

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

Hon. Anita B. Brody

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affairs, home and hobbies and personal care” and that Mr. ██████ “demonstrated decline in executive function, language and attention on the MoCA test.” *Id.* at 10.

Reviewing a neuropsychological evaluation conducted by Dr. ██████, Dr. ██████ determined that Mr. ██████’s tests were consistent with “Level 1.5 Neuropsychological Impairment in Attention and Processing Speed” and “Level 2.0 Neuropsychological Impairment in Learning and Memory.” *Id.* at 9. Additionally, Dr. ██████ found that Mr. ██████ exhibited “neuropsychiatric symptoms most consistent with depression that can contribute to or be related to his current presenting cognitive findings.” *Id.* at 10. Finally, Dr. ██████ reviewed the results of biomarker tests, ultimately concluding that they were unreliable:

Neuro-imaging with 3T MRI was within normal limits, however the computerized quantitative evaluation noted possible decreased volume of the hippocampus, not seen on subjective evaluation. Unfortunately, the FDG-PET result was not reliable likely due to a high blood glucose levels from patient’s diabetes. . . At this time I do recommend repeat FDG PET-CT scan once his blood glucose is better controlled by his primary care doctor.

Id. at 9-10.

Nonetheless, Dr. ██████ was confident in diagnosing Level 1.5 Neurocognitive Impairment because Mr. ██████’s “neuropsychological and cognitive evaluation demonstrate[d] significant impairment in memory, learning, and attention.” *Id.* at 10. Dr. ██████ wrote, “It is my opinion that the patient’s current cognitive decline is likely related to his significant history of multiple concussions and pre-concussions during his football career given significant cognitive decline in a patient of his age.” *Id.*

Mr. ██████ submitted a Claim for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on July 12, 2017. Doc. 90540. On March 22, 2018, a reviewing Consultant assured the Claims Administrator that “the player meets criteria for level 1.5 neurocognitive impairment,” noting that “the settlement is agnostic as to cause of neurocognitive impairment” and that “the injury definitions exclude impairment due to ‘delirium, acute substance abuse, or medication side effects’ but do not mention mood disorders as exclusionary.” Doc. 290909 at 1-2. Therefore, on April 18, 2018, the Claims Administrator granted Mr. ██████ a Monetary Award. Doc. 168031.

On November 15, 2022, Mr. ██████ submitted a supplemental Claim for a Qualifying Diagnosis of Alzheimer’s Disease. Doc. 273404. The diagnosing physician, board-certified neurologist Dr. ██████, examined Mr. ██████ on January 13, 2022. Doc. 273406 at 1. Dr. ██████ observed “a significant and meaningful decline in his condition” since 2016 and explained that “depression cannot account for his decline in cognitive and adaptive functioning.” *Id.* at 2.

In his review of the medical records surrounding Mr. ██████’s 2016 Diagnosis of Level 1.5 Neurocognitive Impairment, Dr. ██████ noted:

3T brain MRI with and without contrast, August 24, 2016, shows total hippocampus volume at less than 5% of normal, but subjective review by the radiologist was noted as normal. FDG PET-CT, August 24, 2016, shows decreased overall radiotracer distribution making study not reliable, likely due to increase blood glucose level.

Id. at 1-2.

Later in the “Impression” section of the report, Dr. [REDACTED] briefly mentioned these tests again: “Aug 2016 MRI show low total hippocampus volume FDG PET with possible decreased metabolic activity right cingulate gyrus.” *Id.* at 3. After summarizing Mr. [REDACTED]’s “documented history of gradual progressive functional and cognitive decline going back 5 years observationally” and the results of a 2021 neuropsychological evaluation, Dr. [REDACTED] concluded:

Based on these past and present findings and evaluations, and no evidence of alternative or additive neurodegenerative, systemic (other than CRF/hemodialysis), predominating mental, cerebrovascular process, I am diagnosing him with Alzheimer’s Disease with a date of onset of Nov 24 2016 (per qualifying diagnosis of level 1.5 neurocognitive impairment and supplemental benefit at that time and continuous progression of cognitive decline from that time).

Id. at 3-4.

Dr. [REDACTED] relied for his conclusions on a neuropsychological evaluation dated July 17, 2021, by Dr. [REDACTED], a board-certified clinical neuropsychologist. *Id.* at 5-15. Dr. [REDACTED] examined Mr. [REDACTED] on July 1, 2021, and interviewed his ex-wife, [REDACTED], on July 13, 2021. *Id.* at 5, 7. Mr. [REDACTED] reported “having problems with thinking abilities,” including struggling to recall “recent events and conversations,” repeating himself often, needing to look at his phone to tell the day of the week, having difficulty concentrating, getting distracted easily, having trouble “coming up with words,” and slurring his speech. *Id.* at 5. He also described struggling with “feelings of worthlessness and guilt most every day.” *Id.* at 6. Ms. [REDACTED] explained that Mr. [REDACTED] veered off the road when driving, no longer engaged in household chores or family activities, experienced difficulty conversing with others, and required assistance to cook, dress, groom his beard, and brush his teeth. *Id.* at 7.

Dr. [REDACTED] conducted a battery of neurocognitive testing. *Id.* at 10-15. He also completed a *Slick* criteria checklist and determined that only one criterion—“suboptimal scores on embedded and stand-alone performance validity measures”—was triggered because Mr. [REDACTED] had performed “below cutoff on 3 of 5 embedded validity measures, although within normal limits on both stand-alone performance validity measures.” *Id.* at 9. All the other *Slick* criteria were benign. *Id.* Dr. [REDACTED] explained that other than the one triggered criterion, “there were no other indicators of invalid cognitive test performance observed. Thus, his test results are likely valid.” *Id.*

Ultimately, Mr. ██████'s "neurocognitive test scores met criteria for Level 2.0 Impairment in Attention, Memory, and Executive Functioning, as per the NFL Concussion Settlement." *Id.* at 11. Dr. ██████ found that Mr. ██████'s cognitive deficits were interfering with his "capacity for independence in everyday activities," did "not occur exclusively in the context of a delirium," and were "not better explained by another mental disorder," explaining that:

Mr. ██████ was previously determined to have Level 1.5 neurocognitive impairment based on neurological and neuropsychological evaluations performed in 2016. The current findings represent a significant and meaningful decline in his cognition since that time. While Mr. ██████ likely has Major Depressive Disorder (see below), this was also true at the time of his 2016 evaluations, and as such depression cannot account for his decline in cognitive and adaptive functioning.

One factor to consider is whether his kidney failure and dialysis treatment might contribute to Mr. ██████'s cognitive decline, as he was not undergoing dialysis during 2016. A literature review from 2015 indicated that dialysis patients frequently experience cognitive impairment (Seliger & Weiner, 2015, *Am J Kidney Dis*, doi: 10.1053/j.ajkd.2012.12.002). However, a controlled clinical trial of persons with renal disease showed that adequately dialyzed patients remain relatively stable over time, even though cognitively below matched controls. (Harciares et al. 2009, *J Int Neuropsychol Soc*, doi: 10.1017/S13556177099902210). To the extent that Mr. ██████'s prior neurocognitive impairments were determined to be related to his occupational exposure during NFL play, it is reasonable to conclude that repeated concussions is the primary etiology for Mr. ██████'s major neurocognitive disorder.

Id. at 11-12.

On April 17, 2023, the Claims Administrator granted Mr. ██████'s Claim for a Monetary Award for a Qualifying Diagnosis of Alzheimer's Disease. Doc. 280897. After extensions to the original May 17, 2023 appeal deadline, The NFL Parties appealed this determination on July 10, 2023, arguing that "Dr. ██████ did not exclude mixed etiologies of end-stage renal disease and dialysis as well as major depression, and failed to meet even the most minimal standard of care in rendering an Alzheimer's diagnosis" because he relied on "flawed imaging in making his diagnosis" and did not "order or review biomarker testing such as an Amyloid PET scan or a cerebrospinal fluid ('CSF') test." Doc. 285728 at 1, 3. The NFL Parties also contended that it was "inappropriate" for Dr. ██████ to defer to Dr. ██████'s medical reasoning on the kidney disease issue, and that the study Dr. ██████ relied on was "wholly irrelevant" to Mr. ██████. *Id.* at 2.

Mr. ██████, through his attorney ██████,¹ responded on August 27, 2023, arguing that the NFL Parties had not shown, by clear and convincing evidence, that the Claims Administrator erred in granting the Award. Doc. 288311.

¹ Mr. ██████ was recently censured after an adverse audit proceeding in the Settlement Program. *See* Special Master Ruling on ██████ (June 28, 2023), <https://www.nflconcussionsettlement.com/Docs/>

DISCUSSION

The NFL Parties have the burden of proving, by clear and convincing evidence, that the Claims Administrator granted Mr. ██████'s Claim in error.² As they are aware, the appeal process is “built around layered deference to expertise.”³ Especially when front-line clinicians articulate their medical decisions with “care and fastidiousness,”⁴ the reviewing process is unlikely to come to a contrary conclusion. As I’ve previously written:

Sometimes, that reviewing task will uncover facts that the examining clinician or physician missed, or errors in carrying out complex calculations. Correcting such mistakes (and making sure they do not recur) is one of the essential roles for the Settlement’s advisory medical experts. But there will inevitably be other instances—in which a reviewing AAP Member or Consultant’s own judgment will differ from that of the examining clinician. And in these instances, the Settlement asks its experts to perform a different, but vital and admittedly extremely challenging task: 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.

This is the core deferential standard which applies to so much of the Program’s review processes. Clearly, the degree of (and justification for) deference will wax with the carefulness of the underlying reasoning. cursory reports will fairly provoke more skepticism than thoughtful assessments.⁵

This two-step approach animates the Claims Administrator’s role in ascertaining whether a Claim sufficiently supports an Award under the Amended Settlement.

To meet their burden here, the NFL Parties raised multiple technical objections to Mr. ██████'s Diagnosis. Their arguments were not—as the Claimant’s brief rashly charged—in “bad faith,” Doc. 288311 at 8, but rather flowed directly from their informed view of the evidence. I requested review by the AAP, which wrote a very thorough advisory report. After summarizing the evaluations by Dr. ██████ and Dr. ██████ and parsing the Settlement’s diagnostic criteria for Alzheimer’s Disease, the AAP concluded:

cuthbert_audit_decision_sm.pdf. Under the terms of that Audit, the Claims Administrator was required to certify that Mr. ██████'s Claim was “entirely free” from the issues it raised. *Id.* It did so. Doc. 286473.

² Settlement Agreement, Section 9.8 (“The Court will make a determination based upon a showing by the appellant of clear and convincing evidence.”).

³ Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_SM.pdf.

⁴ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 5 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

⁵ Special Master Ruling on Stroke Definition, at 9 (Apr. 25, 2021), https://www.nflconcussionsettlement.com/Docs/stroke_sm_2.pdf

Taken as a whole, it is clear that this player has cognitive and functional impairments that are severe enough to be consistent with the presence of dementia and that the Player's condition declined between the 2016 and 2021 evaluations which would be consistent with a clinical diagnosis of Alzheimer's disease and that other aspects of the diagnostic criteria are adequately fulfilled.

Doc. 289624 at 2.

The AAP considered each of the NFL Parties' arguments in turn. Because Mr. ██████'s kidney failure started in 2020 and "the cognitive decline was reported to be gradual and progressive since 2016," the AAP was confident that "the kidney failure requiring hemodialysis could not adequately explain the cognitive and functional decline between 2016 and 2020." *Id.* Therefore, even if Mr. ██████'s kidney failure contributed to the neurocognitive impairment observed in his evaluations in 2021 and 2022, the kidney failure "does not confound the diagnosis of Alzheimer's disease." *Id.*⁶

Second, the AAP explained that Dr. ██████ did meet the standard of care in diagnosing Alzheimer's disease:

The NFL Written Statement of Appeal also suggested that Dr. ██████ failed to meet the standard of care in rendering a diagnosis of Alzheimer's disease by relying on flawed imaging since the 2016 FDG PET/CT scan was not reliable due to decreased overall radiotracer distribution and there was an apparent discrepancy between the quantitative hippocampal volume and the radiologist's subjective interpretation of the 2016 brain MRI scan. Dr. ██████ did mention the results of these studies in his report and in the impression section but did not indicate any clear conclusions based on the findings of these studies or indicate that the findings were either consistent with or supportive of the diagnosis of Alzheimer's disease.

In any case, the Settlement Criteria does not specifically include any requirement for functional brain imaging results such as reported in the FDG PET/CT scan and the main use of the brain MRI scan in the clinical diagnosis of Alzheimer's disease is to exclude other potential causes of cognitive decline such as presence of strokes, hemorrhage, or tumors. Consequently, the invalidity of the FDG PET/CT scan results and the FDG PET/CT can results in general are inconsequential and the

⁶ The AAP did not address the NFL's argument that Dr. ██████ should not have deferred to Dr. ██████. The Settlement expressly contemplates that neuropsychologists, even though they (as the NFL Parties put it) are "not medically trained, did not attend medical school, and did not complete a neurology residency," would assist physicians in making Qualifying Diagnoses. Doc. 285728 at 2. The AAP does not appear to agree with the NFL Parties that the study Dr. ██████ cited, which the AAP called "a controlled clinical trial," was particularly flawed. Doc. 289624 at 1. And in all events, Dr. ██████'s decision to defer to Dr. ██████'s professional judgment was reasonable not because of the study but because Mr. ██████ experienced cognitive decline between 2016 and 2020—*before* he began dialysis. Doc. 289624 at 2.

brain MRI scan discrepancy about the hippocampal volume would not be expected to affect the exclusion of other potential etiologies.

Id. at 2-3.⁷

Lastly, with respect to depression, the AAP explained that although “it does appear that depression did contribute to the cognitive impairment,” it nonetheless recommended “deferring to the determinations by the examining providers (Dr. [REDACTED] and Dr. [REDACTED]) that this was not the predominant cause of the cognitive decline and consequently that it would not confound the clinical diagnosis of Alzheimer’s disease.” *Id.* at 3.

Guiding the AAP to this conclusion were the Settlement’s criteria for a Qualifying Diagnosis of Alzheimer’s Disease: the DSM-5 and the ICD-10.⁸ As the AAP noted, the DSM-5 definition “indicates 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.” Doc. 289624 at 2. Likewise, the ICD-10 definition “requires the absence of clinical evidence to suggest that the mental state may be due to other systemic or brain disease which can induce a dementia.” *Id.*

At the same time, however, the Settlement’s Long-Form Notice stated that Players “do not need to prove” that their “Qualifying Diagnosis was caused by playing professional football.”⁹ 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,”¹⁰ such as Mr. [REDACTED]’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.

⁷ In other words, the images’ unreliability would matter only if they were central to Dr. [REDACTED]’s medical reasoning: if he really was, as the NFL Parties charge, “*relying upon* flawed imaging in making his diagnosis.” Doc. 285728 at 3 (emphasis added). But that is not how the AAP reads the file, and therefore it is not what I conclude. Merely mentioning the results of flawed imaging without offering “any clear conclusions based on the findings of these studies” and without indicating “that the findings were either consistent with or supportive of the diagnosis of Alzheimer’s disease” is not reliance. Doc. 289624 at 2. Dr. [REDACTED] relied on his personal examination of Mr. [REDACTED], his holistic review of the medical records surrounding the prior Diagnosis of Level 1.5 Neurocognitive Impairment, and Dr. [REDACTED]’s neuropsychological evaluation in making his Diagnosis. And that clinical assessment, the AAP advised, is consistent with an Alzheimer’s Diagnosis in the DSM-5 and the ICD-10. *Id.*

⁸ Settlement Agreement, Exhibit A-1, Section 3(a) (“For living Retired NFL Football Players, a diagnosis while living of the specific disease of Alzheimer’s Disease as defined by the World Health Organization’s International Classification of Diseases, 9th Edition (ICD-9), the World Health Organization’s International Classification of Diseases, 10th Edition (ICD-10), or 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), made by a Qualified MAF Physician or a board-certified or otherwise qualified neurologist, neurosurgeon, or other neuro-specialist physician, as set forth and provided in Sections 6.3(b)-(d) of the Settlement Agreement.”).

⁹ Settlement Agreement, Exhibit A-5, Section 15.

¹⁰ *Id.*

The AAP offered a sensible approach to reconciling these terms: the essential question is, was depression the “predominant cause” of the cognitive decline? Doc. 289624 at 3. If it was, that would “confound the clinical diagnosis of Alzheimer’s disease” because it would provide evidence of mixed etiology. *Id.* But if not, the mere presence of 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.

Mr. [REDACTED] had depression in 2016, and he had it in 2021. All the while, his neurocognitive functioning declined. Nothing in the record suggests that the examining providers erred in exercising their medical judgment—if anything, the timeline reinforces their conclusions. Deference to their articulated judgment was appropriate here.

Diagnostic accuracy, as the NFL Parties correctly point out, is crucial to the faithful administration of the Settlement program. Doc. 285728 at 3. This goal, after all, is why the Settlement allows for independent AAP review and consultation as part of the appeals process. It’s why, too, the Settlement is structured around layered deference to medical expertise. I have been advised by the Settlement Program’s independent medical experts that Dr. [REDACTED] provided articulated justifications for key aspects of the Diagnosis, and that he met the standard of care. I defer to that analysis.

CONCLUSION

Because the NFL Parties have not provided clear and convincing evidence of error, I deny the appeal.

Date: October 16, 2023



David A. Hoffman, Special Master