

IN RE: NATIONAL FOOTBALL LEAGUE
PLAYERS' CONCUSSION INJURY
LITIGATION

MDL No. 2323

THIS DOCUMENT RELATES TO:
APPEAL OF SETTLEMENT CLASS
MEMBER [REDACTED] REGARDING
DENIAL OF SUPPLEMENTAL
MONETARY AWARD

I deny his Appeal.

CLAIM HISTORY

He next submitted a Claim for Level 1.5 Neurocognitive Impairment diagnosed through the BAP. Doc. 224653. After an AAP review to resolve conflicting diagnoses from his neurologist, Dr. [REDACTED], and neuropsychologist, Dr. [REDACTED], the Claims Administrator approved Mr. [REDACTED] for a Monetary Award on August 17, 2020. Docs. 224647; 227434.

In 2021 and 2022, Mr. ██████ sought supplemental testing through the MAF. He was evaluated by MAF neurologist Dr. ██████ on June 21, 2021, January 6, 2022, and February 4, 2022; she relied on Dr. ██████'s neuropsychological evaluation, which he completed during Mr. ██████'s BAP evaluation in 2019. Doc. 243684. Mr. ██████ also submitted to an MRI on July 12, 2021 and an FDG-PET scan on July 22, 2021. Docs. 243682; 243683. Neither imaging battery revealed abnormalities. *Id.*

Dr. [REDACTED], submitting a report and the Diagnosing Physician Certification Form on March 10, 2022, reaffirmed Mr. [REDACTED]'s BAP Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 243684.

Five months later, on August 8, 2022, Dr. [REDACTED] reevaluated Mr. [REDACTED]. Doc. 273129. She conducted a new CDR evaluation and assigned Mr. [REDACTED] scores of 1.0 in Memory, 1.0 in Orientation, 2.0 in Judgment & Problem Solving, 1.0 in Community Affairs, 2.0 in Home & Hobbies, and 2.0 in Personal Care. *Id.* She also administered a new MoCA on which Mr. [REDACTED] scored 11.5/30. *Id.* This compared to a score of 21/30 when she performed the same test a year earlier. *Id.* Dr. [REDACTED] also reviewed Mr. [REDACTED]'s neuropsychological test scores from 2019, which had been rescored under the New Method. *Id.* In 2019, Dr. [REDACTED] had assigned Mr. [REDACTED] scores of Level 1.5 in Learning & Memory, Level 2 in Language, Level 0 in Visual Perceptual Processing, Level 2 in Complex Attention, and Level 1.5 in Executive Functioning. Doc. 243675. Under the New Method, Mr. [REDACTED] scored Level 2 across the domains of Complex Attention, Learning & Memory, Executive Functioning, and Language; he displayed no impairment in Visual Perceptual Processing. Doc. 273053.

Given this combination of functional impairment, the MoCA and her review of Dr. [REDACTED]'s (rescored) testing, Dr. [REDACTED] submitted an amended Diagnosing Physician Certification Form reflecting a Diagnosis of Alzheimer's Disease. Doc. 271360. She elaborated in her report:

The patient has had decline in his memory with a drop in his MOCA score. He is unable to plan and retain information. This has greatly interfered with his ability to live independently and he relies on his girlfriend and family. He needs assistance with ADLs and displays low drive and apathy. No other etiologies have been found to cause his dementia.

Doc. 273129 at 4. Mr. [REDACTED] submitted his supplemental Claim Form, asserting an Alzheimer's Diagnosis, on October 18, 2022. Doc. 271465.

A member of the AAP Leadership Council (AAPLC) reviewed Mr. [REDACTED]'s Claim and provided feedback to the Claims Administrator:

Dr. [REDACTED] concludes that Alzheimer's disease is the cause of cognitive and functional decline. However, a steadily progressive course is not supported by objective findings. MoCA was 16/30 in 2016 ([REDACTED]), 21/30 in 2021 ([REDACTED]), and 11.5/30 in 2022. A score of 11.5 is not valid, as no half-points can be assigned under MoCA scoring rules. The DSM-5 criteria require that no other mental disorder better explains the condition. Dr. [REDACTED] identifies depression as present. The medical reasoning as to why depression is not the driving factor is not articulated. Sleep disturbance, medications (Tylenol PM), and refractory headaches are noted but not addressed as causes of, or contributors to, the syndrome (i.e. "mixed

etiology” in the ICD-10 classifications). A negative FDG-PET following years of cognitive decline is not generally consistent with Alzheimer’s disease of mild or moderate severity.

Doc. 277133 at 1-2 (cleaned up). Passing those concerns on to Dr. [REDACTED] on February 9, 2023, the Claims Administrator asked her to provide an addendum addressing the course of Mr. [REDACTED]’s progressive decline and explanations for “mixed etiology” and Mr. [REDACTED]’s negative FDG-PET scan. *Id.*

Responding on April 11, 2023, Dr. [REDACTED] explained that she was measuring Mr. [REDACTED]’s steadily progressive decline based on the evaluations he completed in her office: he scored 21/30 on the MoCA on June 21, 2021, 17/30 on February 4, 2022, and 14/30 on August 8, 2022 (she noted that the final score was adjusted from 13.5/30 and did not explain his earlier record of a 11.5 score). Doc. 280464. Addressing Mr. [REDACTED]’s depression, Dr. [REDACTED] referenced Dr. [REDACTED]’s 2019 report, in which he concluded that Mr. [REDACTED] did “not meet DSM-5 criteria for any psychiatric disorder at this time.” *Id.* at 1.

Regarding her own evaluations, she explained: “Although depression and anxiety are listed in ROS, it is not a significant symptom. For all other evaluations although the patient mentions lability of emotions which can be seen in AD, frank depression was not discussed.” *Id.* She also noted that Mr. [REDACTED]’s headaches and difficulty sleeping had alleviated since he began seeing her in 2021. *Id.* Finally, she conceded that “a negative FDG-PET following years of cognitive decline is not generally consistent with Alzheimer’s disease of mild or moderate severity.” *Id.* at 2. “However,” she concluded, “there are patients with Alzheimer’s dementia with normal FDG-PET scans because other factors may play a role.” *Id.*

The AAPLC, reviewing that explanation on May 28, 2023, found it insufficient. Doc. 283552. The reviewer evaluated Mr. [REDACTED]’s Claim using the ICD-10 and DSM-5 criteria for Alzheimer’s disease and enumerated inconsistencies between Mr. [REDACTED]’s evaluations and two of those criteria: the “progressive course” of and “absence of other causes” for his impairment. *Id.* at 1-2.

Progressive course: Dr. [REDACTED]’s addendum cites MoCA scores of 21 (6/21/21), 17 (2/4/22), and 14 (“corrected from 13.5”) on 8/8/22 as indicative of progressive decline. There is a discrepancy; the original note of 8/8/22 a MoCA score of 11.5. However, in a 2016 BAP evaluation, Dr. [REDACTED] reported a MoCA score of 16/30, worse than that seen in 2021.

Notably, the player’s complaints of cognitive change show minimal change over the interval from 2016 to 2022. The cognitive elements related to functional decline are clearly present in the third party statement of 2016 and not clearly worse in the Knowledgeable Informant documentation of 2022. The third-party statement of 2022 identifies changes due to withdrawal and apathy rather than progressive cognitive loss.

Absence of other causes: In her addendum of 4/10/23, Dr. [REDACTED] stated – citing her 6/21/21 note – that the player had emotional lability but that “frank depression was not addressed.” She referred to Dr. [REDACTED]’s 2019 evaluation that identified no depression. However, on the date of the claimed diagnosis, 8/8/22, she reported “the patient is depressed” and attributes it to his cognitive decline. Earlier in the same note she reported “When the patient was alone with me, he reports that he is doing worse than he stated in front of [his girlfriend]. He became very emotional and teary-eyed.” In her 8/9/2021 note, Dr. [REDACTED] stated, “Currently, the patient reports that he still feels depressed.” The reported decline in MoCA scores with Dr. [REDACTED] coincides with the emergence of depression reported in her notes.

Dr. [REDACTED] identified depression as a contributing factor in 2019, stating “I do have some concerns about a possible confounding aspect of depression” and “he spoke several times about feelings of low self-worth, lack of interest in prior social activities, and poor sleep, all of which again may be hallmarks of depression.” Dr. [REDACTED] concluded “I feel strongly though that he should be given treatment for depression, after which a repeat evaluation of his cognitive and other skills would very much be indicated.”

Drs. [REDACTED], [REDACTED], and [REDACTED] all identify that the player has poor sleep. Problems with sleep are documented in records dating to 2010 when possible sleep apnea was identified by Dr. [REDACTED]. The influence of sleep disruption on cognition and daily function is unaddressed by Dr. [REDACTED]. The DSM-5 criterion requiring “no evidence of mixed etiology (including mental or systemic disease or condition likely contributing to cognitive decline)” is therefore not fulfilled.

In the context of these concomitant conditions, a history of cognitive complaints for more than a decade with variable rather than progressive change on MoCA, and an existing diagnosis of dementia (Level 1.5 NCI) a negative FDG-PET is highly inconsistent with a diagnosis of Alzheimer’s disease. The review article cited by Dr. [REDACTED] does not address the issue of negative FDG-PET in clinically diagnosed Alzheimer’s disease. Work by many of the same authors (Chetelat G et al, Lancet Neurology. 2020;19: 951-962 [https://doi.org/10.1016/S1474-4422\(20\)30314-8](https://doi.org/10.1016/S1474-4422(20)30314-8).) states, “18 F-FDG-PET is also useful for staging of disease and for differential diagnosis, because the patterns of brain hypometabolism are closely associated with type and severity of cognitive deficits, and are relatively distinct in different neurodegenerative diseases and even among their variants.

Id. (cleaned up, breaks added). Ultimately, the AAPLC concluded, “The medical records and Dr. [REDACTED]’s evaluation do not fulfill the criteria to diagnose Alzheimer’s disease as the cause of the player’s impairments.” *Id.* at 2.

The Claims Administrator denied Mr. ██████'s Claim on the basis of the AAPLC's assessment on July 17, 2023. Doc. 286068. Mr. ██████ appealed on September 13, 2023. Doc. 289113.

RESOLVING THIS APPEAL

On appeal, Mr. ██████ argues that the AAPLC—and the Claims Administrator, by adopting the AAPLC's reasoning—erred in concluding that Mr. ██████'s MoCA scores, depression and migraine symptoms, and biomarker testing intertwined to contraindicate Alzheimer's Disease. Doc. 296321. His burden is to offer clear and convincing evidence in support of that assertion.

The Settlement defines Alzheimer's Disease through the ICD-9/10 or DSM-5 diagnostic criteria.¹ The AAPLC who considered Mr. ██████'s Claim in May of 2023 advised that Mr. ██████'s MoCA scores contradicted the ICD-10 requirement that dementia present through “insidious onset with slow deterioration,” and the DSM-5's parallel presentation of “steadily progressive, gradual decline in cognition, without extended plateaus.”² Doc. 283552. Mr. ██████'s depression symptoms and chronic headaches, per the reviewer, implicated bars on “evidence of mixed etiology” from the DSM-5 and on “clinical evidence... to suggest that the mental state may be due to other systemic or brain disease which can induce a dementia” from the ICD-10.³ *Id.* Finally, the reviewer opined that Mr. ██████'s normal FDG-PET scans were inconsistent with his Diagnosis.⁴ *Id.*

To determine whether the AAPLC reached these conclusions in error, I solicited a second round of expert medical review from a different AAP Member. That second reviewer disagreed with the first on the significance of Mr. ██████'s depression and migraine symptoms. Doc. 300540. The reviewer concluded that migraines and headaches are not cognitive disorders and therefore do not fall within the umbrella of “mixed etiology” or other “clinical evidence” that would preclude an Alzheimer's Diagnosis under the DSM-5 or ICD-10. *Id.* And it applied the Settlement's deference standard by giving credence to Dr. ██████'s explanation for Mr. ██████'s

¹ “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.” Settlement Agreement, Exhibit A-1(3)(a).

² WORLD HEALTH ORGANIZATION, THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS: CLINICAL AND DIAGNOSTIC GUIDELINES 47 (1993); AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSIS AND STATISTICAL MANUAL OF MENTAL DISORDERS 611 (5th ed. 2013).

³ *Id.*

⁴ Mr. ██████, in seeking biomarker testing for Alzheimer's, followed a diagnostic protocol which I understand to be the emerging standard of care, per the AAP. Biomarker testing is not, however, required by the Settlement, since neither the ICD 9/10 nor the DSM-V adopt it as stigmatic. Special Master Ruling on Alzheimer's Disease Diagnosis and Biomarker Testing (Sep. 8, 2023), https://www.nflconcussionsettlement.com/Docs/alz_biomarkertesting_sm.pdf.

“labile affect”: she attributed it to pseudobulbar palsy, not depression. *Id.* at 5. The AAP Member concluded that she had reasonably explained his confounding symptoms as an “affective disorder” that “was neurologically based,” “part of his brain illness,” and “a common manifestation of dementia.” *Id.*

Nevertheless, the second AAP review supported the Claims Administrator’s denial of Mr. ██████’s Claim. Both AAP members agreed that the non-linear trajectory of Mr. ██████’s MoCA scores suggests an explanation other than Alzheimer’s for his cognitive decline. Under the test battery that Dr. ██████ administered between June 2021 and August 2022, Mr. ██████’s MoCA scores did decline steadily, from 21 to 18, 17, and finally 14 (or 13.5 or 11.5; the record is unclear). His Claim includes earlier testing, however, and his 2016 MoCA score of 16 disrupts the trajectory of his deterioration. In the AAP’s expert medical judgment, the “high level of inter-rater reliability for the MoCA” weighs in favor of “the validity of Dr. ██████’s [2016] MoCA score.” *Id.* at 4. I will adopt that judgment to conclude that the first expert reviewer and the Claims Administrator did not err (and certainly did not err under the “clear and convincing” standard) in considering Mr. ██████’s 2016 score when charting his decline and concluding that it was not “steadily progressive.”⁵

Both rounds of AAP review and the Claims Administrator evaluated Mr. ██████’s performance on the MoCA in the context of his normal FDG-PET scans. The use of biomarkers, common in neurological offices today, is permissible under the Amended Settlement when used as probative, rather than dispositive, evidence in making a Diagnosis.⁶ That is, although biomarker testing should not (today) be the *only* factor weighing against or for a Diagnosis, it can be *a* factor: Diagnosing physicians and the Settlement’s medical experts may consider the *absence* of biomarkers signifying Alzheimer’s alongside other contravening evidence. This is consistent with the DSM-5, which states that “[s]ince amyloid beta-42 deposition in the brain occurs early in the pathophysiological cascade, amyloid-based diagnostic tests such as amyloid imaging on brain positron emission tomography (PET) scans and reduced levels of amyloid beta-42 in the cerebrospinal fluid (CSF) may have diagnostic value.”⁷ The Settlement permits the weighing of such evidence when it is available.

The AAP report for this Appeal opined that Mr. ██████’s improvement on the MoCA between 2016 and 2021 indicates

⁵ Mr. ██████ argues that Dr. ██████’s score should be discounted because Dr. ██████ worked “along side” Dr. ██████, who was disqualified. Doc. 289113 at 1. But there is no evidence of any wrongdoing by Dr. ██████, who did not work in Dr. ██████’s practice, and the consequences of this kind of taint-by-association would be net harmful for many Claimants in the Program.

⁶ Special Master Ruling on Alzheimer’s Disease Diagnosis and Biomarker Testing (Sep. 8, 2023), https://www.nflconcussionsettlement.com/Docs/alz_biomarkertesting_sm.pdf (affirming the Claims Administrator’s approval of an award under the clear and convincing standard, and holding that the absence of biomarkers for Alzheimer’s is not dispositive for the absence of the disease under the Settlement). Thus, I cannot agree with the NFL Parties that a “negative scan, on its own, should rule out a Qualifying Diagnosis of Alzheimer’s under the current terms of the Settlement Agreement.” Doc. 296321 at 5.

⁷ AMERICAN PSYCHIATRIC ASSOCIATION, *supra* note 2.

...an alternative or ‘mixed’ disorder such as vascular dementia, that would further violate the DSM 5 criterion for ‘No evidence of mixed etiology (i.e., absence of other neurodegenerative or cerebrovascular disease,’ as might be suggested by a previous MRI reportedly showing ‘6-7 small strokes’ (although a later MRI was reportedly normal).

Id. at 4. That AAP Member, like the AAPLC in the initial review, believed that Mr. ██████’s FDG-PET scan weighed in favor of the alternative explanation suggested by his MoCA scores: “The normal FDG-PET scan in this case is strong evidence arguing against, *though not absolutely excluding*, a diagnosis of dementia due to Alzheimer’s disease.” *Id.* at 5 (cleaned up, emphasis added). Here, then, the absence of biomarkers permissibly colored the interpretation of test scores that were already inconsistent with the Settlement’s Injury Definitions.

Had Dr. ██████ provided articulated reasoning for why Mr. ██████’s normal biomarker testing did not exclude the Diagnosis, weighing the earlier MRI evidence of strokes and the inconsistent MoCA scoring, that judgment would have been entitled to deference. The AAP Member on Appeal appropriately applied just that sort of deference to Dr. ██████’s description of Mr. ██████’s depression.⁸ But her explanation regarding the biomarker evidence was both cursory and general: “A negative FDG-PET following years of cognitive decline is not generally consistent with Alzheimer’s disease or mild or moderate severity. However, there are patients with Alzheimer’s dementia with normal FDG-PET scans because other factors may play a role. The patient may need repeat testing over time.” Doc. 280464 at 2. Dr. ██████ identified no “factors” specific to Mr. ██████ suggesting why a normal scan would have been irrelevant. The AAP Member thus had no individualized and articulated medical judgment to defer to. It fairly conducted its own independent review.⁹

Following that review, the Claims Administrator considered Mr. ██████’s negative FDG-PET scan as one of several factors when denying Mr. ██████’s Claim. The use of that scan in the total mix of information was not clear and convincing evidence of error.

⁸ Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_sm.pdf.

⁹ An aspect of a neurologist’s individualized medical judgment is choosing the appropriate diagnostic tests. The Settlement does not require biomarker testing for an Alzheimer’s Diagnosis. But if a neurologist has a practice of using a particular biomarker to diagnose Alzheimer’s—or another form of testing—in their day-to-day practice, and deviates from that practice for Settlement Claimants, it could be appropriate for the Claims Administrator to ask why. Consistent application of diagnostic practices within and between neurological offices is good medicine and advances the Settlement’s overall goals of diagnostic accuracy, efficiency, equity, and avoidance of fraud.

CONCLUSION

Mr. [REDACTED] has not offered clear and convincing evidence that the Claims Administrator erred in denying his supplemental Claim: I deny his Appeal. However, nothing in this Opinion precludes him from seeking further supplemental testing and support through the Settlement.¹⁰

Date: March 15, 2024



David A. Hoffman, Special Master

¹⁰ The AAP review of Mr. [REDACTED]'s Appeal lays out a roadmap for that process: "...the BAP neuropsychological testing showing Level 2 cognitive impairment was done 3 years prior to the clinical diagnosis of Alzheimer's disease. It seems unlikely to me, based on the current reported severity of the Player's dementia, that he would be able to provide interpretable data from a complete neuropsychological test battery to support a Level 2 diagnosis, but Dr. [REDACTED] should be consulted with this question in mind. A more up to date third party affidavit would be helpful to support the presence of Level 2 functional impairment in the Player's daily living activities." Doc. 300540 at 1.