

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 MONETARY
AWARD

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.

Id. at 4. Dr. [REDACTED] initially placed Mr. [REDACTED] date of Diagnosis at September 7, 2010, linking his date of Diagnosis to his 2010 diagnosis, through a worker's compensation evaluation, of "DSM-IV Class 4 multi-domain cognitive impairment related to brain injury." *Id.*

The AAPLC solicited clarification from Dr. [REDACTED] about potential mixed etiology in an email on May 5, 2023:

Dr. [REDACTED] evaluated Mr. [REDACTED] on 1/24/2022 and diagnosed him with Alzheimer's Disease with a diagnosis date in 2010. The criteria for Probable AD require no evidence of mixed etiology. Multiple other evaluators between 2010 and 2022 provided diagnoses of major depressive disorder and generalized anxiety disorder. Per ICD-10 guidance, early onset AD would be expected to have rapid progression, which is not supported by the sequential neuropsychological and neurological records over the interval from 2017 to 2020 that show consistent, but not worsening complaints and impairments. Dr. [REDACTED] assertion 'There is evidence of concurrent depression, which by interview, CDR, MoCA, exam performance does not supersede or by itself explain these dysfunctions and deficits' does not override the criterion requirements that mixed etiology not be present.

Doc. 282251.

Dr. [REDACTED] responded by revising Mr. [REDACTED] date of Diagnosis to October 20, 2022 and by providing records from follow-up neurology visits. Doc. 286234.¹ Those visits occurred on

¹ These follow-up neurology visits fit a pattern I previously described, in which a third-party funding entity paid Dr. [REDACTED] (at a per-visit rate significantly higher than other MAF neurologists) to conduct frequent neurological exams of Claimants *after* their Diagnosis Date. The funders then asserted an assigned right to collect from the Claimants and when they received a payment from the Settlement Program. [REDACTED], Mr. [REDACTED] lawyer, represented those prior claimants and arranged for the funding system. I recently denied Mr. [REDACTED] attempt to recover the third-party funders' bills (not yet paid by anyone) as his costs. *See* Lien Rules Implementation Opinion Regarding Asserted Attorney Costs (June 24, 2024), https://www.nflconcussionsettlement.com/Docs/2024.06.24_asserted_attorneys_costs.pdf. Dr. [REDACTED] noted in Mr. [REDACTED] charts that the payer was "Attorney Lien / MAF," suggesting that here, too, he and Mr. [REDACTED] used such a funding system. Doc. 287913. Dr. [REDACTED] follow-up visits did not buttress Mr. [REDACTED] Alzheimer's Diagnosis. If Mr. [REDACTED] were to ultimately submit a successful claim, it is an open question whether any of these visit charges, even if advanced by Mr. [REDACTED] would be recoverable as reasonable case costs or could be otherwise asserted as cognizable medical liens.

March 7, 2022, May 17, 2022, July 26, 2022, and October 20, 2022. Doc. 287913. They documented “treatment with duloxetine, donepezil, escitalopram, and serial observation/examinations, CDR functional sub- scores of 2, 2, 1.” *Id.*

The Claims Administrator referred Mr. [REDACTED] Claim to the AAP for guidance on whether the intervening records provided by Dr. [REDACTED] sufficiently addressed the concern of mixed etiology. In an October 28, 2023 report, quoted by the Claims Administrator in the Denial Notice, the AAP concluded they did not:

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 daily 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] 2019 report specifically notes that the Player has a ‘severely depressed mood’ and met DSM criteria for Major Depressive Disorder.

Dr. [REDACTED] 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.

Doc. 299663 (cleaned up, breaks added).

Relying on the AAP’s explanation, the Claims Administrator denied Mr. [REDACTED] Claim. *Id.* Mr. [REDACTED] timely appealed. Doc. 303112.

RESOLVING THIS APPEAL

There is 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. But the AAP nevertheless found he had not submitted documentation consistent with the relevant requirements for making a Qualifying Diagnosis of Alzheimer’s Disease. To prevail on appeal, Mr. [REDACTED] must show by clear and convincing evidence that the Claims Administrator erred in adopting the AAP’s judgment.

His counsel’s primary argument is that Mr. [REDACTED] symptoms need only be “general[ly] consistent” with the Injury Definition for Alzheimer’s Disease and that the AAP’s “literal application” of the Settlement’s criteria was therefore in error. Doc. 303112 at 6-7. Counsel fundamentally misunderstands both the Settlement’s text and the rules that the Claims Administrator must follow. The generally consistent standard does not apply to post-effective date Alzheimer’s Disease claims: that standard is reserved for Level 1.5 and Level 2 Neurocognitive Impairment diagnosed through the MAF program (when they could be otherwise diagnosed through the BAP). BAP exams cannot diagnose Alzheimer’s Disease.² There is therefore no need for a parallel MAF standard for diagnosing such claims.

There is an FAQ—101—stating exactly this, which counsel simply ignores.³ His brief seems to confuse Mr. [REDACTED] situation with the rules governing a *pre-Effective Date* Alzheimer’s

² Settlement Agreement, Section 5.2.

³ *Frequently Asked Questions: FAQ #101* (Which diagnostic criteria must a physician use when making my Qualifying Diagnosis? When and to what diagnoses does the “generally consistent” criteria apply?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com> (“Diagnoses of Alzheimer’s Disease, Parkinson’s Disease, ALS and Death with CTE are not made in the BAP and are all made following the diagnostic criteria set out in Exhibit 1 (and the “generally consistent” standard does not apply.)”); *see also* Diagnosis and Review

Disease claim.⁴ But Mr. ██████ claimed date of Diagnosis is October 20, 2022. Dr. ██████ MAF Diagnosis was not made as a pre-Effective Date submission, the deadline for which had long since passed.

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.⁵ 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-10.⁶ Dr. ██████ documented extensive symptoms of depression beginning in Mr. ██████ initial January 24, 2022 evaluation, echoing references to depression across Mr. ██████ medical history. Applying the Settlement's explicit rules, the AAP concluded that that consistent documentation of depression indicated impermissible mixed etiology under the Settlement's criteria.

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."⁷ 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.

This is not the first time this exact problem has come up in the Program. In a decision that Mr. ██████ counsel neither cited nor discussed, I explained the Settlement's approach and applied it to a claimant with a history of depression:

[T]he 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 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

Requirements, NFL CONCUSSION SETTLEMENT, https://www.nflconcussionsettlement.com/Docs/Diagnosis_Review_Table.pdf.

⁴ Settlement Agreement, Section 6.4 (discussing general consistency for pre-effective date evaluation).

⁵ "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).

⁶ AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSIS AND STATISTICAL MANUAL OF MENTAL DISORDERS 611 (5th ed. 2013); WORLD HEALTH ORGANIZATION, THE ICD-10 CLASSIFICATION OF MENTAL AND BEHAVIORAL DISORDERS: CLINICAL AND DIAGNOSTIC GUIDELINES 47 (1993).

⁷ Settlement Agreement, Exhibit A-5, Section 15.

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.

[Claimant] 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.⁸

Dr. [REDACTED] (sparse) notes do not merit that same deference.⁹ He knew from Mr. [REDACTED] extensive file that his patient had long suffered depression and suicidal ideation. Nonetheless, he stated summarily that depression could not “by itself explain [Mr. [REDACTED] dysfunctions and deficits.” Doc. 276921. The AAPLC naturally asked him for an additional explanation. Dr. [REDACTED] 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.

As the AAPLC found after careful review, those exams instead reinforced Mr. [REDACTED] retained diagnoses of unspecified depression and an unspecified sleep disorder across multiple appointments. Doc. 287913. At these visits, he and his brother discussed symptoms which could be indicia of either Alzheimer's or depression, or both, including Mr. [REDACTED] “daily function, behavior, mood, activity” and “‘incidents’ of memory.” *Id.* at 7, 11. And Dr. [REDACTED] prescribed medications for these symptoms of impairment, including some medications that the AAP has identified as anti-depressants, which appeared to yield improvements. *Id.*; Doc. 299663.

Dr. [REDACTED] 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.

⁸ Special Master Ruling on Alzheimer's Disease Diagnosis (Oct. 16, 2023), https://www.nflconcussionsettlement.com/Docs/alz_diagnosis_sm.pdf (internal citations omitted).

⁹ Dr. [REDACTED] was terminated from the MAF Program after its neutral and expert panel repeatedly questioned whether his diagnoses complied with the applicable rules. His termination preceded appreciation of the information I described in note 1 regarding his unusual billing arrangements, mediated by Mr. [REDACTED] counsel, Mr. [REDACTED]. As a part of that arrangement, Dr. [REDACTED] collected thousands of dollars for multiple follow-up visits from funders, who then doubled those fees when asserting liens against Dr. [REDACTED] patients. There are indications that potentially dozens of Players have agreed to these high medical bills, possibly because they were told that they would only owe money when they received a Settlement Award. There is no evidence that Dr. [REDACTED] initial exam fees were conditioned on making a Diagnosis. That said, in a conversation with the Claims Administrator in January of 2022, Dr. [REDACTED] stated that he had by then seen 10-12 Claimants and found all but one had a Qualifying Diagnosis. Dr. [REDACTED] received additional payments for regular “follow-up” visits, which would seem to be arranged only if he had first made such a diagnosis. That background, when considered along with the substantive deficits in his reports, erodes the normal case for deference to his judgment here or in any future case.

██████ chart. Doc. 287913. The AAPLC was left with no choice but to determine that his Diagnosis was simply inconsistent with the record evidence.

The Claims Administrator's evaluation of Mr. ██████ Claim appropriately applied the Settlement's diagnostic criteria for Alzheimer's Disease. The AAP determined that the medical record of Mr. ██████ depression and anxiety provides evidence of a mixed etiology which excluded (especially given Mr. ██████ physician's failure to provide further explanation) the Qualifying Diagnosis under review.¹⁰ Mr. ██████ has not identified clear and convincing evidence of error in that medical and factual judgment. I therefore adopt it.

CONCLUSION

Mr. ██████ has not identified clear and convincing evidence of error in the Claims Administrator's decision. I deny his Appeal.

Date: July 16, 2024



David A. Hoffman, Special Master

¹⁰ I agree with the NFL Parties that if he has not submitted evidence consistent with Alzheimer's Disease as of 2022, asserting the same Diagnosis as of 2010 (which Dr. ██████ in all events abandoned) would be futile.