

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

HON. ANITA B. BRODY

INTRODUCTION

██████████, a Retired NFL Football Player and Class Member under the Amended Class Action Settlement Agreement, filed a Claim for benefits based on a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. The Claims Administrator, denying Mr. ██████████ Claim, determined that his neuropsychological testing was not generally consistent with the criteria for Level 1.5 Neurocognitive Impairment.

Because Mr. [REDACTED] has not shown by clear and convincing evidence that the Claims Administrator erred, I deny his Appeal.

CLAIM HISTORY

This is Mr. [REDACTED] first Claim.¹ It results from evaluations by then-Qualified BAP neuropsychologist [REDACTED] and Qualified MAF neurologist [REDACTED]. Doc. 281026.

On January 7, 2023, Dr. [REDACTED] after examining Mr. [REDACTED], found that he displayed Level 2 impairment in Complex Attention & Processing Speed,² Level 1 impairment in Executive Function, but no impairment in the three other neurocognitive domains. Docs. 276110 at 7; 276085

¹ In 2019, Mr. █████ went through the BAP, with a neuropsychological evaluation by Dr. █████, Doc. 262822. In 2022, Mr. █████ became eligible for automatic retrospective rescoring on the BAP under the Norming Agreement. Doc. 262449. After rescoring, Mr. █████ displayed Level 2 impairment in Complex Attention & Processing Speed, but no impairment in the four other neurocognitive domains, leading to a finding of a no impairment overall. Doc. 262822 at 3-4.

² Mr. [REDACTED] T-scores in Complex Attention & Processing Speed were 32, 27, 42, 34, 40, and 34 (3 scores or more below a 38, as well as 2 or more scores below a 38 *and* at least one score below a 33). Doc. 276085 at 2.

at 2-4. In Executive Functioning, Mr. [REDACTED] received T-scores of 55, 34, 34, and 44. Doc. 276085 at 3.

Dr. [REDACTED] also completed a *Slick* criteria checklist. *Id.* at 6-7. She flagged criterion #1 because “Mr. [REDACTED] scores on some measures of stand-alone performance validity fell below cutoff scores,” though “his performance on embedded measures of validity was acceptable.” *Id.* at 6. She continued that “[t]his pattern of inconsistency raises the question of validity with regard to all aspects of the cognitive assessment . . . [i]n the context of administering multiple performance validity measures, however, these test results cannot be deemed blatantly invalid.” *Id.*

Dr. [REDACTED] also found that Mr. [REDACTED] testing triggered *Slick* criteria #7 and #8. *Id.* at 7. She did not have enough information to code criterion #6. *Id.* Dr. [REDACTED] summarized her *Slick* findings:

Application of the *Slick* criteria to Mr. [REDACTED] presentation, history, self-reported symptoms, and neurocognitive performance are suggestive of invalidity. In particular, Mr. [REDACTED] self-reported symptoms and how such symptoms affect his daily functioning are discrepant from known parameters and his own neurocognitive performance. While such findings are indicative of an element of exaggeration, a genuine somatic or cognitive disorder cannot be completely ruled out.

Id.

At the close of her report, Dr. [REDACTED] declined to certify a Qualifying Diagnosis, writing:

Based on the clinical history and available test data, Mr. [REDACTED] exhibits mild cognitive difficulties across the domains of Complex Attention & Processing Speed and Executive Functioning, meeting criteria for a Level 1.0 impairment rating. These findings are presumed valid based on performance validity measures. While his overall impairment rating has worsened from prior evaluation in November 2019, analysis of test data reflects significant variability, as there is evidence for some notable improvements and other areas of decline. Based on the current findings, Mr. [REDACTED] does not meet criteria for any allowable diagnoses under the MAF parameters.

Doc. 276110 at 9.

She went on:

In terms of symptom ratings and psychological functioning, Mr. [REDACTED] self-reported complaints appear to be unrealistic and, in all probability, exaggerated. Symptom validity indicators call into question the veracity of his self-report of cognitive and somatic symptoms. Indeed, Mr. [REDACTED] reported cognitive symptoms

are significantly worse than what would be expected based upon his neurocognitive performance, providing additional evidence for symptom exaggeration.

Id.

Dr. [REDACTED] disagreed with Dr. [REDACTED]. Doc 281004 at 7. After examining Mr. [REDACTED], she certified a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. *Id.* Though Dr. [REDACTED] had originally evaluated Mr. [REDACTED] on November 8, 2022, she prepared her report after Dr. [REDACTED]'s evaluation in January 2023 and acknowledged Mr. [REDACTED] neuropsychological test results. *Id.* Dr. [REDACTED] concluded her report:

Mr. [REDACTED] fulfills the criteria for a Level 2 neurocognitive impairment: Mr. [REDACTED] and his wife and parents all have concerns about cognitive decline. On neuropsychological testing, Mr. [REDACTED] had impairment in the two cognitive domains of Complex Attention, and Executive Function, with poor performance in a third domain . . .

By the criteria for Neurocognitive Impairment, Mr. [REDACTED] fulfills the criteria for a Level 2 Neurocognitive Impairment. However, because he has different levels of impairment on neuropsychological testing (a 2 in Complex Attention and Processing Speed, and a 1 in Executive Function), a Level 1.5 Neurocognitive Impairment is probably the more accurate diagnosis currently.

Id. (break added).

To reconcile these contrasting views, the Claims Administrator requested review by the Appeals Advisory Panel (AAP). Doc. 283575. The AAP Consultant found Dr. [REDACTED]'s report "detailed," her evaluation "very thorough" and her clinical reasoning "thoroughly explained." *Id.* at 2. On the other hand, the AAP Consultant reported that "Dr. [REDACTED]'s report contains multiple statements of history that are either not credible or are contradicted by history contained in Dr. [REDACTED]'s report." *Id.* The AAP Consultant could "see no reason to override [Dr. [REDACTED]'s] judgment in favor of Dr. [REDACTED]'s" and concluded that Mr. [REDACTED] did not meet the diagnostic criteria for Level 1.5 Neurocognitive Impairment. *Id.*

After the AAP Consultant's initial report, the Claims Administrator asked Dr. [REDACTED] to further substantiate her Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 286497. In particular, it pressed on validity and impairment level. *Id.*

Responding to the Claims Administrator's request to address Dr. [REDACTED]'s conclusions about validity, Dr. [REDACTED] quoted from Dr. [REDACTED]'s report on page 6, section 16, where Dr. [REDACTED] wrote that Mr. [REDACTED] suboptimal scores on performance validity indicators did not "reach the threshold for outright invalidity." Doc. 298823 at 1. Dr. [REDACTED] also contended that:

It is not usual practice to give definitive psychiatric diagnosis . . . based solely on scales administered in the course of neuropsychological testing. Similarly, memory

complaints can't be determined to be non-credible solely on the basis of scales, when the actual testing results show significant impairment in two areas and the clinical complaints are corroborated by the player's family.

Id. at 1-2.

Addressing Mr. ██████ neuropsychological test scores, Dr. ██████ argued that Mr. ██████ met the criteria for Level 1.5 Neurocognitive Impairment, writing:

Mr. ██████ received a Level 2 Neurocognitive Impairment in the domain of Complex Attention and Processing Speed; and a Level 1 Impairment in the domain of Executive Function. I am unclear as to why the Level 2 Impairment was not considered in the overall impairment rating. The most accurate overall impairment rating, according to the neuropsychological testing, is between a Level 1 and Level 2 impairment.

Id. at 1.

At the request of the Claims Administrator, the AAP Consultant reviewed Dr. ██████'s response and new evidence submitted by Mr. ██████ Counsel. Doc. 300332 at 2. It found that Dr. ██████ failed to adequately address the validity concerns raised by Mr. ██████ neuropsychological test results. *Id.* at 3. It noted that in the section of Dr. ██████'s report that Dr. ██████ excerpted, Dr. ██████ "was referring ... specifically to [Mr. ██████] neurocognitive test scores, not her overall findings." *Id.* at 2. The AAP Consultant pointed out that "Dr. ██████ clearly states that her analysis of Slick criteria results in an 'invalid' exam. She found criteria #1, #7 and #8 to be present." *Id.*

The AAP Consultant also disagreed with Dr. ██████'s implication that Dr. ██████ "solely" diagnosed Mr. ██████ based on "scales." *Id.* at 3. "In fact," the AAP Consultant noted, "Dr. ██████ took a complete history from the patient and his wife and conducted a structured psychiatric interview (the MINI). This is far more than what most physicians (including neurologists) do when they assign mental health diagnoses." *Id.*

The AAP Consultant then rejected Dr. ██████'s explanation of Mr. ██████ neuropsychological test scores, writing:

The 48-page [document from Mr. ██████ counsel] contends that, as the MAF-authorized examining physician, Dr. ██████'s "articulated reasoning" as described in her "contemporaneously reports" should be given deference. It also reviews the reports of third-parties, re-states the reasoning behind Dr. ██████'s [Clinical Dementia Rating (CDR)] ratings of 2 (moderate dementia) in the three relevant functional domains, and argues that Dr. ██████'s finding of Level 1 overall cognitive impairment rather than 2 is in error. None of the arguments made are

persuasive, since they seek to over-ride Dr. [REDACTED]'s objective, quantitative test scores with Dr. [REDACTED]'s subjective, impressionistic opinions.

This patient's only Level 2 (severe) cognitive impairment was in Complex Attention & Processing Speed. His lowest score in this domain was on WAIS-IV Arithmetic (T = 27). In fact, this is his lowest score in the entire neurocognitive test battery (the next lowest being T = 32). In this regard, it is worth noting that the patient reported difficulty with mathematics as a high-school student. If his weakness in solving verbal arithmetic problems is of developmental origin, and not a reflection of cognitive impairment, it might be appropriate to discount this score. If we did so, the patient would have only Level 1.5 impairment in Complex Attention & Processing Speed. This, combined with the absence of any impairment at all in three neurocognitive domains, supports Dr. [REDACTED]'s assignment of Level 1 overall neurocognitive impairment.

Id.

The AAP Consultant ultimately did “not find—in any of the newly proffered documents—reason to change [the AAP Consultant's] prior opinion that the neuropsychological findings are NOT generally consistent with Level 1.5 Neurocognitive Impairment.” *Id.*

The Claims Administrator adopted the AAP Consultant's conclusion and, on June 17, 2024, denied Mr. [REDACTED] Claim. Doc. 344450. Mr. [REDACTED] timely appealed the Claims Administrator's decision. Doc. 354211.

RESOLVING THIS APPEAL

Mr. [REDACTED] argues that his scores were valid and generally consistent with a finding of Level 1.5 Neurocognitive Impairment. Therefore—he contends—there is clear and convincing evidence that the Claims Administrator erred in denying his Claim. I do not agree.

Neuropsychological test results that nearly or almost meet BAP scoring criteria are not, by virtue of their approximate numerical fit, generally consistent with the BAP.³ As I wrote in 2020:

[I]t would be a perverse result if every player diagnosed outside of the BAP received an award based on results which would have rendered him ineligible within it: the exercise cannot be a mechanical one, where all ties goes to the runner. If that were what the Parties had intended, the Agreement would not have said ‘generally consistent:’ it would have explicitly directed that non-BAP diagnoses may meet a *lower*, not a *different*, standard.⁴

³ Special Master Ruling on Clinical Judgment on Generally Consistent Standard, at 3 (May 27, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=physician_judgment_sm.pdf.

⁴ *Id.*

Notwithstanding this long-established precedent, Mr. ██████ argues in his brief that since his “scores in executive function were *nearly* identical to the BAP for a Level 1.5,” his neuropsychological test results must be generally consistent with BAP criteria. Doc. 354208 at 15. But, again, “generally consistent” can’t mean “close enough.”

Instead, if a MAF Physician or Clinician deviates from the BAP testing or criteria, and yet concludes that a Qualifying Diagnosis is generally consistent with those rubrics, he or she must provide a “reasoned, individualized, clinical judgment” explaining the deviation.⁵ Dr. ██████’s conclusions do not meet this standard. Instead, she advances “subjective, impressionistic opinions” which don’t provide a basis on which to defer to her views. Doc. 300332 at 3.

First, at the most basic level, Dr. ██████ failed to provide a “reasoned, individualized, clinical judgment” explaining the deviation from BAP criteria when asked directly to do so. In her addendum, Dr. ██████ re-stated her reasoning for assigning CDR ratings of 2 in three relevant functional domains and reiterated without support that “the most accurate overall impairment rating, according to the neuropsychological testing, is between a Level 1 and Level 2 impairment.” Doc. 298823 at 1. As the AAP Consultant pointed out, this reads like an attempt to “over-ride Dr. ██████’s objective, quantitative test scores with Dr. ██████’s subjective, impressionistic opinions.” Doc. 300332 at 3.

The closest Dr. ██████ comes to justifying the deviation from BAP criteria comes on the final page of her initial report, when she concluded that “Mr. ██████ fulfills the criteria for a Level 2 neurocognitive impairment: Mr. ██████ and his wife and parents all have concerns about cognitive decline.” Doc. 281004 at 7. But Dr. ██████ has never articulated an adequate medical reason *why* these concerns support a finding that Mr. ██████ symptoms were generally consistent with BAP criteria.

Second, Dr. ██████’s report contains confusing internal contradictions and seems belied by other parts of the record.

The AAP Consultant found that Dr. ██████’s report relayed facts about Mr. ██████ history that were either not credible or were contradicted by information contained in Dr. ██████’s report. Doc. 283575 at 2. For example, Dr. ██████ reported that Mr. ██████ did not graduate college despite Dr. ██████’s report that Mr. ██████ graduated from the ██████. *Id.* Dr. ██████ noted that Mr. ██████ denied a history of depression and never took antidepressant medications, but Dr. ██████ documented Mr. ██████ history of suicidal thought and his wife’s report of his previous diagnosis of bipolar disorder. *Id.* While Dr. ██████ wrote that Mr. ██████ regularly urinates all over the commode and forgets to wipe himself after toileting, the AAP Consultant points out that this is an asserted level of impairment “incompatible with a MMSE of 25” and Mr. ██████ other life activities, including caring for a toddler. *Id.*

Dr. ██████’s addendum also suggests a lack of clarity about the Settlement’s requirements. She highlighted that “on neuropsychological testing, Mr. ██████ received a Level 2

⁵ *Id.*

Neurocognitive Impairment in the domain of Complex Attention and Processing Speed; and a Level 1 Impairment in the domain of Executive Function.” Doc. 298823 at 1. She then expressed being “unclear as to why the Level 2 Impairment was not considered in the overall impairment rating.” *Id.* But the Settlement requires—for the asserted Level 1.5 Qualifying Diagnosis—that Mr. █████ must receive at least Level 1.5 impairment in *two* cognitive domains.

Similarly confused is her assertion that “the most accurate overall impairment rating, according to the neuropsychological testing, is between a Level 1 and Level 2 impairment,” which suggests that she believes that Mr. █████ satisfies the criteria for Level 1.5 Neurocognitive Impairment because, when averaged, 2 and 1 make 1.5. *Id.* The Settlement Agreement does not define Level 1.5 Neurocognitive Impairment as a cognitive status somewhere “between” Level 1 and Level 2, but rather as a Qualifying Diagnosis with its own independent criteria—including evidence of at least Level 1.5 impairment in more than one cognitive domain.

Third, even if Mr. █████ had submitted scores which qualified him for an award, the Claims Administrator was not wrong in concluding the testing was invalid. His examining neuropsychologist, after all, indicated that multiple *Slick* criteria had been triggered, suggesting that the overall testing profile was invalid. Doc. 276085 at 7.⁶ Dr. █████, quoting Dr. █████’s finding that Mr. █████ “performance on cognitive measures appears to be valid overall,” appeared not to recognize that this excerpt applied only to Mr. █████ suboptimal performance on quantitative validity indicators. Doc. 300332 at 2. Given the conflict between the two examining doctors, as well as the deficiencies in Dr. █████’s report, the AAP Consultant was correct in offering its own independent judgment. It found that Mr. █████ had not offered sufficient evidence of valid testing. I see nothing in the record that (by clear and convincing evidence) demonstrates its conclusion was wrong.

CONCLUSION

Mr. █████ submitted a Claim relying on test results that were not generally consistent with the Injury Definitions, and which his own examining neuropsychologist determined were not necessarily valid estimates of his cognitive functioning. The Claims Administrator issued a denial

⁶ Dr. █████ was less emphatic about invalidity than the AAP Consultant or NFL Parties make her out to be, but her overall view is clear enough from her reports:

- “Application of the *Slick* criteria to Mr. █████ presentation, history, self-reported symptoms, and neurocognitive performance are suggestive of invalidity.” Doc. 276085 at pg. 7.
- “In particular, Mr. █████ self-reported symptoms and how such symptoms affect his daily functioning are discrepant from known parameters and his own neurocognitive performance. While such findings are indicative of an element of exaggeration, a genuine somatic or cognitive disorder cannot be completely ruled out.” *Id.*
- “In terms of symptom ratings and psychological functioning, Mr. █████ self-reported complaints appear to be unrealistic and, in all probability, exaggerated. Symptom validity indicators call into question the veracity of his self-report of cognitive and somatic symptoms. Indeed, Mr. █████ reported cognitive symptoms are significantly worse than what would be expected based upon his neurocognitive performance, providing additional evidence for symptom exaggeration. While feigned symptoms cannot be completely ruled out, a Somatic Symptom Disorder may be more likely.” Doc. 276110 at 9.

after a thoughtful review. Finding no error in either that process or its outcome, I deny Mr. [REDACTED] Appeal.

Date: February 6, 2025



David A. Hoffman, Special Master