

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

THIS DOCUMENT RELATES TO:
APPEAL OF SETTLEMENT CLASS
MEMBER [REDACTED]
REGARDING DATE OF QUALIFYING
DIAGNOSIS

██████████, a Retired NFL Player and Class Member under the Amended Class Action Settlement, filed a Claim for benefits based on a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. The Claims Administrator granted the Claim, adopting the date of Mr. ██████████ evaluation by a Qualified MAF Physician and board-certified neuropsychologist—February 25, 2021—as the date of Diagnosis. Mr. ██████████ now appeals the Claims Administrator’s decision not to date his Qualifying Diagnosis back to September 12, 2015.

Mr. ██████ filed his first Claim for benefits on July 8, 2017, based on a pre-Effective Date Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Docs. 88931–88933. After an audit of Mr. ██████ diagnosing physician and counsel yielded findings of malfeasance and resulted in their disqualification from the Settlement, the Claims Administrator denied the Claim on May 29, 2020. Doc. 224965.

On March 17, 2021, assisted by new counsel, Mr. ██████ filed his second Claim for benefits based on a new Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Doc. 233828. Dr. ██████, a Qualified MAF Physician, evaluated Mr. ██████ on October 15, 2020, with follow-up appointments on December 1, 2020, January 5, 2021, January 27, 2021, and February 22, 2021. Doc. 233343. Mr. ██████ also underwent neuropsychological testing on December 22, 2020, with Dr. ██████, a board-certified neuropsychologist. *Id.* at 3.

Doctors [REDACTED] and [REDACTED] determined that Mr. [REDACTED] satisfied the criteria for Level 2 Neurocognitive Impairment in the categories of Learning and Memory and Language, but not Complex Attention and Processing Speed, Executive Functioning, or Visual-Perceptual

Processing.¹ Docs. 233343 at 5–6; 239125. After interviewing [REDACTED], Mr. [REDACTED] wife, they also concluded that “[a] CDR rating of 2.0 is warranted,” as Mr. [REDACTED] drove only in the immediate area, rarely shopped for his own needs (and required a list in order to do so), did not engage in hobbies or independent activities outside the home except for an occasional round of golf with friends, no longer performed chores, and had difficulty properly dressing himself and maintaining adequate hygiene. Doc. 233343 at 6.

Additionally, Dr. [REDACTED] conducted a records review of Mr. [REDACTED] MRI from November 23, 2015, neuropsychological testing from September 12, 2015, and neurology assessment from February 8, 2010. *Id.* at 25–26. The September 12, 2015 testing, performed by Dr. [REDACTED], contained only one performance validity metric. *Id.* at 33. The report stated:

Performance validity: Response consistency was evaluated formally and by evaluating the internal consistency of test performance among the various neuropsychological measures. There were no indications of conscious deception or exaggeration of test performance. Cognitive screening revealed 12/15 items recalled for the Rey 15 item examination. This performance is below average but acceptable. In light of other findings, this level may be considered consistent with other measures showing a cognitive change.

Id. Dr. [REDACTED] dated Mr. [REDACTED] Qualifying Diagnosis back to January 8, 2010. Doc. 233344. Dr. [REDACTED] explained, “I feel that the onset of symptoms would be when first evaluated by neurology about 10 years ago (please see records).” Doc. 233343 at 1.

On April 19, 2021, an AAP Consultant examined Dr. [REDACTED] neuropsychological testing. Doc. 234878. The Consultant noted that “[performance] validity measures are marginal and symptom validity measures are ‘failed.’ I think an argument could be made that only 1 Slick criteria (overstatement of symptoms) is met. Thus, I defer to examiner in terms of . . . concluding the assessment was valid overall.” *Id.* The Consultant also emphasized that a CDR rating of 2.0 was “overcalled” and that Mr. [REDACTED] evaluation was “more consistent [with] [L]evel 1.5 impairment overall.” *Id.* (emphasis omitted).

On June 15, 2021, identifying a variety of deficiencies, the Claims Administrator requested additional information to ensure that Mr. [REDACTED] testing was generally consistent with the BAP requirements for Level 1.5 and Level 2 Diagnoses.² Doc. 236162. The Claims Administrator, a

¹ Dr. [REDACTED] reported that Mr. [REDACTED] had scored a Level 1 in the Language domain, which led the AAPC to conclude that he “only meets neuropsych criteria for level 1.5 impairments.” Docs. 233343; 234878. Dr. [REDACTED] then clarified that Mr. [REDACTED] raw scores (33, 29, and 40) did in fact satisfy the Language criteria for Level 2 Neurocognitive Impairment (two or more scores below 35). The AAPC later concluded that Mr. [REDACTED] did actually “meet neuropsychological criteria for a level 2.0 finding.” Docs. 239125; 239666.

² It identified the following insufficiencies: (1) Mr. [REDACTED] testing for evidence of cognitive decline was performed after the date of his Qualifying Diagnosis; (2) the documentary evidence of Mr. [REDACTED] functional decline was gathered after the date of his Qualifying Diagnosis; (3) a more sufficient explanation was needed about how the diagnosing physician determined Mr. [REDACTED] CDR rating based on the types of activities Mr. [REDACTED] was engaged in and the descriptions from Mr. [REDACTED] family members and third parties; (4) a more sufficient

member of the Appeals Advisory Panel Leadership Council, and Dr. ██████ spoke over the phone about the additional explanations needed to process Mr. ██████ Claim and corresponded over email about FAQ 101.³ Docs. 239420; 238476. On October 13, 2021, Dr. ██████ submitted a written addendum addressing the Claims Administrator's concerns. Doc. 239125. Regarding functional impairment, Dr. ██████ explained:

Although the player does have frequent headaches and severe depression it is my medical opinion that these are secondary and not primary factors causing his cognitive problems. My opinion is based on the patient's slow progressive cognitive decline which would be more consistent with the neurodegenerative diseases. Typically pain disorders and/or mood disorders can have a comorbid memory impairment, but these typically would be fluctuating and often temporary in nature. In addition, the patient's prominent slow processing speed (2021 neuropsychological testing assessment revealed processing speed index in the 2nd percentile) and language impairment (significant problems with fluency and naming on neuropsychological testing) would be more consistent with a neurodegenerative/dementia process. . . .

[A Level 2 Neurocognitive Impairment] is also consistent with the patient's clinical dementia rating of 2.0. The patient notably has prominent impairments in the areas of driving, directional sense, socialization, household chores and care (ex. unable to go to the grocery store and get items by himself), and ADLs (ex. wife notes that he needs prompting with hygiene and dressing). This rating seems to be consistent in reporting to both myself and Dr. ██████ (clinical neuropsychologist). . . .

In regards to his severe depression, this is felt to be a comorbidity and has been addressed at different times with treatment as well as with psychotherapy. Unfortunately, this [has] been refractory to treatment. Again, it is the examiner's opinion that [Mr. ██████] cognitive dysfunction does "*not occur exclusively in the context of a delirium, acute substance abuse, or the results of medication side effects.*"

Id.

On October 13, 2021, Dr. ██████ submitted a new Diagnosing Physician Certification Form with an updated Diagnosis date of February 25, 2021. Doc. 239126. Subsequently, ██████ Mr. ██████ attorney, called the Claims Administrator to inquire about the updated

explanation was needed about how the diagnosing physician attempted to isolate Mr. ██████ functional impairment due to cognitive loss from other emotional/psychiatric factors; (5) the diagnosing physician did not explain why Mr. ██████ evaluation and test results were "generally consistent" with the BAP criteria; (6) additional information was needed regarding the diagnosing physician's decision to assert a diagnosis date of January 8, 2010; (7) the diagnosing physician needed to address the discrepancies between Mr. ██████ reported activities and the assessed CDR rating of 2, and demonstrate that Mr. ██████ functional impairment was due to cognitive decline and not effects from other causes. Doc. 236162.

³ *Frequently Asked Questions: FAQ #101* (How is the date of a Qualifying Diagnosis determined?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

date of Diagnosis and a few days later sent an email asserting that “under the strict scrutiny standard the Claims Administrator is required to apply, [Mr. ██████] [had] a 2.0 diagnosis in 2015 on which Dr. ██████ can rely if he chooses under FAQ 101.” Docs. 240577; 239572.

The Claims Administrator shared Mr. ██████ email with the AAPC and AAPLC. Doc. 240577. Upon review of Mr. ██████ email and Mr. ██████ file, the AAP Consultant highlighted two issues:

First, is whether the player met the neuropsychological criteria for a Level 2.0 finding. . . . [At] issue is the rating of the CDR. As previously noted, the player continued to drive, continued to play golf with friends, required only prompting for personal cares. My opinion is consistent with the opinion of the AAPL that these findings are not generally consistent with moderate dementia using the standard of “no pretext of function in the community.” The level of impairment described is more consistent with CDRs of 1 in community affairs and personal cares **In my opinion the documentation is adequate to support a finding of level 1.5 impairment.**

A final issue is the lawyer’s request to date the onset of impairment (presumptively but erroneously stated to level 2.0) to the 2015 rule 88 evaluation of Dr. ██████ I make the following observations. Dr. ██████ is not a qualified neuropsychological examiner (not boarded), did not perform an adequate assessment of performance validity (gave only 1 stand-alone test, even after the player scored in the questionable range on that test) and also overstated the level of functional impairment (gave scores of 2.0 in spite of the fact that the player flew from ██████ ██████ and drove himself to the assessment alone). In my opinion this assessment does not meet [Settlement] standards to serve as a basis for an earlier diagnosis but I defer to the [Claims Administrator] and APP member to apply prevailing standards in this regard.

Doc. 239666.

On November 24, 2021, the Claims Administrator granted Mr. ██████ Claim, affirming a Level 2.0 Neurocognitive Impairment and adopting Dr. ██████ second date of Diagnosis, February 25, 2021, as the Qualifying Diagnosis Date. Doc. 240572. The Claims Administrator emphasized that the “AAPC concluded that Dr. ██████ 2015 neuropsychological testing could not serve as a basis for an earlier diagnosis date because Dr. ██████ ‘did not perform an adequate assessment of performance validity . . . and also overstated the level of functional impairment.’” Doc. 240577.

Mr. ██████ timely appealed and submitted new evidence, including a third Diagnosing Physician Certification Form and accompanying explanation from Dr. ██████ which defended using September 12, 2015, as the proper date of Diagnosis, a letter from Dr. ██████ explaining the validity testing he performed in 2015, and an updated affidavit regarding functional impairment

from [REDACTED] contextualizing Mr. [REDACTED] ability to travel from [REDACTED] in 2015 for his evaluation with Dr. [REDACTED] Docs. 243744; 243466; 243467.

DISCUSSION

Mr. [REDACTED] submitted a Claim asserting his entitlement to relief for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment as of 2021. The Claims Administrator approved that Claim, and the NFL Parties do not appeal its determination. The only question is the Diagnosis' Effective Date. Mr. [REDACTED] examining physician has variously dated the Diagnosis to 2010, 2021, and now (on appeal) has revised it again back to 2015. The issue here is thus narrow (though economically consequential): whether there is clear and convincing evidence that the Claims Administrator was wrong to adopt February 25, 2021, as Mr. [REDACTED] Qualifying Diagnosis Date.

The Settlement does not expressly discuss the dating of Qualifying Diagnosis Dates back to a time before the examining MAF or BAP physician makes a Qualifying Diagnosis.⁴ The Special Masters nevertheless approved administrative guidance which permitted the practice in certain circumstances. The most important provision of relevance to this Appeal is FAQ 101. That FAQ describes when a Qualifying Diagnosis may predate a Diagnosing Physician's personal examination of a Player.⁵

FAQ 101 by its terms applies only if the Diagnosing Physician's Certification states that an earlier Diagnosis date is apt. The Diagnosing Physician Certification generating this appeal offers a 2021 date, though Dr. [REDACTED] has offered a potential replacement one (dated to 2015) in his supplementary submissions. Doc. 243744. The NFL Parties, though they disagree with Dr. [REDACTED] latest analysis, appear to accede to the proposition the Claims Administrator could (under FAQ 101) backdate a diagnosis based on a Diagnosing Physician Certification filed as a part of an Appeal. I will therefore analyze the hypothetical: what would follow had Dr. [REDACTED] prior to this Appeal, used Dr. [REDACTED] 88 Plan examination to support a Qualifying Diagnosis Date of September 12, 2015.⁶

⁴ As Judge Brody wrote: "Only physicians with sufficient qualifications in the field of neurology may make Qualifying Diagnoses . . . Objectors, in effect, wish to expand this list to include friends, family members, and others without formal medical training who may have observed symptoms in a Retired Player before he received a Qualifying Diagnosis. The potential for wrongful manipulation of such an exception is too great. Even if an appropriately credentialed physician subsequently confirms a diagnosis, it would be very difficult to retrospectively determine with any certainty when the condition first manifested. Contemporaneous evaluation of a Retired Player's symptoms by a clinician is necessary. The formal diagnosis requirement incentivizes Retired Players to actively seek the care they need, whether through the BAP or a Qualified MAF Physician." Memorandum and Final Order and Judgment Approving Settlement, 307 F.R.D. 351, 407-08 (E.D.Pa. 2015) (internal citations omitted).

⁵ *Frequently Asked Questions: FAQ #101* (How is the date of a Qualifying Diagnosis determined?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>; but cf. *Frequently Asked Questions: FAQ #25* (Are the Settlement benefits connected to any NFL or NFLPA-related benefits programs?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com> ("No. The Settlement benefits are completely independent of any benefits programs that have been created by or between the NFL and the NFL Players Association (for example, the 88 Plan or the Neuro-Cognitive Disability Benefit).")

⁶ Mr. [REDACTED] asserts that a neurological exam administered by Dr. [REDACTED] supported by a report from Dr. [REDACTED] corroborates the 2015 date. But as the NFL Parties point out, the Special Masters have already

FAQ 101(b) starts with the “general rule” for determining the timing of Qualifying Diagnosis:

The date of a Qualifying Diagnosis other than Death with CTE is when the diagnosing physician has enough information and materials, including test results, to be able to render a *medically sound and reliable judgment* about the Player’s condition, the way a physician normally does in his or her clinical practice. *In some cases, using sound medical judgment*, a physician may conclude that a Qualifying Diagnosis existed at some prior point in time.⁷

Subsequently, FAQ 101(c) sets out “rules” for “other cases when the Qualifying Diagnosis might be before the date the physician personally examines the player,” including (c)(2), which covers 88 Plan diagnoses:

88 Plan diagnoses: If the diagnosis was made by an 88 Plan neutral physician who cannot or will not sign the Diagnosing Physician Certification Form, the date of the diagnosis made as part of the 88 Plan Independent Medical Examination (“IME”) may be used where: (a) the Player sees a Qualified MAF Physician for an independent examination or Qualified BAP Providers for a BAP exam; (b) the Player provides the Qualified MAF Physician or Qualified BAP Providers with all records of the prior 88 Plan IME diagnosis in his possession or to which he has access and all records of evaluation and treatment for that impairment between the dates of the 88 Plan IME and the Qualified MAF Physician appointment or BAP exam in his possession or to which he has access; (c) the Qualified MAF Physician performs an independent examination or the Qualified BAP Providers perform a BAP exam of the Player and review the additional records provided by the Player; and (d) if the Qualified MAF Physician or Qualified BAP Providers find the same Qualifying Diagnosis—both as of the date of the independent examination and the prior IME for the 88 Plan—then the date of [the] Qualifying Diagnosis *will be the date* of the 88 Plan IME.⁸

The FAQ concludes with the injunction that “any such diagnosis”—including earlier diagnoses based on 88 Plan examinations—“will be strictly scrutinized in the claims review process.”⁹

As I read his counsel’s brief, Mr. [REDACTED] believing FAQ 101(c)(2) to be applicable, appears to argue that it creates a conclusive rule (“will be the date”) that 88 Plan diagnoses

determined after an audit investigation that these providers did not submit reliable information: they were consequently disqualified, and their Diagnoses subject to independent review by the AAP/AAPC. It is self-evident that these records could not independently corroborate Dr. [REDACTED] conclusions.

⁷ *Id.* (emphasis added).

⁸ *Id.* (emphasis added).

⁹ *Id.* It is this language that Mr. [REDACTED] briefing describes as the requirement of “strict scrutiny.” Because that phrase absorbs meaning from constitutional law, I will avoid it.

establish earlier Diagnosis dates if elements (a) through (d) are satisfied. If that is counsel's view, I disagree on two independent grounds.

First, FAQ 101(c)(2) does not create such a categorical rule. That reading would make surplusage out of FAQ 101(b), stating the "general rule" that the Diagnosis date must be medically sound and reliable, as well as the FAQ's concluding section, requiring the Claims Administrator to strictly scrutinize any backdating. It would also run afoul of the Settlement's text, which assigns the Claims Administrator the duty to review each Claim's sufficiency.¹⁰

The better reading of 101(c)(2)—that is, one that harmonizes the FAQ with itself and the Settlement—makes 88 Plan Diagnoses paradigmatic examples of evidence that *could* justify a Diagnosing Physician in offering an earlier date. But even 88 Plan Diagnoses must be strictly scrutinized, as the FAQ contemplates, to ensure that the earlier diagnosis sufficiently substantiate an earlier date. Part of that scrutiny involves ensuring that the earlier diagnosis was *reliable*, as the Settlement defines that term.

Second, to trigger 101(c)(2) a Diagnosis must be made by an "88 Plan neutral physician who cannot or will not sign the Diagnosing Physician Certification Form." But Dr. [REDACTED] is a neuropsychologist and not a physician: the Settlement Agreement would not have permitted him to certify a Qualifying Diagnosis at all. By its terms, 101(c)(2) does not apply to these facts.

Instead, the relevant provision is FAQ 101(c)(5), which reads:

(5) *Sound clinical medical judgment*: Also, the physician making a diagnosis may conclude, in the exercise of his or her sound medical judgment, that he or she has enough information from personal examination, medical records from other healthcare providers, medical history, corroborating evidence from non-family members and other information that medical specialists rely on in their clinical practices, to form a sound medical judgment that the Player's Qualifying Diagnosis conditions existed at a date earlier than the date of a personal examination of the Player by the physician making the diagnosis and signing the Diagnosing Physician Certification Form.

Thus, under both 101(c)(2) (if it applied) and 101(c)(5), the appropriate question is whether the underlying medical records provide *reliable* evidence from which Dr. [REDACTED] could conclude that the Qualifying Diagnosis existed earlier than the date of his personal examination in 2021. And for the purposes of this Appeal, Mr. [REDACTED] must show that there is clear and convincing evidence of error in the Claims Administrator's careful scrutiny of that evidence.

The Claims Administrator declined to adopt September 12, 2015, as the date of diagnosis because Dr. [REDACTED] "did not perform an adequate assessment of performance validity." Doc. 240577. On appeal, Dr. [REDACTED] submits a letter disputing the AAPC's characterization of his performance validity testing as inadequate. Doc. 243466 at 5–8. Contrary to the AAPC's

¹⁰ Settlement Agreement, Section 8.6.(b).

contention that he only conducted one performance validity test (the Rey 15), Dr. [REDACTED] states that he actually administered multiple validity measures, such as the “Neuropsychological Assessment Battery,” “Advanced Clinical Solutions (Intellectual functions),” “Advanced Clinical Solutions (General Intelligence vs. Memory performance),” “Behavior Rating Inventory of Executive Function Scales,” “Personality Assessment Inventory Validity Scales,” and “Structured Interview of Malingered Symptoms.” *Id.* at 5–6.

I asked the AAPC if Dr. [REDACTED] letter altered their initial assessment.¹¹ The AAP Consultant stated:

I have reviewed Dr. [REDACTED] 2/18/2022 . . . letter and it does not change my original opinion . . . except to further convince me that performance and symptom validity was not adequately addressed. Where validity was assessed it would point towards invalidity. Again however, without more formal evaluations of validity, no firm conclusion can be made. As I originally noted Dr. [REDACTED] gave only a single Performance Validity Test (The Rey 15) and the player scored in the questionable range. Further the player’s MMPI results suggest overstatement of symptoms. In the recent letter under the heading “*Validity testing completed included (sic) the following*” Dr. [REDACTED] essentially lists the cognitive [test] scores or summary indices thereof. Those are not Performance Validity Tests. Rather they are a mix of indicators as to whether the word recognition reading measure would be a good proxy for premorbid IQ, whether overall memory performance deviates from expectations from IQ, etc. **These do not bear on whether the player displayed adequate and consistent task engagement during the evaluation.** In the letter, Dr. [REDACTED] also acknowledges an elevated score on the Structured Interview for Malingered Symptoms which should have provided a further basis for inclusion of more Performance Validity Tests in his battery. Thus it continues to be my professional opinion that Dr. [REDACTED] original assessment does not provide an adequate basis to support the presence of Level 2 impairments at the time.

Doc. 270249. (emphasis added). A few days later, the AAPLC member who reviewed the underlying claim considering the AAPC’s input and offered their perspective:

In my opinion, the new/additional information included in the letter by Dr. [REDACTED] dated 2/18/2022 . . . would not change my view of the diagnosis and would not

¹¹ The briefs moot whether Dr. [REDACTED] later-arriving letters are “post hoc advocacy,” to be discounted as such. Docs. 265249; 266451; 268140. The Claims Administrator should, prudentially, defer to the contemporaneous and well-reasoned justifications of examining physicians, particularly those who have been vetted by the Program. That practice of deference follows directly from the Settlement’s text and its core purpose of efficient and fair claim resolution. *See, e.g.,* Special Master Ruling on Stroke Definition, at 9 (Apr. 25, 2022), https://www.nflconcussionsettlement.com/Docs/stroke_sm_2.pdf. Later-arriving letters, particularly those produced on Appeal, do not justify this same deference. Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 11 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf. That is true even if they provide useful feedback (as Dr. [REDACTED] letter does) to the AAPC and can inform its reviewing function.

affect my prior recommendation that the date of the neuropsychological evaluation by Dr. [REDACTED] in 2021 be used as the Diagnosis Date. The AAPC review . . . provides very convincing reasons why the neuropsychological evaluation by Dr. [REDACTED] in 2015 should not be considered valid or generally consistent with the Settlement Criteria.

Doc. 270586.

Relying on these expert analyses, I cannot conclude that Mr. [REDACTED] has offered clear and convincing evidence of error in the Claims Administrator’s scrutiny or in its decision. What Dr. [REDACTED] now describes as performance validity measures from his 2015 exam simply do not evaluate task engagement—that is, whether the person undergoing neuropsychological testing was fully engaged in exerting their maximal cognitive effort. Instead, they measure different attributes, such as “whether the word recognition reading measure would be a good proxy for premorbid IQ,” and “whether overall memory performance deviates from expectations of IQ.” Doc. 270249. These results are not sufficiently probative of whether Mr. [REDACTED] was engaged effortfully during his neuropsychological testing in 2015.

Insufficient task engagement is not malingering. On appeal, Mr. [REDACTED] underscores that “there was no evidence that Mr. [REDACTED] was prevaricating, malingering, or exaggerating, or that the test results were anything but valid.” Doc. 243743. Dr. [REDACTED] letter also states:

With regard to the feigning of deficits, the issue implies that one is consciously deceptive toward the examiner and the examination process. At no time in my clinical judgment based on 20 years of clinical experience at that time, and seeing >10,000 traumatic brain injuries from concussion to severe trauma with profound deficits, did I view Mr. [REDACTED] case as invalid because of any disingenuous effort.

Doc. 243466 at 7. But this focus on conscious deception misses the point. Performance validity encompasses more than a deliberate exaggeration of symptoms. Indeed, neither the Claims Administrator nor the AAPC, in questioning performance validity in Mr. [REDACTED] 2015 testing, indicated or concluded that Mr. [REDACTED] was behaving disingenuously. There are a host of reasons why a person may not provide full task engagement during neuropsychological testing; for example, if they are suffering from a mood disorder or experiencing sleep disturbances. The Settlement’s performance validity requirement is primarily intended to measure task engagement, and not necessarily to screen for conscious deception.

Because Dr. [REDACTED] newly asserted performance validity measures do not assess task engagement, the Rey 15 remains the only cognizable validity measure in Mr. [REDACTED] 2015 neuropsychological evaluation. As the Settlement explains, a single performance validity metric does not provide enough information to indicate either validity or invalidity.¹² And the questionable outcome of the one performance validity metric administered to Mr. [REDACTED] in 2015—“below average but acceptable”—counsels towards invalidity, if anything. Doc. 233343 at 33. As a result,

¹² See Settlement Agreement, Exhibit A-2 (“There will be at least seven performance validity metrics utilized during each assessment.”).

there is no clear and convincing evidence that the earlier Diagnosis provides a medically sound and reliable basis to conclude that Mr. [REDACTED] suffered from Level 2 Neurocognitive Impairment prior to 2021.¹³

CONCLUSION

There is no clear and convincing evidence that the Claims Administrator erred in relying on Mr. [REDACTED] 2021 testing, instead of his 2015 testing, to establish a Qualifying Diagnosis Date. I therefore deny his Appeal.

Date: November 1, 2022



David A. Hoffman, Special Master

¹³ The parties also disagree about whether Mr. [REDACTED] had a CDR rating of 1.0 or 2.0 in 2015, and consequently, a Level 1.5 Neurocognitive Impairment or a Level 2 Neurocognitive Impairment. Docs. 243743; 265249. The reviewing AAP Consultant stated:

The conclusion by Dr. [REDACTED] that the Player's ability to travel independently to the evaluation should not be considered an adequate indicator of overall cognitive functioning does not adequately address the concern that this would not be consistent with the Player not having the pretense of independent functioning outside the home in 2015, which is what is stated in the anchor text for a score of 2 in the CDR category of Community Affairs. Consequently, the new/additional information provided by Dr. [REDACTED] and Dr. [REDACTED] would not change my view of the diagnosis and would not affect my prior recommendation regarding the Diagnosis Date.

Doc. 270586. Given this input, I conclude Mr. [REDACTED] has not shown by clear and convincing evidence that it was error to find that Dr. [REDACTED] 2015 testing was not consistent with the CDR scale's Category 2.0 criteria. As that 2015 testing would at best reflect a Level 1.5 Qualifying Diagnosis, even had Dr. [REDACTED] administered sufficient validity metrics, Mr. [REDACTED] Claim cannot be dated back to 2015 because his 2015 and 2021 evaluations did not yield the same Qualifying Diagnosis.