

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

SPID 100012968

displayed Level 2 Impairment in the Learning and Memory, Visual-Perceptual, and Language domains.³ *Id.* at 5-7.

During this visit, Mr. [REDACTED] completed multiple standalone and embedded measures of performance validity. *Id.* at 4. His results on the ACS Effort Profile and Test of Memory Malinger (ToMM) were optimal, but Dr. [REDACTED] found his performance on the Medical Symptom Validity Test (MSVT) suboptimal because “[h]e scored at the cutoff on the delayed recall of the MSVT placing his score at the border of the suboptimal range.” *Id.* at 5.

Dr. [REDACTED] then completed a *Slick* criteria checklist. *Id.* Because of Mr. [REDACTED] performance on the MSVT, she found *Slick* criterion #1 present. *Id.* She indicated, however, that she had “insufficient information” to determine the presence of *Slick* criteria #4 and #8. *Id.*

Otherwise, Dr. [REDACTED] denied the presence of all other *Slick* criteria. *Id.* She determined that, despite Mr. [REDACTED] score on the delayed recall portion of the MSVT, “[h]is ACS analysis of 5 tests and his TOMM scores were optimal. Overall, the performance validity of the evaluation is classified as valid.” *Id.*

Ultimately, Dr. [REDACTED] concluded:

[d]uring the current evaluation, Mr. [REDACTED] level of performance validity was considered valid and the overall results are considered a valid representation of his cognitive functioning. Mr. [REDACTED] met level 2 impairment in the Learning and Memory, Language, and Visual Perceptual domains. He did not meet impairment criteria in the remaining cognitive domains.

Per the Clinician’s Interpretation Guide, Mr. [REDACTED] overall cognitive impairment rating is Level 2. This cognitive rating will need to be considered in conjunction with the functional impairment rating which includes evaluation with a CDR assessment, for determination of the overall impairment level. The findings are consistent with an Alzheimer’s pattern although given his relatively young age, other etiologies should be considered.

Id. at 7 (breaks added).

On July 9, 2024, Mr. [REDACTED] attended an appointment with Dr. [REDACTED] Doc. 347870. Dr. [REDACTED] reviewed the previous MAF evaluations of Mr. [REDACTED] as well as a third-party affidavit completed by one of Mr. [REDACTED] friends. *Id.* at 1-2. She also interviewed Mr. [REDACTED] and his wife, who reported that:

[a]t his previous job, he was compelled to resign due to failing to manage a critical situation where a child tried to escape and [REDACTED] forgot to inform management about the incident and did not complete all tasks/ necessary actions related to that

³ He displayed No Impairment in the other domains. Doc. 347872 at 7.

issue. In his current full-time position, which he started in January 2023, he continues to struggle with memory lapses, frequently forgetting to share information with the next shift, completing paperwork slowly with tasks often carrying over for hours, and making errors in his work . . . [i]f he has to fill out a new kind of paperwork, it will take him hours, sometimes days, to complete. His overall work performance has suffered due to cognitive issues, and it is clear he is unable to handle responsibilities at the same level as before. He has been told by his supervisors that he will likely do better with a lower stress/less responsibility job.

At home, [REDACTED] is consistently reminded by his wife for daily care tasks such as showering, shaving (needs assistance), dressing appropriately (not dressing for the season or mismatched clothes), medications, and personal hygiene. Of note, he has issues with button-down shirts and may need assistance from his wife. Wife has also needed to help him shave as he cannot seem to understand instructions when he misses a spot.

Since 2022, he has not participated in any household chores. He is unable to perform chores due to lack of focus, which is affecting his performance, quality of work, and speed. He used to be in charge of household cleaning but if his wife has stopped asking him to do any cleaning because she will have to follow him around as he would often miss spots. The only thing he does is to take the trash to the door but will only do so when his wife asks him to. He does not do any grocery shopping. He cannot do any minor household repairs.

He has also missed multiple mortgage and bill payments and thus wife took over finances in 2022.

[REDACTED] driving has also become unsafe as he often loses focus and gets lost or distracted, particularly when faced with construction or deviations from his regular route. His wife strongly believes he should no longer drive due to this. He drives strictly from house to work and vice versa, but if there are any detours along the way he will get lost. He calls his wife when he drives so his wife is able to keep tabs on him. His wife will otherwise drive whenever they go anywhere.

Id. at 2-3.

Dr. [REDACTED] assigned Clinical Dementia Rating (CDR) scores of 1.0 in Community Affairs, 3.0 in Home and Hobbies, and 2.0 in Personal Care. *Id.* at 7. She reasoned that

[a]lthough he is still working, it is apparent that his work performance is sub par and lacking in many aspects (it is unclear to me why he is still employed). Although he is still driving, he only drives to-from work/home and does not drive otherwise, reported also as tendency to get lost if there is a detour on his route. He does not participate in any household chores, has no social activities outside the home and

does not have any hobby/unable to perform any hobbies. He needs prompting and some assistance with personal care.

Id. Ultimately, Dr. [REDACTED] found that “[b]ased on above data, [REDACTED] has Neurocognitive Impairment Level 2.” *Id.* at 8.

On July 19, 2024, Mr. [REDACTED] submitted a Claim for Level 2 Neurocognitive Impairment. Doc. 349342.

Because Dr. [REDACTED] validity analysis was incomplete, the Claims Administrator referred Mr. [REDACTED] Claim to the Appeals Advisory Panel (AAP) Leadership Council (“AAPLC”) for review. Doc. 350902; Doc. 418463 at 24. The Advisory Panel raised concerns, which were communicated in summary form to Dr. [REDACTED] on September 19, 2024. It wrote:

Regarding Dr. [REDACTED] exam:

- 1) The patient actually passed all PVTs. Only the immediate recognition, delayed recognition, and consistency scores of the MSVT are considered PVTs, and all are at or above cut-off. Slick criterion #1 is not met.
- 2) However, scores on many of the neurocognitive tests are so low as to not be credible in a person who employed, engaging in coherent conversation, etc. He performed at or below the 1st percentile on five tests. His scores on the Boston Naming Test (T = 19) and the BDAE Complex Ideational Material Test are (T = 12) are especially suspect (<0.1 percentile.) This triggers Slick criterion #4.
- 3) Having normal executive function, complex attention, and processing speed with severe impairment in memory, language, and spatial cognition is extremely unlikely and is not consistent with any known CNS disorder. Slick criterion #2 is triggered.

Regarding Dr. [REDACTED] exam:

- 1) No abnormalities of mental functioning were observed. This is inconsistent with the reported symptoms and 10-year history of decline (Slick criteria #6 and #8), the neuropsychological testing (Slick criterion #3) and Dr. [REDACTED] own diagnosis.
- 2) A [Montreal Cognitive Assessment] MoCA score of 22 is well within the normal range. That, and the fact that his MoCA score actually increased four points between 2021 and 2024, argues strongly against the patient having a progressive cognitive decline. This is further evidence for Slick criterion #2.

Doc. 363500.

After a few nudges from the Claims Administrator, Dr. [REDACTED] added an addendum to her report on October 13, 2024. Doc. 362421.

She first addressed *Slick* criteria #4:

I agree with the reviewer that the scores on BNT and BDAE are lower than I would expect based on his job functioning and conversational ability. BDAE complex ideational material has challenges as a language test and low scores can be found in credible responders.

However, in conjunction with the low BNT score (19T), which is also not consistent with his observed language functioning, I agree with the reviewer's conclusion that Slick Criteria #4 is triggered.

Id. at 1-2 (breaks added).

Next, regarding *Slick* criteria #2, she found that:

The statement that he has normal executive function, complex attention, and processing speed with severe impairment in memory, language, and spatial cognition is based on criteria used in the settlement for defining impairment within the cognitive domains. Within the attention and processing speed domain, his scores on tests of processing speed are 40T (Coding), 31T (Symbol Search), and 38T (Cancellation).

Despite being considered normal, this is more than a standard deviation below expectation. Among impaired domains, his memory scores range from 25T to 35T, and visual spatial scores range from 20T to 34T (34T, 34T, and 20T). While these scores are low, I don't find sufficient evidence to conclude that the results are not consistent with any known CNS disorder.

Id. at 2 (breaks added).

In response to the AAP Member's analysis of Dr. [REDACTED] exam, Dr. [REDACTED] noted that she did "not have a copy of this evaluation." *Id.* But, she added that

[a] score of 22 on the MoCA tends to be indicative of mild cognitive impairment and would provide clinical justification for doing further cognitive testing. The improvement in the MoCA score over time, however, is inconsistent with a progressive cognitive disorder. I recognize that this finding poses a threat to validity in that the improving score occurred over a span of 3 years, which speaks against progressive decline.

Id.

Thus, "[i]n summary:"

the language domain does not hold up as a valid representation of his ability in this area. There are concerns captured by Slick criteria #2. I hesitate however, with concluding that the neuropsychological evaluation is invalid overall beyond the language domain for determining Mr. [REDACTED] level of functioning at the time I evaluated him in November 2023.

My behavioral observations of him suggest an individual with somewhat empty/simple speech and reduced fluency and losing track of his thoughts, which is consistent with a degree of cognitive impairment. Impairment in his functioning was described with instrumental activities of daily living although his work functioning is not suggestive of dementia.

My best interpretation of the data is that the overall results do not sufficiently support impairment at the level of dementia, although mild cognitive impairment is not ruled out.

Id. (breaks added).

As the Claim continued to wind its way through review, Counsel for Mr. [REDACTED] contacted the Claims Administrator, displeased with its questioning of Dr. [REDACTED] Doc. 418463 at 27. Notably, Counsel took issue with the AAP Member's statement that a MoCA score of 22 is well within the normal range, because "[t]he MOCA itself states '(Normal $\geq 26/30$)' with a point added for examinees such as Mr. [REDACTED] with 12 years of education." *Id.* Counsel also contended that "[p]erhaps the most disturbing aspect of the review is the failure to provide the Neurology Report (and presumably not the 3rd Party or MOCAs) to Neuropsychologist to review." *Id.* at 30.

The Claims Administrator replied to Counsel, confirming that it had indeed not sent Dr. [REDACTED] a copy of Dr. [REDACTED] neurology report, which it agreed was a "definite oversight." *Id.* at 27.

On January 14, 2025, the Claims Administrator asked Dr. [REDACTED] to review the AAP Member's feedback anew—this time, "disregard[ing] the prior . . . questions about the MoCA score" and now considering Dr. [REDACTED] report and a third-party affidavit. Doc. 373778.

In an addendum responding to this request dated January 23, 2025, Dr. [REDACTED] reiterated her analysis of *Slick* criteria #4 and #2, once again "agree[ing] with the reviewer's conclusion that Slick Criteria #4 is triggered," and disputing the Member's analysis of *Slick* criterion #2 because she did not "find sufficient evidence to conclude that the results are not consistent with any known CNS disorder." Doc. 375132 at 1-2.

She then analyzed Dr. [REDACTED] exam, noting that:

Dr. [REDACTED] describes a normal neurological exam. This includes a cursory overview of his memory, attention, language, and fund of knowledge. However, she reports a

score of 22 on the MoCA which tends to be indicative of mild cognitive impairment, or even mild dementia if paired with related impairment in functioning. My behavioral observations of him suggest an individual with somewhat empty/simple speech and reduced fluency and losing track of his thoughts, which is consistent with a degree of cognitive impairment.

Id. at 2.

Thus, “in summary,” Dr. [REDACTED] largely repeated her earlier conclusion, this time incorporating some of Dr. [REDACTED] findings and the reports in the third-party affidavit:

the language domain does not hold up as a valid representation of his ability in this area. There are concerns captured by Slick criteria #2. I hesitate, however, with concluding that the neuropsychological evaluation is invalid overall beyond the language domain for determining Mr. [REDACTED] level of functioning at the time I evaluated him in November 2023.

Impairment in his functioning was described with instrumental activities of daily living although his work functioning is not suggestive of dementia. The work functioning is inconsistent with the affidavit in which he is described as someone who is unsafe driving, not capable of doing much of anything, and unable to take care of home responsibilities.

It is possible that he is being protected at his job, but he works in a position that involves protecting and providing security for others which I expect would require an adequate degree of cognitive and safety awareness. On the other hand, he has been in this line of work for a long time, resigned from one position in lieu of being fired, and his job responsibilities appear to be fairly limited (e.g., checking that doors are secured and walking around to the pods to check that officers are taking care of the kids) with redundancy such that someone in this position could operate on routine with the buffer of other officers who are providing security.

Given the overall functional difficulties described in the affidavit, which do appear overstated, and the presence of cognitive impairment on testing, albeit with the caveats addressed above, and my behavioral observations of him, this profile could fall at the border of mild cognitive impairment/mild dementia. In the interest of the Player, I do not find compelling evidence to exclude the possibility of Neurocognitive Impairment that reaches a 1.5 level.

Id.

In May of 2025, the Claims Administrator also contacted Dr. [REDACTED] It asked her to:

clarify how [Mr. ██████] could be both cognitively able to work and drive but at the same time not be cognitively able to have meaningful function for household chores and require assistance with seemingly much cognitively simpler activities such as shaving, dressing, and washing/grooming. It is not clear . . . why there is an apparent discrepancy between the level of functioning/impairments for Community Affairs and in the relevant CDR categories.

Doc. 393342.

On June 6, 2025, Dr. ██████ responded:

[a]s per my history taking, this is what I gathered. At his previous job, he was compelled to resign due to failing to manage a critical situation where a child tried to escape and ██████ forgot to inform management about the incident and did not complete all tasks/ necessary actions related to that issue. In his current full-time position, which he started in January 2023, he continues to struggle with memory lapses, frequently forgetting to share information with the next shift, completing paperwork slowly with tasks often carrying over for hours, and making errors in his work.

His upper management does notice these errors and would send work back for him to correct. If he has to fill out a new kind of paperwork, it will take him hours, sometimes days, to complete. His overall work performance has suffered due to cognitive issues, and it is clear he is unable to handle responsibilities at the same level as before. He has been told by his supervisors that he will likely do better with a lower stress/less responsibility job.

It seems to me that there is definitely a problem with work performance and I question myself why he is still employed. He was forced to resign from his last job due to issues with judgment. I asked the wife how he has not been fired from current job despite repeated issues with work performance that has been noted but supervisors; wife did not know why he is still employed. There is nothing else I can add to this.

Doc. 395152 at 8-9.

On September 4, 2025, the Claims Administrator denied Mr. ██████ Claim for failure to satisfy criteria (ii) and (iii) of a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Doc. 405330.

For criterion (ii), the Notice of Denial explained:

[a]n AAPC member reviewed Dr. ██████ 11/7/2023 report and concluded at least five Slick criteria for functional, non-neurological, malingered and/or grossly

exaggerated neurocognitive disorder were present and consequently the results would not support a diagnosis of either Level 2 Neurocognitive Impairment or Level 1.5 Neurocognitive Impairment. An addendum by Dr. [REDACTED] clarified that Slick criterion 4 should also be coded positive but disputed if Slick criterion 2 should be coded as positive, discussed inconsistencies related to the reported functional abilities/impairments, and concluded that level 1.5 neurocognitive impairment could not be excluded.

Additional review by the AAPC concluded that Dr. [REDACTED] agreed that Slick criterion 4 should be coded positive, discussed reasoning regarding interpretation of the scores for Executive Functioning and Complex Attention domains, reiterated that the pattern of dysfunction is inconsistent with any known CNS disorder, and noted that Dr. [REDACTED] agreed that the improvement in MoCA scores over time was inconsistent with a progressive cognitive disorder.

The AAPC review concluded that a diagnosis of either Level 1.5 or Level 2 Neurocognitive Impairment was not supported by the neuropsychological testing results. Consequently, overall, the information would not support a diagnosis of either Level 1.5 Neurocognitive Impairment or Level 2 Neurocognitive Impairment because there is report of suboptimal performance on validity tests and multiple Slick criteria are agreed as indicating invalid performance (Slick criteria 1 and 4).

Therefore criterion (ii) is not fulfilled.

Id. at 2 (breaks added).

As for criterion (iii), per the Notice:

[t]he Player is reported to continue to work and drive, which would support a rating of 0.5 for Community Affairs rather than 1. Additionally, the information supports a rating of 2 for Home/Hobbies since the Player no longer performs household chores and has abandoned hobbies such as golf, and a rating of 2 for Personal Care since the Player is reported to need assistance with Personal Care activities. However, it is unusual for someone to be both capable of continuing to work/drive but also not cognitively able to perform chores and require assistance with basic personal care activities, so the Diagnosing Physician was asked to clarify this apparent discrepancy.

The Diagnosing Physician clarified that the Player was employed but made errors at work that affected his performance, was no longer able to handle the same level of responsibilities as before, and it was not clear why he was still employed, essentially concluding that the Player is more impaired for Community Affairs than would be expected by his continued ability to work and drive. However, this does

not adequately resolve the apparent discrepancy because it would require ignoring the fact that the Player does still work/drive and assigning a higher score for Community Affairs despite the continued ability to function independently outside the home.

The research literature is very consistent in revealing a hierarchical relationship between ADL's and IADL's, with transportation (driving or using public transportation) at the highest level [Spector et al., 1987; Kempen & Suurmeijer, 1990; Kempen et al., 1995]. Successful automobile driving was dependent on, not simply correlated with, intact cognitive functioning as measured by neuropsychological tests [Wolfe & Lehouckey, 2016; Silva et al., 2009]. It therefore is not credible that the Player would be able to drive but also show severe impairment on testing in every cognitive domain and be truly incapable of cooking, cleaning, and household chores.

Additionally, Dr. [REDACTED] acknowledges that the Player's work functioning is not suggestive of dementia and that his "overall functional difficulties described in the affidavit ... appear overstated."

Therefore, criterion (iii) is not fulfilled because the discrepancy between the level of functioning for the relevant CDR categories is not resolved, indicating the information should not be considered reliable enough to determine an overall CDR score.

Id. at 2-3.

Mr. [REDACTED] timely appealed. Doc. 419858.

RESOLVING THIS APPEAL

To prevail on appeal, Mr. [REDACTED] must show, by clear and convincing evidence, that the Claims Administrator erred both in finding his testing invalid *and* his functional impairment insufficient. His arguments on appeal are heated.⁴ He charges the Claims Administrator with procedural malpractice, and the AAP with a variety of sins, loosely organized around working from a denial backward to its reasoning.

To shed light, I requested additional independent review by a new AAP Consultant, who had not previously been consulted on the file. That AAP Consultant agreed with the first reviewer that Dr. [REDACTED] validity analysis did not deserve deference. To start, the Member noted that:

⁴ Counsel, a respected member of the Bar and a valued participant in the Program's ongoing efforts to ensure efficient claims processing, begins his brief: "[t]his Denial is the worst that this Firm has seen in years. There are so many critical errors that it is difficult to know where to begin." Doc. 418463 at 1. I do not share counsel's view.

the examiner did not initially provide a complete articulation of the Slick criteria, marking the 2 items related to collateral information as having “insufficient information”. This is confusing since the player’s wife was noted to have attended the examination and could easily have provided collateral information. It was an error for the examiner not to obtain this collateral information.

Doc. 429698.

Considering the whole, the new AAP Consultant agreed that Dr. [REDACTED] analysis was not internally coherent:

the prior AAPC notes several instances in which the examiner’s statements and judgements are clearly erroneous, for example initially labeling Slick criteria 1 as met when it was not, and claiming Slick criteria 4 was not met (but later conceding that it was). In subsequent analysis the examiner acknowledges having made errors in those cases.

Further the examiner ultimately acknowledges that performance in the language domain was likely invalid. It is not consistent with typical standards of care to consider one measure or domain as having been invalid. There is no clear clinical basis for saying that less than full effort contributed to one set of low scores but no others. Standard of care is to consider (in)validity as attaching to the whole of an evaluation.

Because the examiner initially failed to articulate their judgment through complete Slick analyses, acknowledges errors and subsequently deviates from standard of care, the AAPC was right to follow Special Master guidance by providing an independent analysis of Slick criteria.

Id.

Then, the new AAP Consultant confirmed that “I not only defer to the AAPC’s independent assessment but concur with said assessment.” *Id.*

I accept this conclusion and find, as a matter of fact, that the neuropsychological tests that Mr. [REDACTED] filed in support of this Claim, like those that supported his last claim, do not sufficiently evidence validity. Thus, he cannot recover an Award. And, I find none of Mr. [REDACTED] arguments on appeal, individual or collectively, identify a procedural error in review that amounts of clear and convincing evidence of error necessitating a different outcome.

Mr. [REDACTED] argues that the Claims Administrator acted contrary to my prior decisions in denying his Claim. First, Mr. [REDACTED] contends that, per my decision from July 14, 2023,

invalidity requires the presence of at least three *Slick* criteria. Even if this were true, which is not,⁵ Mr. [REDACTED] circumstance can be readily distinguished from that case. Here, Mr. [REDACTED] testing *did* trigger more than three *Slick* categories—the AAP Member found at least five *Slick* criteria present.

Mr. [REDACTED] also argues that the Claims Administrator’s finding that *Slick* criterion #4 is present overlooks a “warning” issued in my April 1, 2022 decision.⁶ Doc. 418643 at 6. There, I quoted an AAP Member who found that “apparently,” a Player can show no “dysarthria, word-finding difficulties, aphasia, paraphasias, or neologisms,” and still validly display impairment on tests in the Language domain.⁷

But Mr. [REDACTED] overreads my prior decision. Just because a Player *can* retain certain language abilities and nonetheless display impairment in the Language domain does not mean that doctors should ignore a Player’s actual language ability when conducting a validity analysis. Here, each of two AAP Consultants *and* Dr. [REDACTED] agreed that *Slick* criterion #4 was triggered. In reaching that conclusion, the AAP Members properly relied on the fact that Mr. [REDACTED] low scores on language tests did not fit with the reports that he was employed and able to engage in coherent conversation.

Mr. [REDACTED] next argues that the AAP Member improperly relied on a single piece of evidence across multiple *Slick* criteria. Here he refers to the AAP Member’s analysis that Dr. [REDACTED] failure to report observing any “abnormalities of mental functioning” conflicted with Mr. [REDACTED] reported symptoms, alleged ten-year history of cognitive decline, and neuropsychological testing, thus implicating *Slick* criteria #6, #8, and #3, respectively.

Mr. [REDACTED] cites my decision from March 27, 2023 to support the contention that Dr. [REDACTED] report cannot be used across multiple *Slick* criteria.⁸ In that case, AAP reviewers used evidence that a Player recorded dozens of podcast episodes to find multiple *Slick* criteria triggered.⁹ Upon review, an AAP Consultant found that the use of a single piece of evidence across multiple *Slick* criteria may *sometimes* be inappropriate.¹⁰

⁵ In that case, two AAP Members disagreed about the validity of a Player’s test performance. One of the Members concluded that the issue boiled down to “whether the presence of the two test-based *Slick* criteria is sufficient to determine the evaluation invalid.” That Member then found, that “[i]n my opinion, *in this case*, it is not.” (emphasis added). On its own terms, the decision does not stand for the proposition that three or more *Slick* criteria must *always* be present to show invalidity. That decision—as will be typically be the case—the AAP Members engaged in an individualized review of a Player’s test results, and were not setting out a categorical rule. Special Master Ruling on Validity Testing, at 6 (Jul. 14, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_testing_11_sm.pdf.

⁶ Special Master Ruling on Validity Testing, at 4 (Apr. 1, 2022), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_testing_5_sm.pdf.

⁷ *Id.*

⁸ Special Master Ruling on Validity Testing, External Evidence, and Functional Impairment, at 16 (Mar. 27, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_evidence_impairment_sm.pdf.

⁹ *Id.*

¹⁰ *Id.* at 16.

I therefore directed the Claims Administrator to “conven[e] the AAP and AAPC to discuss a set of guidelines and training materials that clarify when . . . it is permitted to use a single piece of evidence to trigger multiple *Slick* categories and thus justify a finding of invalidity.”¹¹ At the same time, I noted that “the single use rule is not ironclad.”¹² The AAP’s resulting group discussion led to conclusion that the case correctly summarized the medicine: one should not overuse a single piece of evidence.

But even more importantly, the analogy between the podcast evidence in that case and Dr. ██████ report here does not hold. Multiple *Slick* criteria—including *Slick* criteria #3 and #8—demand a comparison between the behavior a doctor observes and other evidence. Thus, a reviewer will necessarily rely on behavioral observations across factors. This adherence to *Slick* requirements is unlike to the double dipping flagged in the March 27, 2023 decision.

Mr. ██████ does identify three oversights made by the Claims Administrator in the review process.¹³ None is material. What matters in evaluating whether he has met his burden on appeal is that Mr. ██████ neuropsychologist was given multiple opportunities to clarify her findings after she submitted a facially incomplete validity analysis. Mr. ██████ received a Denial that accurately reported the diagnostic criteria he failed to satisfy. He had access to the lengthy back and forth between the Claims Administrator and his doctors. He had the opportunity to rely on that record to file a fulsome appeal and did so accordingly.

That is, he has received a full helping of process, which in good faith attempted to understand why his neuropsychologist appeared to overlook what were plain discrepancies in how he presented and how he tested.

Notwithstanding his many objections, Mr. ██████ has not met his burden of showing clear and convincing evidence of error. Two AAP Consultants have found, in detailed reports, that Dr. ██████ *Slick* analysis contained fundamental flaws, and those two AAP Members found that

¹¹ *Id.* at 17-18.

¹² *Id.* at 16-17.

¹³ Specifically, Mr. ██████ points out that the Claims Administrator forgot to attach a copy of Dr. ██████ report to its first request for information from Dr. ██████ and accidentally stated that *Slick* criterion #1 was triggered at one place on the Notice of Denial.

Third, he notes that that, in its analysis of criterion (iii), the Denial states that “[i]t therefore is not credible that the Player would be able to drive but also show severe impairment on testing in every cognitive domain and be truly incapable of cooking, cleaning, and household chores.” Doc. 418463. As Mr. ██████ rightly points, he did *not* show severe impairment in every cognitive domain. While I am not persuaded that this misstatement amounts to clear and convincing evidence of error, given the process he received and the Claim’s failure on validity alone, I do agree that the Claims Administrator should take special care in preparing Notices of Denial. “Claimants (and the NFL Parties) should be able to rely on these notices in deciding whether to appeal.” Special Master Ruling on Late Arriving Evidence and Deference, at 16 (Apr. 8, 2025), <https://www.nflconcussionsettlement.com/Search.aspx?search=%22should+be+able+to+rely%22&tagname=Published+Decisions>.

As such, I have brought these errors to the Claims Administrator’s attention.

Mr. [REDACTED] test results do not meet the Settlement's criteria for validity. The Claims Administrator acted appropriately when it adopted those conclusions.

Mr. [REDACTED] also argues that the Claims Administrator erred in adopting the AAP Member's views that his functional impairment did not satisfy the requirements for Level 2 Neurocognitive Impairment. His arguments here are complex and facially persuasive. But given that I have found as a matter of fact that his test scores did not sufficiently establish validity, and to avoid further delay, I do not reach this issue.

CONCLUSION

On appeal, Mr. [REDACTED] faces a heavy burden: to demonstrate, by clear and convincing evidence, the Claims Administrator erred in finding that he failed to satisfy both criterion (ii) and criterion (iii) of a Qualifying Diagnosis Level 2 Neurocognitive Impairment.

I conclude that he did not satisfy criterion (ii) for lack of valid test scores. I thus deny the Appeal.

Date: April 28, 2026



David A. Hoffman, Special Master