

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

Appeal 2026-21

THIS DOCUMENT RELATES TO:
NFL PARTIES' APPEAL OF CLAIM
DETERMINATION FOR
SETTLEMENT CLASS MEMBER

During his neuropsychological examination, Mr. [REDACTED] received aberrant scores on certain performance validity measures: Test of Memory Malingering (TOMM), the ACS Visual Reproduction Recognition (ACS VR Recognition), and the Response Bias Scale (RBS). *Id.* at 5, 8. Discussing these scores, Dr. [REDACTED] wrote:

The examinee's performance validity (PVT) indicators showed optimal performance on all but two visual memory/recognition tasks (i.e., TOMM and ACS VR Recognition); however, this likely reflects his overall poor attention and memory performance across related tasks. Further, his performance on the TOMM was just below the recommended cutoff of 45. In sum, the examinee's overall efforts on the tests are judged to be adequate and the data herein is interpretable.

Id. at 8.

On his accompanying provider report, Dr. [REDACTED] further explained that Mr. [REDACTED]'s "endorsement of psychological symptoms may, to some degree, be overly-reported or exaggerated" but that "data are formulated in this light." Doc. 275444 at 4. Dr. [REDACTED] also noted that "no [additional] records were available at the time of this evaluation" for him to review. *Id.* at 3.

On June 24, 2025, Qualified BAP neurologist Dr. [REDACTED] completed Mr. [REDACTED]'s BAP neurological evaluation. Doc. 399953. On the CDR Worksheet, Dr. [REDACTED] detailed Mr. [REDACTED]'s "significantly reduced capacity" and "clear decline in his ability to function." *Id.* at 2, 3. Dr. [REDACTED] determined scores of 2 for Community Affairs and Home & Hobbies, and a score of 1 for Personal Care. *Id.* He then offered an overall CDR Rating of 2, explaining:

In my clinical opinion, Mr. [REDACTED] currently exhibits evidence of early-stage dementia . . . [w]hile full criteria for moderate dementia are not yet met, his current clinical presentation reflects early-stage neurodegenerative changes consistent with a diagnosis of mild neurocognitive disorder likely progressing toward a dementing illness.

Doc. 399955 at 5.

On August 20, 2025, the BAP Administrator reached out to Dr. [REDACTED] probing the method and outcome of his validity analysis. Doc. 403920. On September 24, 2025, Dr. [REDACTED] responded:

The portal now accurately reflects "Insufficient Information" for items related to collateral reports and documented history, consistent with the fact that no collateral informants or medical records were available. I reviewed the portal "HINTS" by the BAP for various data entry points (e.g., determining education, using reading scores as premorbid estimates). For your reference, I've included below the

rationale we noted in the portal for using alternative PVTs. I also cross-checked the Slick Criteria in the portal against the current report. I set Slick Criteria 4 and 5 to “Insufficient” since I lack collateral reports or documented history/records . . . In the attached narrative report, all Slick items were discussed to provide a comprehensive interpretation of performance validity, including consideration of suboptimal PVT scores and symptom validity indicators.

No collateral interviews or historical records were available. The report acknowledges these limitations and interprets findings conservatively, framing observed and measured cognitive performance as likely a lower-bound estimate of true abilities.

Recommended computerized PVTs (VSVT and MSVT) from the protocol were not able to be used due to a computer technical error on the date of testing. In place of the computerized measures, the Dot Counting Test and Rey 15-Item Test, alongside TOMM and embedded ACS measures were administered. These alternatives provide clinically valid indicators of effort and performance validity, and interpretation followed established guidance and the Slick Criteria, ensuring defensible evaluation of effort. Cutoff Scores: (1) DOT e-score cutoff is 20 for TBI group (DOT Manual); (2) Rey FIT Recall cutoff score is <9 (Lezak et al. 2004); (3) Rey FIT Recall + Recog Combined Score (total FIT score + [recognition score - false positives]) cutoff score is <20 (Boone et al. 2002).

The elevated Response Bias Scale (RBS = 88T) was considered a potential indicator of emphasized cognitive complaints.

Despite this, the overall cognitive profile is internally consistent, plausible given premorbid ability and TBI history, and aligns with reported functional difficulties, supporting interpretation as a conservative estimate rather than definitive invalidity. See attached revised report.

Doc. 407838. (cleaned up).

On November 5, 2025, the BAP Administrator contacted Dr. [REDACTED] requesting that he review the Third-Party affidavit completed by [REDACTED] and provide an addendum clarifying whether the information corroborates the assigned CDR scores. Doc. 412795. Dr. [REDACTED] responded two days later, stating his diagnostic impression and functional assessment of Mr. [REDACTED] remained unchanged. Doc. 413149 at 2.

The BAP Administrator published Mr. [REDACTED]’s Level 2 Diagnosis on November 19, 2025. Doc. 414681.

On November 21, 2025, Mr. [REDACTED] filed his Claim for a Level 2 Neurocognitive Impairment. Doc. 415222.

After a routine audit check, on May 4, 2026, the Claims Administrator determined that Mr. [REDACTED] was entitled to a Monetary Award based on his Level 2 Neurocognitive Impairment Claim. Doc. 432711.

The NFL Parties timely appealed. Doc. 438745.

RESOLVING THIS APPEAL

As this is an Appeal that turns entirely on whether Mr. [REDACTED]'s test scores are valid, it's worth repeating again the Settlement's settled approach to this question.

[T]he Program's appeals system is not intended to be an inquisitorial one, designed to nitpick the BAP and MAF physicians' clinical judgment. Rather, it is built around layered deference to expertise . . .

This system rests on front-line clinicians following the Settlement's procedures: only by articulating their judgments with care and fastidiousness can the program be assured that claims are being paid appropriately. In the absence of well-articulated medical judgments, we get delay, excessive cost and a dreadful ratio of law to medicine . . .

The AAP should defer to a clinician's Slick-criteria-based validity analysis when it results from reasoning completely articulated in contemporaneous reports, unless the analysis is clearly erroneous. Conversely, when clinicians fail to articulate their judgment through complete Slick analyses, the AAP may thoroughly and independently assure themselves the criteria do not indicate invalid testing.¹

And while the "case for deference is at its apex when evaluating the conclusions of Claimants who come through the BAP," it is impossible to do so when articulated judgments are clearly in error.²

In considering whether the NFL Parties have surmounted this exceptionally high bar, I asked the AAPC to re-review Mr. [REDACTED]'s Claim. Filing a supplemental report, the Consultant advised:

At issue is the validity of Dr. [REDACTED]'s BAP neuropsychological evaluation of October 07, 2022.

¹ In re: Appeal of SPID #100003221, 2020-18 (Oct. 21, 2020), at https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=slick_validity_testing_sm.pdf.

² In re: Appeal of SPID #900003700, 2024-7 (July 15, 2024), at https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_functional_impairment_sm.pdf.

Dr. [REDACTED] did not administer the full complement of performance validity tests (PVTs) required in the BAP. Specifically, neither the MSVT, VSVT nor WMT was administered. In an addendum to his report (Doc ID 407383), Dr. [REDACTED] attributes this to “a computer technical error on the date of testing.” He substituted the Rey 15-Item Test and the Dot Counting Test. Although he wrote that he prefers these tests, they are not of equivalent clinical value and were not chosen for the BAP for this reason. In addition, the Settlement Agreement does not make provisions for PVT substitutions.

Some deference might be afforded to Dr. [REDACTED]’s performance validity analysis were it not for the fact that the patient failed 1 of the 5 ACS PVTs (by a lot) and the TOMM. A prior AAP neuropsychology consultant erred in writing that all PVTs other than the TOMM are within the valid range (Doc ID 410563).

Dr. [REDACTED] interprets this as due to the severity of the patient’s genuine memory disorder. But this clinical reasoning is faulty. Except in cases of severe dementia (which Dr. [REDACTED]’s clinical diagnosis of mild neurocognitive disorder does not indicate), memory test scores are to be interpreted in light of PVTs, not the other way around.

In his revised report (Doc ID 407839), Dr. [REDACTED] coded Slick criterion #1 to be present and criteria #2, #3, #7, and #8 to be absent. Because he did not have collateral informants or prior records, he reported having insufficient information to code the remaining four criteria . . .

In addition, criterion #5 must be coded present, since the patient apparently attended his neuropsychological exam alone (i.e., there is no mention of an accompanying person and no collateral was interviewed), was described as driving, working as a personal trainer, and functioning “grossly within normal limits.” This is inconsistent with Level 2 overall cognitive impairment (moderate dementia). An argument might be made that criterion #7 should be coded present as well due to symptom elaboration and/or exaggeration on the MMPI-2-RF. However, the validity scales are only moderately elevated (highest is RBS T=88), and I’d defer to Dr. [REDACTED]’s interpretation of them.

There are concerns as well regarding Slick criterion #2 – performance that is markedly discrepant from currently accepted models of normal and abnormal CNS function. On two of the three tests in the Learning & Memory domain (WMS-IV Logical Memory and WMS-IV Visual Reproductions), the patient performed normatively better on delayed memory than immediate memory. This is unlike the pattern seen in genuine memory impairments . . .

Finally, it should be noted that Dr. ██████ proffered the clinical diagnosis of mild neurocognitive disorder. This indicates less impairment than dementia and is inconsistent with a qualifying diagnosis of Level 2 Neurocognitive Impairment.

In summary, because of the incomplete validity analysis, the incorrect coding of some Slick criteria, and the inconsistency between clinical and qualifying diagnosis, Dr. ██████'s 2022 neuropsychological evaluation should not be considered valid support for the qualifying diagnosis of Level 2 Neurocognitive Impairment.

Doc. 448098 (cleaned up).

As the AAPC pointed out, there are thus two problems with Dr. ██████'s testing.

To start, it did not use the mandated tests of effort. Qualifying Diagnoses made under the BAP must use the test battery set forth in Exhibit A-2 of the Settlement.³ Specifically, examiners should deploy at least seven of the required Performance Validity Tests (PVTs) during each assessment.⁴ The Settlement Agreement does not permit PVT substitutions.

Mr. ██████'s counsel nevertheless defends the Claims Administrator's original decision, arguing that a member of the AAPC previously reviewed and accepted Dr. ██████'s substitution of the "recommended" PVTs for his "preferred" PVTs, that the Rey 15-Item Test and the Dot Counting Test are "psychometrically on par with the MSVT/WMT/VSMT," and that Mr. ██████'s Diagnosis rests on two concurring certifications that "must stand." Doc. 444936 at 1-2.

I will defer to the most recent AAP Consultant's view that both Mr. ██████ and the earlier reviewer were wrong. As the Consultant aptly points out, it is the case that deviations under the BAP are not permitted—unlike the general consistency review that prevails in MAF exams. And I am persuaded by the most recent AAP Consultant that the substituted tests "are not of equivalent clinical value and were not chosen for the BAP for this reason." Doc. 448098.

As I read the Consultant's note, it is possible that this failure alone would not have been dispositive—i.e., answered if Mr. ██████ provided sufficient evidence that his tests themselves provided valid estimates of his function. But the Consultant went on to re-review the PVTs that Dr. ██████ did obtain, and the *Slick* analysis he conducted. The Consultant applied the correct deferential standard—finding Dr. ██████'s analysis to be articulated, but clearly erroneous. I defer to, and adopt, this judgment. That consequently means that Mr. ██████'s Claim is missing a crucial piece of evidence: test scores that are valid. For that reason, the NFL Parties' Appeal is well-taken.

The Program should, and I do, regret this outcome. No one seriously questions his neurologist's analysis of Mr. ██████'s functional impairment. It reveals him to be compromised in his daily function. The fact that his test battery presently does not meet the threshold for a

³ See Settlement Agreement, Exhibit A-2; *see also* Settlement Agreement § 5.2.

⁴ Settlement Agreement, Exhibit A-2.

Monetary Award under the BAP does not make his day-to-day condition any less disabling. I encourage him to undergo retesting and, if appropriate, to submit a new Claim.

And, because today's result follows from errors in BAP test administration and analysis, I direct the BAP Administrator to offer Mr. [REDACTED] an additional free BAP neuropsychological exam. Given the impending BAP deadline, it should make zealous efforts to have Mr. [REDACTED] scheduled for that exam as soon as possible. Once that exam is complete, if it reveals valid and qualifying test scores, the BAP Administrator shall relay them to Dr. [REDACTED] and ask if he wishes to schedule a renewed neurological exam, or to stick with the outcome, and date of Diagnosis onset, of his earlier exam. It should be permissible, in my judgment under these unusual circumstances, to avoid unnecessarily additional BAP testing given how few months remain to obtain its benefits.

CONCLUSION

On appeal, the NFL Parties have offered clear and convincing evidence that the Claims Administrator's determination to award Mr. [REDACTED]'s Claim was incorrect. That decision is, therefore, reversed.

Date: September 28, 2026



David A. Hoffman, Special Master