

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

██████████, a Retired NFL Player and Class Member under the Amended Class Action Settlement Agreement, filed a Claim for benefits associated with a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. The Claims Administrator denied Mr. ██████ Claim because he did not submit a valid assessment of neuropsychological impairment and did not show sufficient evidence of impaired daily functioning.

Mr. [REDACTED] first filed three separate Claims asserting Level 2 Neurocognitive Impairment between March and July of 2017. Doc. 50041; Doc. 87493; Doc. 87744. These Claims resulted from an August 2016 Diagnosis made by neurologist Dr. [REDACTED], and neuropsychological evaluations by Dr. [REDACTED] and Dr. [REDACTED]. *Id.*; Doc. 47901; Doc. 51250.

On January 9, 2018, Mr. ██████ Claims were placed into audit. Doc. 151850. After the Claims Administrator recommended Dr. ██████ disqualification, Mr. ██████ withdrew his Claims. Doc. 171877; Doc. 183695.

Mr. [REDACTED] then filed another Claim on April 26, 2019, again asserting a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Doc. 205793. MAF Physician Dr. [REDACTED] made

the Diagnosis based on evaluations he conducted on August 7, 2018 and March 28, 2019. Doc. 205800; Doc. 205802.

Dr. █████ submitted two separate MAF Diagnosing Physician Certification Forms. On the first, from April 3, 2019, he indicated that Dr. █████ and Dr. █████ assessments assisted him in determining Mr. █████ Qualifying Diagnosis. Doc. 204647. On the second, from April 23, 2019, Dr. █████ again listed Dr. █████ and Dr. █████ as Mr. █████ prior neuropsychologists. But he did not state that either clinician assisted him in making the Qualifying Diagnosis. Doc. 205542. Rather, Dr. █████ certified that neuropsychological testing was medically unnecessary. *Id.*¹ To support this certification, Dr. █████ wrote:

- Short test of mental status done on 3/26/19; score 16/38–appeared to give good effort
- Montreal cognitive assessment showed 16/30 again in my office on August 6, 2018
- Activities of daily living very impaired and sworn by third party affidavits: they were his wife █████ on 3/23/2019, █████, 20 yr. friend dated 3/20/2019, and █████, best friend for 30 years, dated 3/21/19.

Id. (cleaned up). On November 5, 2019, Dr. █████ notified the Claims Administrator that he was retiring “by the end of the year.” Doc. 228698, at 2.

On December 31, 2019, the Claims Administrator issued a Notice of Preliminary Review, seeking more information regarding the absence of neuropsychological test results and the extent to which Dr. █████ considered the impact of emotional and psychiatric factors, acute substance abuse, and medication side effects on Mr. █████ cognitive state. Doc. 219053. That same day, Dr. █████ retired, and his office closed permanently. Doc. 228698, at 2.

On July 6, 2020, the Claims Administrator denied the Claim, largely based on an analysis of Dr. █████ testing. Doc. 226246. I remanded the Claim for re-review on October 2, 2020. Doc. 228710. On January 26, 2021, the Claims Administrator re-issued the Denial:

The Qualifying Diagnosis of Level 2 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria. Dr. █████ diagnosed Level 2.0 Neurocognitive Impairment on the basis of an examination conducted on 8/6/2018, neuropsychological testing by Dr. █████ reported

¹ The NFL Parties emphasize that on this revised MAF Diagnosing Physician Certification Form, Dr. █████ “continued to list Drs. █████ and █████ as supporting neuropsychologists and used as the purported dates of diagnosis dates that corresponded with their evaluations.” Doc. 235362. This is correct, but Dr. █████ did not indicate on this revised form whether their assessments assisted him in making the Qualifying Diagnosis. This ambiguity, and Dr. █████ inability to address it due to his retirement, is unfortunate. However, Dr. █████ revised Certification Form makes clear that, even if he did consider this prior testing, he considered it unreliable due to the severity of Mr. █████ impairment.

on 9/2/2016, and 3rd party affidavits dated 3/20/2019 and 3/21/2019. Additional materials reviewed include documents submitted 8/5/2020 through 10/2/2020. However, no new clinical evaluations were identified among these materials. The Player's wife submitted an additional affidavit and provided information to Dr. [REDACTED] in the assessment of the CDR. A diagnosis of Level 2 Neurocognitive Impairment (severe dementia) rendered outside of the BAP must be generally consistent with these four diagnostic criteria: (i) concern of severe decline in cognitive function; (ii) evidence of a severe cognitive decline . . . in two or more cognitive domains; (iii) functional impairment; and (iv) not exclusively in the context of delirium, acute substance abuse, or medication side effects.

(i) Concern for severe decline in cognition: Dr. [REDACTED] noted that the Player reported a "continued decline" in memory and cognitive function for "at least 10 years." Despite the Player's complaint of "continued decline," neurological and neuropsychological results as far back as 2008 suggest chronic but stable low performance with prominent contributions of a primary psychological and/or psychiatric disturbance. Conclusion: This criterion is fulfilled.

(ii) Evidence of a severe cognitive decline on neuropsychological testing: Dr. [REDACTED] provided conflicting information regarding the role of neuropsychological testing. On one DPC dated 4/2/2019, he cited testing by Dr. [REDACTED] and Dr. [REDACTED] and on another dated 4/23/2019, he indicated that the Player's impairments were severe enough to establish a diagnosis of Level 2 Neurocognitive Impairment without neuropsychological testing.

The Player obtained a score of 16/30 on the MoCA administered by Dr. [REDACTED] on 8/6/2018. This is not generally consistent with a severe stage of dementia. According to the test developers, a score of 16 on the MoCA is "average" for mild stage Alzheimer's disease (range 11-21; <https://www.mocatest.org/faq/>). Across a wide range of dementia etiologies, a MoCA Score of 16 was determined to map to an MMSE score of 23-24 (Bergeron D, et al. JAGS 2017;65:1067-1072). Similarly, across a spectrum of diagnostic categories, an MMSE score of 21-25 predicted mild overall impairment (i.e, a CDR score = 1) (Pernecky R, et al. Am J Geriatr Psychiatry 2006;14:139- 44). Dr. [REDACTED] further notes that the Player "may not have been able to give his best effort in answering all the questions." Dr. [REDACTED] assertion that his findings indicated sufficient severity to bypass the neuropsychological testing requirement is not supported by his own cognitive testing results, the available medical literature related to the documented test scores, and his observation that explicitly identifies poor effort as a contributor to overall performance.

Dr. [REDACTED] evaluation demonstrated severe deficits across multiple domains, but the Player did not obtain passing scores on any of the performance validity tests. Dr. [REDACTED] reports that an MMPI-2-RF was administered but no details are

reported. In the absence of more details on the MMPI-2-RF, the reliability of symptom reporting and the Player's self-perception of the origins of his complaints cannot be established. Dr. [REDACTED], a board-certified neuropsychologist, reviewed Dr. [REDACTED] testing and administered the Adaptive Behavior Assessment System-II on 3/25/17. He concluded that the results of Dr. [REDACTED] testing were indicative of severe neurocognitive impairments and that "the effort tests do not reflect poor effort or malingering." However, Dr. [REDACTED] appears to contradict himself, subsequently stating the Player's "cognitive performance is strongly effected [sic] by his emotional and physical condition, markedly decreasing his performance level."

An AAPC emphasized the extreme severity of impairment across all domains on both Dr. [REDACTED] and Dr. [REDACTED] testing. The severity of these deficits (23 scores at the 1st percentile, all scores at 16th percentile or lower on Dr. [REDACTED] exam) is not consistent with the degree of retained function reported by the Player's wife (can drive with GPS assistance; can perform laundry tasks, but makes errors; can prepare food, but forgets to turn off stove). There are multiple additional indicators of invalid test performance in Dr. [REDACTED] report. The Player achieved a raw score of 40 on the Boston Naming test. This is associated with 96-100% specificity for invalid performance (Erdodi L et al Psychological Injury and Law 2018;11:1-8). His raw score of 7 on the BDAE-CIM similarly predicts performance invalidity with 95-100% sensitivity (Erdodi L, Roth R. Appl Neuropsychol Adult 2017; 24:264-278). Furthermore, the Player's scores of 6 on Category Fluency and 13 on Controlled Oral Word Fluency are each associated with a =90% sensitivity for poor effort on testing (Sugarman MA, Axelrod BN. Appl Neuropsychol Adult 2015;22:141-146). Dr. [REDACTED] reported that expressive and receptive language were adequate for testing purposes, but did not identify the mismatch between spontaneous language and test performance in assessment of the Slick criteria. Additionally, Dr. [REDACTED] asserted "[h]e was clearly both severely depressed and in pain, factors which combined to exacerbate his cognitive losses."

In the absence of valid assessments of neuropsychological impairment, notation of noncognitive factors that limit effort and performance, failure of reliable assessment of the Slick Criteria, and performance on cognitive screening by Dr. [REDACTED] in the mild dementia range in 2018, this criterion is not supported.

(iii) Declines in daily function generally consistent with CDR scores of 2 in Community Affairs, Home & Hobbies, and Personal Care: Third-party affidavits from 2019 and the CDR conducted in 2018 do not provide sufficient information to address the Player's capacity as of the claimed date of diagnosis two to three years earlier than Dr. [REDACTED] assessment. The sworn statements from earlier (2016) focus on troubling motivation and emotional symptoms to a greater extent than functional losses due to cognitive decline. The retained functions identified in the CDR and third-party affidavits as noted above (can drive with GPS assistance; can

perform laundry tasks, but makes errors; can prepare food, but forgets to turn off stove) are not generally consistent with scores of 2 in the required CDR domains (i.e., no pretense of independent function in the community, requires assistance in personal care activities).

The AAPC identified a consistent pattern of unreliable performance on validity testing and symptom reporting dating back to at least 2011. Furthermore, records from the assessment of Dr. [REDACTED] in 2010 also show patterns strongly indicative of symptom exaggeration on other scales. For instance, the Player responded yes to 11 of 12 questions regarding sleep anomalies, reported the maximum possible score on the Epworth Sleepiness Scale, provided high-level responses (e.g., “a lot of difficulty”) to a large majority of physical symptom questions on a disability questionnaire, and reported the maximum possible score on the Fatigue Severity Scale. Similarly, in 2011 his responses on both the Beck Depression Inventory and the Beck Anxiety Inventory were over 90% of the maximum possible scores. At a minimum, these self-reports indicate substantial non-cognitive contributors to loss of daily function, but much more likely reflect consistently non-credible symptom reporting and effort limitation in daily tasks associated with noncognitive factors. Therefore, neither the requisite severity nor the CDR scoring requirement that losses in daily function be attributed to cognitive decline, not other factors, is fulfilled.

(iv) The deficits do not occur exclusively in the context of delirium, substance use or medication side effects: There is no evidence reported to indicate the effects delirium, medications or substance use are exclusively associated with the player’s complaints. This criterion is fulfilled. Based on the failure to meet criterions (ii) and (iii), the diagnosis made by Dr. [REDACTED] is not generally consistent with the Settlement criteria for the Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

Doc. 232308. Mr. [REDACTED] appealed. Doc. 234185.

DISCUSSION

The Claims Administrator denied Mr. [REDACTED] Claim for lack of evaluation and evidence generally consistent with criterion (ii) and criterion (iii) for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. On appeal, I will overturn this decision if Mr. [REDACTED] presents clear and convincing evidence that it was in error.

For criterion (ii) and the absence of neuropsychological testing, I apply Settlement FAQ #363:

Generally, deference is given to the determinations made by a diagnosing Qualified MAF Physician because of the doctor’s eminence and training, as well as his or her

personal evaluation of the Player. However, if the Qualified MAF Physician indicates that neuropsychological testing is medically unnecessary because of the severity of the Player's dementia, the Claims Administrator has the obligation to determine if that conclusion was "reasonably determined." In this context, the Qualified MAF Physician's conclusion is "reasonably determined" if the doctor's conclusion can be identified as an application of the Settlement's narrow exception to the testing requirement. In other words, it was reasonable for the doctor to conclude that the testing would not generate valid results (note: stating that a task or test will be difficult for a Player is not the same as saying the testing would not generate valid results).

As I have written, the "reasonably determined" standard has two aspects:

Under the Settlement, particularly Section 8.6(b), the Claims Administrator has the authority to verify the sufficiency of both prongs of that reasonableness inquiry: How *severe* was the impairment; and, Why does the impairment's severity make the testing *unnecessary*? That is not the same as saying that the Claims Administrator's supervisory authority is plenary. The Parties have interpreted the agreement to mean that the Claims Administrator cannot disagree with the clinician's Certification merely because it would have made a different choice. The clinician's articulated reasons for certifying must be *unreasonable*. But the Claims Administrator possesses ample authority to require a complete explanation, and to ensure it is internally consistent.²

Here, the Claims Administrator reasoned that Dr. [REDACTED] decision was not reasonably determined because it was "not supported by his own cognitive testing results, the available medical literature related to the documented test scores, and his observation that explicitly identifies poor effort as a contributor to overall performance." Doc. 232308.

In his April 2019 MAF Diagnosing Physician Certification, completed after his August 2018 and March 2019 assessments of Mr. [REDACTED] Dr. [REDACTED] explained why he decided that testing was unnecessary. In part, he relied on Mr. [REDACTED] Short Test of Mental Status score.³ Doc. 205542.

² Special Master Ruling on Qualified MAF Physician's Certification that Testing is Medically Unnecessary, at 3–4 (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_certification_testing_sm.pdf (emphasis in original).

³ The Short Test of Mental Status (STMS) is a "standardized short mental status examination that can be quickly completed and reliably scored [and] is a very helpful first step in assessing cognition . . . Brief screening tests such as STMS should never be used as the sole diagnostic instrument in neurological examinations for dementia. Factors such as depression, aphasia, agitation, or uncooperativeness for any reason could impair performance in all psychometric measures as well as in STMS. Corroborating evidence of cognitive impairment must be sought from other sources, such as collateral history, evaluation of activities of daily living, and psychological testing. The STMS should be seen as an early probe to gain information regarding cognition, thereby helping to direct the evaluation process." Emre Kokmen, Glenn E. Smith, Ronald C. Petersen, Eric Tangalos, & Robert C. Ivnik, *The Short Test of Mental Status: Correlations with Standardized Psychometric Testing*, 48 ARCHIVES OF NEUROLOGY 725, 725–728 (1991). I have previously explained that "while cognitive screening tests not included in the Settlement's prescribed test battery may be used as a part of neuropsychological examinations, it would be erroneous to rest a Denial entirely

Dr. [REDACTED] also considered Mr. [REDACTED] MoCA score, as well as documentary evidence of his daily cognitive functioning that those intimately involved in his life submitted. Doc. *Id.*

Although the Claims Administrator argued that the available medical literature did not support Dr. [REDACTED] analysis, an AAP Consultant (who I asked to review the Claim on appeal) has since disagreed:

I am very familiar with the Short Test of Mental Status administered by the neurologist. I helped to validate it at Mayo Clinic where it was developed. It is an alternate to the MoCA. The score of 16/38 obtained on this test is at a level where we would have recommended against more extensive testing at Mayo Clinic. Admittedly this practice was based on clinical experience not any rigorous study.

Doc. 237339. The Consultant concluded that “based on this experience in my own clinical practice, I would say it was reasonable for Dr. [REDACTED] to have reached the conclusion that neuropsychological testing was not [indicated].” *Id.* An AAP Leadership Council (AAPLC) report, adopting that conclusion, stated: “criterion (ii) is fulfilled under the exception that a neuropsychological evaluation is not necessary due to the severity of the dementia.” Doc. 237508.

These two independent experts, in reviewing Dr. [REDACTED] articulated judgment, concluded that it was reasonable to determine that the severity of Mr. [REDACTED] cognitive impairment justified bypassing the neuropsychological testing.⁴ I will defer to those judgments. It necessarily follows that Mr. [REDACTED] has offered clear and convincing evidence that Claims Administrator’s analysis of criterion (ii) was in error.

To fulfill criterion (iii), the Settlement requires a Claimant diagnosed outside of the Baseline Assessment Program (BAP) to “exhibit[] functional impairment generally consistent with the criteria set forth in the National Alzheimer’s Coordinating Center’s Clinical Dementia Rating (CDR) scale Category 2.0 (Moderate) in the areas of Community Affairs, Home & Hobbies, and Personal Care.”⁵ According to FAQ #103:

Something is “generally consistent with” something else if the two things have more elements or characteristics in common with each other than they have elements or characteristics that differ from each other. The common elements or characteristics must predominate over the uncommon ones.

or substantially on a Retired Player’s performance on such exams.” Special Master Decision Regarding Validity Testing and Functional Impairment, at 10 n. 32, https://www.nflconcussionsettlement.com/Docs/validity_testing_3_sm.pdf. Similarly here, it would be unacceptable to use such a test as the STMS to determine a Qualifying Diagnosis, but reliance on the STMS in determining whether neuropsychological testing is unnecessary is appropriate when accompanied by other considerations of a Retired Player’s cognitive impairment.

⁴ The NFL Parties argue that Mr. [REDACTED] depression and other psychiatric issues should not and cannot be the reason that testing was bypassed. I agree. However, I do not read Dr. [REDACTED] as relying on Mr. [REDACTED] psychiatric symptoms in justifying the absence of neuropsychological testing, and neither did the independent experts.

⁵ Settlement Agreement, Exhibit A-1, (2)(a)(iii).

The Settlement Agreement states specifically that diagnostic criteria for a diagnosis made outside the BAP do not have to be identical to the diagnostic criteria for a diagnosis made in the BAP. The diagnostic criteria, or the medical rules the doctor must follow to make the diagnosis, outside the BAP do not have to be 100% the same as the Exhibit 1 criteria. The burden is not to replicate the Settlement criteria for a Qualifying Diagnosis, but rather to offer evaluation and evidence “generally consistent” with them.

The Claims Administrator highlighted two deficiencies with Mr. [REDACTED] Claim. First, it noted that a prior AAP Consultant “had identified a consistent pattern of unreliable performance on validity testing and symptom reporting.” Doc. 232308. But this testing is largely irrelevant to Mr. [REDACTED] Qualifying Diagnosis one way or another. What matters is the testing that Dr. [REDACTED] analysis rests upon—testing that Dr. [REDACTED] reasonably determined was medically unnecessary.

Second, the Claims Administrator concluded Mr. [REDACTED] had not sufficiently demonstrated that his functional loss was due to cognitive decline. It emphasized that third-party affidavits “focus on troubling motivation and emotional symptoms to a greater extent than functional losses due to cognitive decline.” *Id.* In a terminal review, a member of the AAPLC wrote:

Unfortunately, the Diagnosing Physician did not provide medical reasoning for excluding effects from depression and anxiety as causes of the functional impairments. The Diagnosing Physician also has since retired and is no longer an MAF physician and did not supply additional clarification information.

Doc. 237508 (cleaned up).

After careful review of the factual record, I conclude that the Claims Administrator erred.

To start, Mr. [REDACTED] *has* offered sufficient evidence of functional loss generally consistent with the asserted Diagnosis. As the most recent AAPLC concluded:

The Diagnosing Physician report dated 8/17/2018 indicated the Player’s wife filled out a CDR worksheet and there is an undated CDR worksheet which reports the Player stopped coaching football in 2007 or 2008 due to cognitive problems and headaches, is not able to work, requires assistance to drive, rarely to never shops or carries out activities outside the home independently, functions in limited household activities only, and requires assistance for dressing and grooming. This information would be generally consistent with scores of 2 for the CDR categories of Community Affairs, Home/Hobbies, and Personal Care.

Doc. 237508 (cleaned up). Given this view—to which I defer—the real dispute is the aspect of the CDR scale which asks the physician to determine whether Mr. [REDACTED] loss of function was due to cognitive loss, and not other factors. FAQ #113 explains:

For example, if the Player's functional impairment resulted from a physical handicap or injury, chronic pain, sleep apnea, or other causes other than cognitive loss, the Player cannot be found to have a Level 1.5 or Level 2 Qualifying Diagnosis. In situations where the diagnosing physician determines that a Player suffers from functional impairment that is due to both cognitive loss and emotional/psychiatric factors such as depression, anxiety, or sleep disorders (other than sleep apnea), the diagnosing physician should, to the extent feasible, then attempt to isolate the functional impairment due to cognitive loss alone and assign a CDR rating based solely on that cognitive loss.

Across both of his reports, Dr. [REDACTED] made clear that he was well aware of Mr. [REDACTED] psychiatric history. He consistently described Mr. [REDACTED] prior physicians' and clinicians' consideration of their patient's mental health disorder. For example, in his August 7, 2018 report, Dr. [REDACTED] wrote:

- "He was seen at the Peach Tree Neurological Clinic on June 6, 2008 by Dr. [REDACTED] . . . He was hospitalized in a psychiatric unit from depression and a nervous breakdown following the death of his mother . . . In review of systems Dr. [REDACTED] noted that he had some unsteadiness, some dizziness, headaches, memory loss, and depression. On examination he appeared to be depressed." Doc. 205800, at 3.
- "Dr. [REDACTED] saw Mr. [REDACTED] again on November 10, 2008 in a follow-up visit . . . There was a suggestion of a lot of psychological factors causing his memory complaints. The MRI of the brain was normal with no evidence of brain injury. Therefore, in Dr. [REDACTED] opinion Mr. [REDACTED] complaints of memory issues were based on psychological issues including depression and anxiety . . . Dr. [REDACTED] stated it was his opinion Mr. [REDACTED] is not specifically disabled from previous football related concussive injuries, but there were a lot of psychological factors playing in his role in his inability to work." *Id.*
- "Mr. [REDACTED] was evaluated by Dr. [REDACTED], a license[d] psychologist, who saw him for cognitive and emotional therapy on May 29, 2012 . . . She did some cognitive therapy and counseling with him. She noted he has some guilty and self-deprecating thoughts and frustrations in regard to adjusting to chronic pain." *Id.*, at 5.
- "Dr. [REDACTED] wrote a note on May 29, 2012 that she was unable to attend a special meeting for Mr. [REDACTED] as relates to his psychiatric records and lawsuit. She did state Mr. [REDACTED] saw her in her office for three months as an outpatient for two sessions per week with cognitive behavioral therapy used in most sessions . . . The three months allocated to his treatment appeared to be insufficient to produce significant change in his treatment goals including depression, coping with voices and adaptive behavior. Dr. [REDACTED] believed he could benefit from continued long-term psychological treatment." *Id.*

- “Mr. [REDACTED] was seen by neuropsychological Dr. [REDACTED] in [REDACTED], Florida on March 15, 2017 . . . When he is left alone he becomes anxious and depressed.” *Id.*
- “There was also a battery of neuropsychological testing done by Dr. [REDACTED] on August 23, 2016 . . . It was his diagnosis that Mr. [REDACTED] has a major neurocognitive disorder due to traumatic brain injury and major depression single episode with psychotic features . . . He believed Mr. [REDACTED] was in desperate need of psychotherapy with a therapist experienced with traumatic brain injuries to help him cope more effectively with his depression and suicidal thoughts.” *Id.*, at 6.

After recounting these examples of prior physicians and clinicians noting, and attempting to treat, Mr. [REDACTED] psychiatric condition, Dr. [REDACTED] concluded: “It is my opinion, based on my evaluation today and all of the records I reviewed that Mr. [REDACTED] likely has a dementia disorder of moderate severity.” *Id.*

In his March 29, 2019 report, Dr. [REDACTED] wrote: “As noted in my first letter on August 7, 2018, he had a neuropsychological battery of tests by a Dr. [REDACTED] on March 25, 2017. It was his opinion Mr. [REDACTED] had Level 2 neurocognitive impairment, and I concurred. Also, on August 23, 2016, which was one year earlier, he saw Dr. [REDACTED] a neuropsychologist. His diagnosis was a major neurocognitive disorder likely due to traumatic brain injury, as well as a major depressive disorder as well.” Doc. 205802, at 2. In the very next sentence, Dr. [REDACTED] wrote: “In my opinion Mr. [REDACTED] continues to have the severe neurological deficits of dementia.” *Id.*

That is, Dr. [REDACTED] was aware of and described Mr. [REDACTED] psychiatric issues in his reports. And repeatedly and proximately thereafter, he concluded that Mr. [REDACTED] functional impairment was consistent with the Diagnosis. It is unfortunate that Dr. [REDACTED] has retired and is no longer associated with the Settlement Program. He cannot now shed further light on precisely how he isolated Mr. [REDACTED] cognitive impairment from psychiatric symptoms in assessing his functional impairment. But his articulated consideration of these factors, and his conclusion that Mr. [REDACTED] nevertheless has dementia, was generally consistent with what the Settlement requires.

The AAPLC, however, took an adverse inference because Dr. [REDACTED] failed to specifically state that he excluded depression and anxiety’s effects. Doc. 237508. But the Settlement does not require the *exclusion* of psychiatric etiologies for functional loss. Rather, the FAQ asks the physician to isolate the functional impairment due to cognitive loss “to the extent feasible.” Here, the AAPLC should have evaluated the Claim’s general consistency with the Injury Definition. In doing so, it would have recognized that Dr. [REDACTED] extremely thorough and careful report—which reached conclusions about functional loss immediately after describing potential psychiatric confounders—sufficed.

FAQ 113 accurately describes how physicians should approach this difficult problem. But given the overall strength of the Claim and Dr. [REDACTED] careful report, which omitted no inculpatory facts, the AAPLC’s inference and recommendation go too far. Denying Mr. [REDACTED]

Claim because Dr. [REDACTED] did not explicitly lay out a small piece of his reasoning would turn a process that generally defers to physicians' reasoned explanations into one that requires magic words to achieve relief.

Therefore, the Claims Administrator wrongly decided that Mr. [REDACTED] did not submit evidence generally consistent with a CDR score of 2.0 in Community Affairs, Home & Hobbies, and Personal Care. It was also incorrect in determining that Mr. [REDACTED] did not demonstrate sufficient evidence that functional impairment was due to cognitive decline.

CONCLUSION

On appeal, Mr. [REDACTED] offered clear and convincing evidence that the Claims Administrator's determination was incorrect. An AAP Consultant's analysis now makes clear that Dr. [REDACTED] conclusion that neuropsychological testing was medically unnecessary was reasonably determined. Furthermore, although Dr. [REDACTED] did not fully explain how exactly he concluded that Mr. [REDACTED] mental health issues were not the cause of his functional impairment, his analysis was nonetheless generally consistent with what the Settlement requires.

I grant Mr. [REDACTED] Appeal.

Date: September 7, 2021



David A. Hoffman, Special Master