary and Interpretation:

The DSM-5-TR updates and supplements are meant to be cumulative and serve as the definitive resource for supporting diagnoses under the *DSM* umbrella. In clinical practice, it would contradict the intent of the updates for a provider to revert to earlier forms of the document, or to choose which update version to use. In the clinical realm, the most recent DSM-5-TR is the DSM-5.

The Special Master’s decision of 10/16/23 cites the original DSM-5 text indicating “that there should be no evidence of mixed etiology (i.e. absence of other neurodegenerative or cerebrovascular disease, or another neurological, mental, or systemic disease condition likely

contributing to the cognitive decline.” This has been struck from the text of the DSM-5-TR. The removed criterion required a degree of specificity which no longer reflected the medicine and science regarding neurodegenerative disease.

Notably, the same Special Master decision of 10/16/23 decision includes that statement:

Thus on the one hand, the DSM-5 and the ICD-10 both call for the absence of mixed etiologies. On the other hand, the Notice stated that Players need not conclusively rule them out.

In reference to the Settlement Program, the allowance for multiple etiologies in the DSM-5-TR is medically reasonable. The Special Master’s 10/16/23 decision cites depression as an appropriate example. Additionally, traumatic brain injury is explicitly listed as a potential etiology in the DSM-5-TR and is likely present in 100% of Class Members. The exclusion of multiple etiologies, if applied in “rigid cookbook fashion,” would preclude essentially all Qualifying Diagnoses of Alzheimer’s disease in the program.

The Special Master’s 10/16/23 decision reinforces the role of medical reasoning and “articulated judgment” in determining a Qualifying Diagnosis. Similarly, the revised DSM-5-TR text emphasizes the importance of “clinical judgment” in diagnostic decision-making. The allowance for multiple etiologies in the 2024 DSM-5-TR update thus aligns with the prior Special Master’s decision and does not alter the requirement for diagnosing physicians to document the medical reasoning required to fulfill the retained Criterion C (“not better explained by [other illness states]”) for a Qualifying Diagnosis of Alzheimer’s Disease.