

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 Settlement Class Member under the Amended Class Action Settlement, filed a Claim based on a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. His clinicians, deviating from the Settlement's cutoffs for finding impairment given his neuropsychological test results, explained their reasoning in detail.

Mr. [REDACTED], appealing this determination with Class Counsel's support, argues that the Claims Administrator erred in not deferring to the articulated judgment of his medical providers. I ultimately sought advice from a joint panel of independent reviewers about the underlying medical issues in this case.

FACTUAL AND PROCEDURAL BACKGROUND

1. Mr. [REDACTED]'s First Claim

On May 15, 2017, Mr. █████ submitted a pre-Effective Date Claim based on a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, dated July 10, 2015, certified by neurologist Dr. █████. Doc. 69444. The Claim package included an assessment conducted in late 2014, when Mr. █████ was 33, by clinical psychologist Dr. █████ *Id.*¹

Dr. █████ conducted a battery of testing and summarized her conclusions as follows:

Assessment results indicate that Mr. █████'s overall intellectual ability falls within the average range; however, notable strengths and weaknesses were discovered by analyzing his performance. While he performed well on a number of subtests, Mr. █████'s performance on several subtests and measures suggest the presence of auditory memory and processing deficits. These problems can be associated with temporal and frontal lobe damage.

Mr. █████ performed better than his peers on tasks of verbal comprehension. His general fund of knowledge is broad and intact. He is articulate and well-educated. It is due to this strength that Mr. █████ is able to appear problem-free. He performed similarly to peers on tasks of perceptual reasoning and working memory, but performed significantly lower on tasks involving processing speed. He takes longer than others his age to process information and produce a response. This is a particularly important finding when relating his score in this area to scores in other areas. In fact, the difference between his scores on processing speed and all other areas was so large that it is not often seen in the general population. When differences such as these are seen, it is often associated with a traumatic brain injury.

Id.

Relying in part on Dr. █████'s evaluation, Dr. █████ diagnosed Mr. █████ with Level 1.5 Neurocognitive Impairment "based on test scores in the domains of learning/memory and executive functioning (processing)." *Id.* Dr. █████ wrote that Dr. █████ used "standardized neuropsychological testing that is generally consistent with diagnostic criteria" in the Settlement, and concluded that "Mr. █████ has a progressive history of cognitive impairment with loss of executive function complicated by the development of depression and the appearance of significant anxiety, irritability and panic attacks." *Id.*

As the Claim asserted a pre-Effective Date Diagnosis, it was subject to automatic AAP review.² On June 28, 2017, an AAP member found that Mr. █████ had the Qualifying Diagnosis

¹ Dr. █████ was later disqualified from the Program and referred to her professional board following an Audit finding that she not only wrote reports for players she had not examined but also changed her findings in response to conversations with attorney █████. But there is no indication of similar conduct affecting Mr. █████'s evaluation. *See* Special Masters' Rule 27 Decision on Report of Adverse Finding Regarding Drs. █████, █████, █████, and █████, at 5 (Sept. 14, 2021), https://www.nflconcussionsettlement.com/Docs/rule_27_doctors_sm.pdf.

² Settlement Agreement, Section 6.4(a).

of Level 1.5 Neurocognitive Impairment and that the Qualifying Diagnosis had been made by an appropriate physician.³ On July 20, 2017, the Claims Administrator issued a Notice of Monetary Award Claim Determination, which set out a net payment amount of \$1,267,406.96, subject to “necessary adjustments based on any further investigation of the claim, including any audit authorized by Section 10.3 of the Settlement Agreement.”⁴

After it had already issued the Notice of Monetary Award, the Claims Administrator became aware of a gap in the AAP member’s review. As part of its regular quality control review of payable claims, the Claims Administrator noticed that the reviewer had not asked a neuropsychological consultant for their views, as the Settlement permits:

“Appeals Advisory Panel Consultants” means three (3) neuropsychologists certified by the American Board of Clinical Neuropsychology (ABCN), a member board of the American Board of Professional Psychology, in the specialty of Clinical Neuropsychology, agreed to and jointly recommended by Co-Lead Class Counsel and Counsel for the NFL Parties, and appointed by the Court, *any one of whom is eligible to advise a member of the Appeals Advisory Panel . . . on the neuropsychological testing referenced in Exhibits 1 and 2 of the Settlement Agreement, as pertaining to the Qualifying Diagnoses of Level 1.5 Neurocognitive Impairment. . .*⁵

The Claims Administrator, seeking to remedy this gap, asked an AAP Consultant to review the neuropsychological testing underlying Mr. ██████’s Claim. This Consultant, reviewing the file on August 12, 2017, wrote: “the player’s neuropsychological performance does **not meet criteria for even Level 1.0 neurocognitive impairment.**” Doc. 296213 (emphasis in original). The Consultant observed that “Dr. ██████ did not appear to follow the [Settlement’s] algorithm in reaching her determination of impairment” because “she deemed a cognitive domain (processing speed) as impaired based on a single outlier scores” and “she interpreted test scores that fell within normal limits as impaired (learning and memory).” *Id.* Ultimately, the Consultant concluded that all five cognitive domains—complex attention and processing speed, learning and memory, visual perception, language, and executive function—revealed “Level 0” impairment. *Id.*

Given this analysis, the original AAP reviewer recommended that the Claim should be denied, but did not provide a written report explaining his findings.⁶

This incomplete record created a problem, as the NFL Parties’ deadline to appeal Mr. ██████’s Claim (which the Claims Administrator now concluded had been wrongfully approved) would run 30 days from July 20.⁷ After consulting by phone with Class Counsel and the NFL

³ This determination was entered directly into Mr. ██████’s portal without a corresponding report.

⁴ The Claims Administrator informs me that this document was subsequently de-activated, and it longer appears in Mr. ██████’s portal.

⁵ Settlement Agreement, Section 2.1(h) (emphasis added).

⁶ As with the reviewer’s June 28, 2017 finding, this determination was entered directly into Mr. ██████’s portal without a written decision.

⁷ See Settlement Agreement, Section 9.7(a) (explaining the 30-day deadline for filing a notice of appeal).

Parties, the Claims Administrator notified Mr. [REDACTED] that his Claim had been selected for an audit under Section 10.3 of the Settlement Agreement. Doc. 116229.⁸ That Notice tolled the NFL Parties' deadline to appeal the July 20 approval for the pendency of the Audit.

The Claims Administrator requested, Doc. 122179, and Mr. [REDACTED] provided, numerous additional medical records and information about his employment history. Docs. 138903; 138904; 144428; 144430; 144431; 144432; 144433; 144434; 144435. As part of the Audit investigation, the Claims Administrator interviewed the diagnosing physician, Dr. [REDACTED], and terminated the Audit without an adverse finding.⁹

On December 4, 2017, notwithstanding the AAP Consultant's August 12, 2017 opinion recommendation that Mr. [REDACTED]'s records did not support *any* level of neurocognitive impairment, and the extension process resulting from the Audit, the Claims Administrator issued a second Notice of Monetary Award. Doc. 145915.

The NFL Parties appealed the Notice of Monetary Award on January 3, 2018, arguing that "Mr. [REDACTED]'s results on the same tests called for under the BAP (as well as other tests) plainly failed to satisfy the criteria necessary for a diagnosis of Level 1.5 Neurocognitive Impairment in any cognitive domain." Doc. 150805 (emphasis in original).

Mr. [REDACTED]'s reply argued that pre-Effective Date Claims did not require neuropsychological testing, so Dr. [REDACTED]'s opinion should stand alone, regardless of any deficiencies in Dr. [REDACTED]'s analysis. Doc. 153235. He also contended that the NFL Parties' Appeal was untimely:

Based upon a final and binding determination of the Appeals Advisory Panel, the Claims Administrator agreed that Mr. [REDACTED] suffered a 1.5 deficit and made a monetary award to Mr. [REDACTED] on July 20, 2017, finding that he is entitled to recover under the settlement and that he currently qualifies for a 1.5 recovery.

Under the Agreement, if the NFL objected to the Claims Administrator's findings, it had 30 days (until August 21, 2017) to appeal. The NFL did not appeal at that time.

On day 32 after the monetary award, Mr. [REDACTED] was advised that his Claim was the subject of a random 10% audit by the Claims Administrator. As part of the audit, on September 7, 2017, the [REDACTED]'s produced 5 years of medical records and 5

⁸ See Settlement Agreement, Section 10.3(c) ("On a monthly basis, the Claims Administrator will audit ten percent (10%) of the total Claim Packages and Derivative Claim Packages that the Claims Administrator has found to qualify for Monetary Awards or Derivative Claimant Awards during the preceeding month. The Claims Administrator will select such Claim Packages and Derivative Claim Packages for auditing on a random basis *or to address a specific concern raised by a Claim Package or Derivative Claim Package*, but will audit at least one Claim Package, if any qualify, each month.") (emphasis added).

⁹ Because the audit did not lead to an adverse finding, there is no written report of the interview with Dr. [REDACTED] in the portal.

years of employment records. The Claims Administrator interviewed Dr. [REDACTED]. During the interview, Dr. [REDACTED] made clear that he did not rely on the [REDACTED] report to formulate his opinion that Mr. [REDACTED] suffered from a 1.5 deficit. . .

Id.

Prompted by a Special Master request on February 15, 2018, on March 12, 2018, an AAP reviewer's "Pre-Effective Date Diagnosis Appeal Report" became part of the record. Doc. 161231. The reviewer's determination was "***Need More Information***" because:

The available information does not support the claim of Level 1.5 Neurocognitive Impairment with a date of 7/10/15. Neither the objective findings of that date nor those from Dr. [REDACTED] in December 2014 are generally consistent with the state of dementia explicitly described in the definitions for Level 1.5 Neurocognitive Impairment. There is also insufficient evidence in the documentation to determine that the reported decrements in daily function are sufficiently severe to be generally consistent with CDR scores of 1 in the three required domains, nor that they are associated with cognitive losses rather than other causes (as required to be generally consistent with the CDR's scoring rules). For instance, a panic attack—not forgetfulness—is the only explicitly described contributor to social avoidance. Additionally, review by an AAPC Neuropsychologist determined that the magnitude and scope of the neuropsychological deficits reported by Dr. [REDACTED] does are not of sufficient severity to qualify for Level 1.5 Neurocognitive Impairment.

There is missing information from the records that might alter these conclusions. The retired player reported to Dr. [REDACTED] on 11/10/16 that additional neuropsychological testing had been recently performed by Dr. [REDACTED]. In the absence of those records, a final determination on the diagnosis, and its potential timing, should be deferred.

Id. (emphasis in original).

Also on March 12, 2018, according to a letter by Mr. [REDACTED]'s attorney dated March 20, 2018, the Claims Administrator notified Mr. [REDACTED] that "the Special Master reviewing the NFL's Appeal of the grant of monetary award to [REDACTED] wants to see the records from Dr. [REDACTED]." Doc. 163634.¹⁰ Mr. [REDACTED] objected to providing these additional records because "[REDACTED], is a neuropsychologist retained by the NFL to evaluate Mr. [REDACTED] for his separate claim of total and permanent disability." *Id.*

The NFL Parties countered that Dr. [REDACTED] "was a 'neutral' neuropsychologist for the NFL Player Disability Plan, which is a Taft-Hartley welfare benefit plan jointly created by the NFL

¹⁰ The Claims Administrator has confirmed to me that it did in fact ask Mr. [REDACTED]'s attorney for Dr. [REDACTED]'s records on March 12, 2018.

Players Association and the NFL Management Council for the payment of disability benefits to eligible former players who qualify.” Doc. 163635. The NFL Parties also argued that more information would allow for a more informed decision, ensuring that “the Special Master has access to the complete record as opposed to cherry-picked filed chosen strategically by Mr. [REDACTED].” *Id.* Mr. [REDACTED]’s March 26, 2018 response reflected his misunderstanding that the Claims Administrator and the AAP were in agreement that he was entitled to an Award:

Mr. [REDACTED] has done everything required of him under the Amended Settlement Agreement. His case was audited by the Physicians’ Advisory Panel, who approved his claim; his claim was audited by the Claims Administrator after the monetary award was made. The Claims Administrator did an extensive review of his medical and employment records and interviewed neurologist Dr. [REDACTED], who is a world renowned expert in head trauma. Then, after the audit concluded, the Claims Administrator again approved the claim under the same qualifying diagnosis.

Doc. 164028.

A month later, on April 27, 2018, Mr. [REDACTED]’s attorney wrote to Special Master Pritchett expressing concern that the parties were “at an impasse” and reiterating the objection “to the use of NFL obtained medical reports performed by NFL Permanent Disability benefit physicians.” Doc. 169356. At Special Master Pritchett’s direction, Dr. [REDACTED]’s report became part of the record on May 2, 2018. Doc. 170121.

The report, dated July 26, 2016, summarized Dr. [REDACTED]’s neuropsychological evaluation, as well as “a second neuropsychological examination conducted by [REDACTED] on 10/27/15” consisting of “cognitive tests assessing the patient’s overall general cognitive ability, memory, executive function, and mood.” *Id.* Dr. [REDACTED] noted that “Dr. [REDACTED] concluded that the results were indicative of inadequate effort and therefore could not support any true neurodegenerative problems or disorders.” *Id.* Dr. [REDACTED] also personally examined Mr. [REDACTED] and concluded, based on all three neuropsychological exams (by Drs. [REDACTED], [REDACTED], and [REDACTED]), as follows:

At some point across the three neuropsychological exams that he has undergone, he obtained average to above-average scores on a number of tests that are sensitive to acquired brain damage, including verbal learning and memory, nonverbal learning and memory, cognitive switching, and processing speed. These findings suggest that he has normal neurocognitive skills. There were some test findings that were consistently below average across exams (e.g., on WCST); however, given his variable test-taking effort, there is insufficient evidence to conclude that he has permanent acquired cognitive impairments due to brain damage.

In the area of emotional functioning, Mr. [REDACTED] endorsed having moderate to severe levels of depressive and anxiety symptoms. During my clinical interview of him, he denied having suicidal thoughts at this time. However, he appeared

genuinely and severely depressed to me, and he would be a good candidate for further psychiatric evaluation and possibly treatment.

Doc. 170121.

Along with Dr. [REDACTED]'s report, Mr. [REDACTED] submitted a letter dated April 16, 2018 from Dr. [REDACTED] in which she echoed her analysis from her original evaluation:

Mr. [REDACTED] presents as cognitively intact because of his strong verbal abilities. He is well-educated and articulate. This makes it easy to conclude that poor performance is related to insufficient effort rather than true impairment. Deficits in processing speed and memory that have been noted prevent him from functioning at a level that would be expected for someone with such strengths. When differences are found across various areas of functioning such as those demonstrated in both my evaluation and Dr. [REDACTED]' evaluation, cognitive decline should be considered.

Doc. 170122.

Supplied with these additional documents, the AAP issued another "Pre-Effective Date Diagnosis Appeal Report" dated May 17, 2018. Doc. 172127. This report appears to revise the March 12, 2018 report, which was requested by the Special Master and had concluded that the AAP needed more information in the form of the Dr. [REDACTED] records. Echoing language from its March 12, 2018 report, the AAP recommended the denial of Mr. [REDACTED]'s Claim—even though it had already been approved—because:

The available information does not support the claim of Level 1.5 Neurocognitive Impairment with a date of 7/10/15. Neither the objective findings of that date nor those from Dr. [REDACTED] in December 2014 and Dr. [REDACTED] in July 2016 are generally consistent with the state of dementia explicitly described in the definitions for Level 1.5 Neurocognitive Impairment. There is also insufficient evidence in the documentation to determine that the reported decrements in daily function are sufficiently severe to be generally consistent with CDR scores of 1 in the three required domains, nor that they are caused by cognitive losses rather than other causes (as is required to be generally consistent with the CDR's scoring rules). For instance, a panic attack—not forgetfulness—is the only explicitly described contributor to social avoidance. Additionally, review by an AAPC Neuropsychologist determined that the magnitude and scope of the neuropsychological deficits reported by Dr. [REDACTED] are not of sufficient severity to qualify for Level 1.5 Neurocognitive Impairment. Both the AAPC reviewer and Dr. [REDACTED] indicate that the player's cognitive function is no more than mildly impaired.

Id.

On May 31, 2018, relying on the AAP's revised analysis, Special Master Pritchett granted the NFL Parties' Appeal. Doc. 179984 at Ex. 1. The Notice included this explanation:

Appeal granted. Appellant provided clear and convincing evidence of error in the Claims Administrator's decision. The Special Master's decision is a factual determination and is final and binding. In deciding this appeal, the Special Master was assisted by a member of the Appeals Advisory Panel and/or an Appeals Advisory Panel Consultant. The Special Master has adopted the analysis from the AAP.

Id.

Mr. [REDACTED] objected, arguing that the Special Master's decision was "cryptically stated." Doc. 179984.

The District Court remanded the case to Special Master Pritchett to further explain his decision on July 19, 2018. Doc. 180031. On September 24, 2018, Special Master Pritchett did so, noting, in relevant part:

Based on the advice of the Appeals Advisory Panel, the Special Master concluded that there is clear and convincing evidence that Claimant's diagnosis was not generally consistent with the Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment as defined in the Settlement Agreement. For living Retired NFL Football Players diagnosed prior to the Effective Date, a diagnosis of Level 1.5 Neurocognitive Impairment must be accompanied by 'evaluation and evidence generally consistent with the diagnostic criteria set forth in' the relevant section of Exhibit A-1 of the Settlement Agreement. (Settlement Agreement Ex. A-1, hereinafter 'Injury Definitions.') Claimant's records do not provide evidence generally consistent with the diagnostic criteria set forth in the Settlement Agreement for Level 1.5 Neurocognitive Impairment.

A Retired NFL Player seeking a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment must exhibit (1) concern that there has been a severe decline in cognitive function, (2) evidence of a moderate to severe cognitive decline from a previous level of performance, and (3) functional impairment. (*Id.*) Claimant has fulfilled the first requirement by virtue of his own report. However, based on the advice of the AAP, the Special Master concludes that there is clear and convincing evidence that Claimant's records are not generally consistent with requirements (2) and (3).

As noted by the AAP Consultant, Claimant's cognitive assessment does not establish moderate to severe cognitive decline. Claimant's records do not include evidence supporting a 1.0 (Mild) score in the Home & Hobbies category, which

requires ‘definite impairment of function at home; more difficult chores abandoned; [and/or] more complicated hobbies and interests abandoned.’”

Doc. 187641.

The decision also addressed Mr. ██████’s timeliness argument, accepting that “he received an initial Notice of Monetary Award Determination on July 20, 2017.” Doc. 187641. Special Master Pritchett concluded that the NFL Parties were not precluded from appealing after the December 4, 2017 Notice on the grounds that they had not done so after the July 20 Notice:

Claimant states that he received an initial Notice of Monetary Award Determination on July 20, 2017. (Doc. 153235, at 1.) His claim was then selected as part of the monthly 10% audit of eligible claims as dictated by §10.3 of the Settlement Agreement. Following conclusion of the audit, Claimant received another Notice of Monetary Award Determination on December 4, 2017. By the express terms of the Settlement Agreement, nothing precludes an appeal from either party within thirty days of such a Notice.

Claimant’s Notice of Monetary Award Determination from December 4 explicitly includes a “Deadline to Appeal” of January 3, 2018. (Doc. 145915, at 1.) The NFL Parties filed their Appeals Form on January 3; accordingly, the NFL Parties’ appeal was timely by the terms of §9.7 of the Settlement Agreement. (Doc. 150806.)

Doc. 187641.

The Claims Administrator subsequently issued a “Post-Appeal Notice of Denial of Monetary Award Claim” on October 11, 2018. Doc. 187657. Mr. ██████ objected (again) to the District Court, now arguing that his pre-effective date diagnosis was not required to be “generally consistent” with the Settlement’s definition of Level 1.5 Neurocognitive Impairment, so long as it was made by an appropriately qualified physician. Doc. 190582.

On July 2, 2019, the Court denied Mr. ██████’s Appeal, holding that the “terms of the Settlement Agreement plainly state that the ‘generally consistent’ standard applies to all Qualifying Diagnoses of Level 1.5 and Level 2 Neurocognitive Impairments, including pre-Effective Date diagnoses.” Doc. 211047. The Court added, however, that:

Due to an error early in the claims process, Appellant was issued a Notice of Monetary Award, despite the fact that he plainly did not meet the medical criteria for a Qualifying Diagnosis. While the Claims Administrator soon realized there had been an error, Appellant’s claim was not denied until after the NFL Parties appealed to the Special Master and the Special Master granted the appeal. The Post-Appeal Notice of Denial of Monetary Claim Award was issued nearly a year after Appellant first submitted his claim.

The Court is troubled by the events leading to this objection and has looked into the matter. The Special Masters and the Claims Administrator have assured the Court that the events leading to this objection will not be repeated.

Doc. 211047.

Mr. ██████ appealed the District Court's decision to the Third Circuit. On November 24, 2021, the Court of Appeals affirmed the District Court, finding no abuse of discretion in its "well-reasoned and detailed analysis" of Mr. ██████'s appeal.¹¹

After the Third Circuit's decision, Mr. ██████ received permission to seek medical evaluations outside of the Settlement's normal location requirements with board-certified clinical neuropsychologist Dr. ██████, and board-certified neurologist Dr. ██████. Docs. 241355; 270905. Following these evaluations, Mr. ██████ submitted a second Claim (this one) for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 276759.

2. Mr. ██████'s Second Claim

This Claim relies on two reports not present in Mr. ██████'s first Claim package: Dr. ██████'s March 2, 2022 report, Doc. 275146, and Dr. ██████'s October 6, 2022 report, Doc. 275145. Dr. ██████ also supplemented his report with a letter. Doc. 276757.

Dr. ██████ was careful to cite my previous decisions on what is required of Diagnoses to be generally consistent with the Settlement's criteria, and then listed four reasons as his "articulated medical judgment." Doc. 275146.

1. ██████'s premorbid IQ is superior. . .

In other words, [in a previous case Dr. ██████ described] the AAPC argues (correctly in my opinion) that some players have benefited from "nominal educational attainment" (p. 3 of the same decision) and therefore have premorbid IQs that are being artificially inflated by attending college that they might otherwise not have been able to attend if not for their athleticism. This same logic should also allow for players on the other end of the spectrum. Mr. ██████ graduated from Stanford University, his IQ has consistently tested at 122 per a review of the medical records, and his Reading Level is a standard score of 120. Having personally tested just over 1,000 players in the NFL Concussion Settlement between the BAP and MAF, I can confirm that Mr. ██████'s premorbid functioning is a statistical anomaly for which the one-size-fits all BAP criteria are insufficient.

An "individualized," per the language of the Special Master, understanding of Mr. ██████'s decline is necessary. Exhibit 2, Section 4 of the settlement reads: "The

¹¹ In Re: Nat'l Football League Players' Concussion Inj. Litig., No. 19-2753, 2021 WL 5505402, at *4 (3d Cir. Nov. 24, 2021).

basic principle for defining impairment on testing is that there must be a pattern of performance that is...1.7-1.8 standard deviations...below the person's expected level of premorbid functioning. Therefore, it is necessary to have more than one low test score in each domain." Using this injury definition, Mr. [REDACTED] would meet Level 1.5 impairment criteria in Complex Attention because he had 2 scores that were *at least* 1.8 standard deviations lower than expected given his IQ and Reading Level. Mr. [REDACTED] would also meet Level 1.5 impairment criteria in Executive Functioning because he had 2 scores that were *at least* 1.8 standard deviations lower than expected. Finally, he would meet Level 1.5 impairment in Learning and Memory because he had 4 scores that were *at least* 1.8 standard deviations lower than expected.

2. [REDACTED] **has extensive medical records indicating impairment.** The following doctors have diagnosed Mr. [REDACTED] as having cognitive impairment:

- 02/05/2014. [REDACTED] (Board Certified Neurologist) diagnosed Mr. [REDACTED] as having cognitive impairment.
- 01/05/2015. [REDACTED] (Clinical Psychologist) stated Mr. [REDACTED] has auditory memory and processing deficits.
- 01/02/2015. [REDACTED] (Board Certified Psychiatrist). Mr. [REDACTED]'s performance on the CPT was "poor" which is consistent with significant attention and executive functioning problems. Dr. [REDACTED] later diagnosed Mr. [REDACTED] as having "Brain Injury NEC, Encephalopathy NOS, Frontal/Temporal lobe disorder and ADHD NOS" on 04/02/2015.
- 07/10/2015. [REDACTED] (Board Certified Neurologist). Diagnosed Mr. [REDACTED] as having Level 1.5 impairment alongside a CDR consistent with Level 1.5 dysfunction.
- 04/16/2018. Dr. [REDACTED] (Board Certified Neurologist). Conclusions indicate the constellation of available records are correlative of "neurocognitive decline related to traumatic brain injury."
- 09/05/2019 to 12/16/2021. Dr. [REDACTED] (Neuropsychiatrist). Diagnosed Mr. [REDACTED] as having Mild Neurocognitive Disorder (due to TBI) alongside a litany of psychiatric diagnoses.
- 01/14/2020. Dr. [REDACTED] (Clinical Psychologist with training in Neuropsychology) noted a discrepancy between crystallized and fluid intelligence indicative of cognitive decline.
- 11/01/2021. Dr. [REDACTED] (family medicine) diagnosed Mr. [REDACTED] as having Early Onset Alzheimer's Dementia and prescribed Nuedexta and Namenda.

To my knowledge, the only two doctors that have NOT diagnosed Mr. [REDACTED] as having cognitive impairment are Drs. [REDACTED] and [REDACTED]. During those evaluations, Mr. [REDACTED] failed the validity tests that were administered.

I am not familiar with Dr. [REDACTED] (nor was the report made available for me to review) but I greatly respect Dr. [REDACTED] and have little reason to doubt the interpretation of the test data. However, failing validity tests necessarily means that his data is not reliable and only represents Mr. [REDACTED]'s minimal capabilities. Mr. [REDACTED] is, in a word, temperamental. And stubborn if I'm allowed to pick a second word. For example, he refused to answer 7 MMPI questions during my evaluation because he insisted that the wording was unfair, and he provided sound reasoning for this refusal. I do not know why Mr. [REDACTED] failed validity tests previously, but I suspect it is because he took issue with the process as opposed to an attempt to malingering. Either way, failed validity tests do not dismiss players from the settlement with prejudice. When he has passed validity (during Dr. [REDACTED], Dr. [REDACTED], and my evaluation), the findings have consistently shown deficits in processing speed, attention, executive functioning, and memory.

3. **[REDACTED] has neuroimaging findings showing abnormalities, particularly in the left-frontal lobe.**

- SPECT scan showing an overall "Brain Health [STEN] Score" of 4.4 (Low End of Expected Range), comprised of a "Thinking" STEN score of 5.1 (Within Expected Range), "Emotion" STEN score of 6 (High End of Expected Range), "Self-Regulation" STEN score of 4 (Low End of Expected Range), and "Feeling" STEN score of 2.5 (Below Expectation). In general, I would consider this to be weak evidence given the empirical support, or lack thereof, for SPECT scans.
- MRI findings of "left frontal lobe damage" (and iron deposits) within each hemisphere. This evidence is far more compelling.
- PET-FDG Scan showing mildly hypometabolic FDG activity involving the posterior aspects of the bilateral frontal lobes and anteroinferior aspects of the bilateral temporal lobes.
- DTI scan showing "abnormal decreased white matter FA within left anterior corona radiata."

4. **[REDACTED]'s collateral informant provides compelling evidence.** Namely, Mr. [REDACTED]'s wife has detailed her concerns about her husband's cognitive decline (and emotional lability) for the past 7 years. She has hundreds of examples about Mr. [REDACTED]'s impairment; capturing them all in this report would result in a length that only Dostoevsky would appreciate. Her examples, and the emotion to which she conveys them, are genuine and overwhelming.

Id. (emphasis in original, breaks added for clarity).

Dr. [REDACTED] endorsed Dr. [REDACTED]'s analysis, writing in his supplemental letter, "I would like to clarify for the record that that there was in fact a deviation between the neuropsychologist's assessment and the BAP diagnostic criteria. I believe that Dr. [REDACTED] does an excellent job in

explaining this deviation.” Doc. 276757. In diagnosing Mr. [REDACTED] with Level 1.5 Neurocognitive Impairment, Dr. [REDACTED] wrote:

This is a complex case. On one hand, Mr. [REDACTED] likely starts at a high cognitive baseline and he performed relatively well during portions of this evaluation. There may be symptom over-reporting based on the MMPI and MINI portions of his neuropsychological assessment. He likely has depression and insomnia of adequate severity to produce some degree of cognitive impairment.

On the other hand, neuropsychological testing performed by Dr. [REDACTED] demonstrated a significant decline in cognition compared to his estimated premorbid level of function. Numerous clinicians, including a senior neurologist at [REDACTED], have opined over the years that Mr. [REDACTED] demonstrated significant neurocognitive impairment. This is consistent with the FDG PET study which reportedly demonstrated hypometabolism in the frontal and temporal lobes, findings which are commonly used to support a diagnosis of dementia. The lack of significant abnormality on the amyloid PET scan only indicates that Mr. [REDACTED] is unlikely to be experiencing dementia due to Alzheimer’s Disease. (AD). Amyloid PET is unable to exclude the possibility of neurocognitive decline from conditions other than AD.

It is opined that Mr. [REDACTED] has significantly declined. His impairments are significantly dysexecutive, which is supported by the results of the FDG PET and are such that bedside cognitive tests are relatively insensitive. Although there are factors which are present, namely depression and sleep disorders, that may contribute to cognitive decline, these factors are considered inadequate to account for the entirety of Mr. [REDACTED]’s cognitive symptoms and certainly should not account for the cognitive abnormalities found on the recent valid neuropsychological tests.

Therefore, based on the above and according to the *NFL Concussion Settlement Program: Qualified MAF Physician Manual*, the following determination is provided for Mr. [REDACTED] with reasonable medical probability:

1.5 Neurocognitive Impairment.

Mr. [REDACTED] should be counseled that the results of this assessment should not be construed as providing the basis of a *clinical diagnosis*, as these opinions were generated under the criteria of legal proceedings. It is beyond the scope of this assessment to opine upon the underlying neuropathology of Mr. [REDACTED]’s probable neurocognitive impairment, except that it is unlikely to be due to Alzheimer’s Disease (supported by normal amyloid PET), Parkinson’s Disease, or amyotrophic lateral sclerosis (ALS).

Mr. [REDACTED] should become established with a local neurologist, ideally a behavioral neurologist, for the purposes of determining a clinical diagnosis and beginning an appropriate course of treatment. He should also aggressively pursue the appropriate mental health services, ideally under the oversight of a psychiatrist. While it can't be determined at this time how much functional improvement may occur with the successful treatment of his depression and insomnia, there would at the least be the expectation of general improvement in quality of life if Mr. [REDACTED]'s depression and sleep disorders improved.

Doc. 275145 (emphasis in original).

Based on this diagnosis, Mr. [REDACTED] filed a Claim on February 1, 2023. Doc. 276759. On February 26, 2023, an AAP Consultant provided the following input:

I see what Dr. [REDACTED] has done here. He has used the topf reading score which falls 1.33 standard deviations above the mean to establish a referent for all of the neuropsychological tests. In other words, he is saying that the premorbid expectation for every single test would be that it falls 1.33 standard deviations above the mean. If you were to translate that into a T score, he would be saying this player should score a 63 on every single subtest. He then calculates their T score according to the post-mediation procedures and determines the difference between that obtained t sore and a 63. He converts this difference back into standard deviation units and uses this to argue for 1.5 levels of impairment.

This is a very literal reading of language in the manual. We do not expect cognitive scores to be so highly correlated that they would all fall at the same score. Further this approach is remarkably discrepant from how the settlement has operated here to fore. Imagine if the player's reading score had been 1.33 standard deviations **below** the mean which would equate to a t score of 37. The player would then have to score below 20 across several T scores to qualify for an award. It is very hard to score below 20. Clearly, this is not how the settlement is operating.

I believe Dr. [REDACTED]'s creativity here in the interest of supporting an award is influenced by other clinical evidence that this player has cognitive impairments. But the scores the player obtains in nearly all domains are not generally consistent in the least, with the updated algorithms This in spite of the fact that the updated algorithms were liberalized relative to prior criteria when defining impairment for those with above average reading scores. I would note that the player does have evidence of impairment in the learning and memory domain according to Dr. [REDACTED], scores. I'm not sure why the portal didn't reflect that. I could not find a document showing the T scores generated by the portal software. In any event, I believe what Dr. [REDACTED] has argued here is not defensible in the broader context of how the settlement has operated.

Doc. 278099 (emphasis in original; paragraph breaks added).

In response, the Claims Administrator uploaded Mr. ██████'s neuropsychological testing results using the updated algorithms the AAP Consultant referenced. The scores revealed "No Impairment" in any of the five cognitive domains, and "No Impairment" overall. Doc. 278252.

On April 6, 2023, the AAP Consultant provided an updated version of the analysis from February 26, removing the previous statement that the "player does have evidence of impairment in the learning and memory domain," Doc. 278099, and again concluding that the "scores the player obtains in nearly all domains are not generally consistent in the least, with the updated algorithms." Doc. 280221. The AAP Consultant concluded again that "what Dr. ██████ has argued here is not defensible in the broader context of how the settlement has operated." *Id.*

The next day, the Claims Administrator issued a Notice of Denial of Monetary Award Claim. Doc. 280274. Although diagnostic criteria (i), "concern for severe cognitive decline," (iii), "functional impairment generally consistent with scores of 1.0 for the Clinical Dementia Rating (CDR) categories of Community Affairs, Home/Hobbies, and Personal Care," and (iv), "not exclusively due to delirium, acute substance abuse, or medication side effects," were fulfilled, criterion (ii), "evidence of moderate to severe cognitive decline in accordance with the standardized neuropsychological protocol in two or more cognitive domains," was not. *Id.* Criterion (ii) was lacking, the Claims Administrator explained, because:

An AAPC reviewed the testing and Dr. ██████'s explanation and indicated Dr. ██████ employed a non-standard method of scoring the neuropsychological evaluation, using an arbitrarily-determined reference based on the Player's Test of Premorbid Functioning (TOPF) reading score, and that Dr. ██████'s explanation was not defensible in the broader context of how the Settlement has operated.

Application of the New Method using an Above Average reading level based on the TOPF Word Reading score resulted in no impairment in Complex Attention, Learning/Memory, Executive Functioning, Visual-Perceptual Processing, and Language, and overall, no cognitive impairment. Therefore criterion (ii) is not fulfilled.

Id.

Mr. ██████ appealed the denial on June 7, 2023. Doc. 284058.

DISCUSSION

I am, as was the District Court in 2019, troubled by the frustrations and disappointments of Mr. ██████ and his family as they tenaciously navigate the Settlement's medical and legal rules. *See* Doc. 211047. I regret both the length and the obscurity of the review that Mr. ██████

experienced, particularly in the adjudication of his first Claim. I have laid that entire process bare to advance the Program's commitment to transparency and accountability.

This Appeal, however, concerns Mr. ██████'s second Claim. Mr. ██████ argues, contrary to the Claims Administrator's judgment, that his neuropsychological testing satisfies the Settlement's injury definitions. Doc. 284058. Mr. ██████ implicitly concedes, however, that under "a uniform analysis" of those injury definitions, his neuropsychological test scores do not qualify him for an Award. *Id.* As the NFL Parties point out:

To meet the criteria for Level 1.5 Impairment in the Complex Attention domain, the BAP protocol requires an individual with an Above Average reading level (like Mr. ██████) to attain 3 scores below a T score of 40, including 2 scores below a T score of 38. (Settlement Agreement, Ex. 1, § 4.) Here, Mr. ██████ did not attain even a single score below a T score of 40, and half of his scores in this domain represent a better than average T score. (██████ Report at 7 (T scores in the Complex Attention domain of 42, 46, 47, 51, 51, and 56).)

To meet the criteria for Level 1.5 Impairment in the Executive Functioning domain, the BAP protocol requires an individual with an Above Average reading level to attain either (i) 3 scores below a T score of 40, or (ii) 2 scores below a T score of 40 including 1 score below a T score of 33. (Settlement Agreement, Ex. 1, § 4.) In this domain, Mr. ██████, again, did not attain even a single score below a T score of 40. (██████ Report at 8 (T scores in the Executive Functioning domain of 41, 44, 47, and 59).)

Finally, to meet the criteria for Level 1.5 Impairment in the Learning & Memory domain, the BAP protocol requires an individual with an Above Average reading level to attain 3 scores below a T score of 40, including 2 scores below a T score of 38. (Settlement Agreement, Ex. 1, § 4.) In this domain, Mr. ██████ attained only one score below a T score of 38, with a single additional score below a T score of 40. (██████ Report at 8 (T scores in the Learning & Memory domain of 35, 38, 41, 45, 47, and 54).)

Doc. 287523 (paragraph breaks added).

Dr. ██████ did not follow the BAP cutoffs or methodology for determining impairment. Rather, he articulated a set of reasons why Mr. ██████'s results were generally consistent with them, as the Settlement permits.¹² Mr. ██████, joined by Class Counsel, argues that the Claims Administrator erred because Dr. ██████ and Dr. ██████ presented an articulated medical judgment that Mr. ██████'s "individual circumstances," namely his "IQ and Reading Level," justify the deviation from the BAP criteria. Doc. 284058. As Class Counsel's cogent brief highlights, Dr. ██████'s explanation was "unusually lengthy and thorough." Doc. 288531. In such a circumstance, Mr. ██████ states, "[w]hile an AAP consultant may disagree, the Qualified

¹² Settlement Agreement, Exhibit A-1 (1)(a)(b).

MAF Physician is ultimately responsible for evaluating the evidence of impairment and determining a final diagnosis.” Doc. 284058, at 4.

The NFL Parties oppose Mr. ██████’s Appeal. Doc. 287523. Acknowledging that “Settlement Program clinicians are afforded some degree of deference,” the NFL Parties argue that nonetheless, clinicians “cannot simply decide to eschew the Settlement Agreement’s clear requirements while claiming to be ‘generally consistent’ with those requirements.” *Id.* Responding to Class Counsel’s filing in particular, the NFL Parties further argue that “No matter how ‘lengthy,’ ‘detailed,’ or ‘thorough’ his justification, Dr. ██████ may not replace the Settlement Agreement’s criteria with his own *lower* standard.” Doc. 289529 (emphasis in original; internal citation omitted).

All parties thus seek to apply the Program’s two-step process for establishing general consistency.¹³ See Docs. 284058; 288531; 289529. That two-step system is founded on appreciation for articulated medical judgments.

Generally consistent does not mean the same [...] And yet, it would be a perverse result if every player diagnosed outside 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 go 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. What’s called for instead is the exercise of reasoned, individualized, clinical judgment [...]

Requiring a written explanation makes sense, as reasons tend to justify, enabling the Claims Administrator to defer to the judgment of the treating physician. That deference in turn promotes the Settlement’s global concern for speedy and equitable administration. The clinician need not offer [...] a “compelling argument.” Rather, it must be merely an *explanation*, i.e., an *accounting*, of why the clinician believed that the deviation was appropriate. It does need to satisfy the Claims Administrator, both as to its rationale and its completeness. Considering the Claims Administrator’s careful selection and training of MAF Physicians, and the Program’s desire to avoid excessive re-litigation of clinical choices, such satisfaction is, and should be, the customary response to *articulated* medical judgments.¹⁴

¹³ Special Master Ruling on Clinical Judgment on Generally Consistent Standard (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_judgment_sm.pdf.

¹⁴ *Id.* at 3 (emphasis in original; internal citation omitted).

When examining clinicians articulate their views with “care and fastidiousness,”¹⁵ the review process is unlikely to come to a contrary conclusion. As a matter of prudence and efficiency, the evaluation of articulated explanations ought to be limited:

Sometimes, that reviewing task will uncover facts that the examining clinician or physician missed, or errors in carrying out complex calculations. Correcting such mistakes (and making sure they do not recur) is one of the essential roles for the Settlement’s advisory medical experts. But there will inevitably be other instances—in which a reviewing AAP Member or Consultant’s own judgment will differ from that of the examining clinician. And in these instances, the Settlement asks its experts to perform a different, but vital and admittedly extremely challenging task: to advise the Settlement’s non-medical-expert decisionmakers on whether *another* medical professional’s articulated conclusion resulted from the exercise of a reasonably determined medical judgment.

This is the core deferential standard which applies to so much of the Program’s review processes. Clearly, the degree of (and justification for) deference will wax with the carefulness of the underlying reasoning. cursory reports will fairly provoke more skepticism than thoughtful assessments.¹⁶

So, the first question is whether Dr. █████ articulated his judgment with care and fastidiousness. I ultimately convened a panel of the neuropsychologists who advise the program—the AAPC. They determined—as Mr. █████ and Class Counsel’s briefs assert—that Dr. █████’s explanation was fully articulated. Doc. 292379. Dr. █████’s explanation was clear, and he laid out his logic for all to see. In this respect, his work was exemplary.

Nonetheless, the AAPC concluded that his report did not amount to a “reasonably determined” medical judgment, or to put it differently, was so out of joint with mainstream medical decision-making that they could not conclude it sufficiently supported the Diagnosis. *Id.* That AAPC appraisal, in turn, relied on a re-review of the underlying medical records performed by an advisory AAP Consultant on October 13, 2023. Doc. 290825. Noting the complexity of this case, the Consultant placed the “greatest weight on the most recent exam by Dr. █████” and concluded that “this former player does not meet Exhibit 2 neuropsychological criteria for Level 1.5 Neurocognitive Impairment.” *Id.* The Consultant explained that “Dr. █████’s judgment is wrong” because:

- i. It assumes that a person of superior premorbid intellect should perform in the superior range on all neuropsychological tests. A large and compelling scientific literature shows that this is simply not the case.

¹⁵ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 5 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

¹⁶ Special Master Ruling on Stroke Definition, at 9 (Apr. 25, 2021), https://www.nflconcussionsettlement.com/Docs/stroke_sm_2.pdf (emphasis in original; paragraph break added).

- 1) For some tests with low score ceilings (e.g., BDAE Complex Ideational Material, Boston Naming Test), there's no such thing as superior performance.
 - 2) This makes Dr. [REDACTED]'s labelling of T-score as high as 46 "abnormal" for this patient simply erroneous.
- ii. Dr. [REDACTED]'s method would make it virtually impossible for a former player with a very low TOPF score to meet criteria for impairment.
 - iii. It substitutes the standardized, current method for accounting for premorbid cognitive functioning (i.e., different cut-offs for below-average, average, and above-average TOPF reading scores) for one that has not heretofore been used, tested, or vetted by experts.

Id.

The consensus AAPC adopted this bottom-line, stating:

[T]here was agreement among the AAP consultants that Dr. [REDACTED]'s reasoning was not "reasonably determined." His substituted method of determining impairment on each neuropsychological test assumes that the expected score for each test is as high as the patient's TOPF reading score (Standard Score = 120).

This is an untenable position and is inconsistent with authoritative neuropsychological literature.¹⁷ It ignores the lack of perfect correlation between neuropsychological test scores, the nonnormal distribution of many test instruments (i.e., some have low ceilings), and different standard error of measurements. Since Dr. [REDACTED] makes assumptions that are factually inaccurate, his interpretation of the patient's performances as deficits cannot be described as "reasonably determined." Therefore, the qualifying diagnosis is not supported.

Doc. 292379 (paragraph break added, footnotes cleaned up).

My role on Appeal, applying the "clear and convincing" evidentiary standard and advised by independent medical experts, is generally to ensure the actors in the review system operate consistently and according to transparent rules, while faithfully carrying out the Settlement's agreed-to procedures. Given the care and fastidiousness evident in Dr. [REDACTED]'s report and Dr. [REDACTED]'s covering memo, the Reviewers should have—and I believe did—approach the question of the sufficiency of Mr. [REDACTED]'s neuropsychological testing aiming to defer to his doctors. But contrary to Mr. [REDACTED]'s argument that deference to "the consistent diagnoses of two highly-trained medical professionals [...] is appropriate and necessary," Doc. 284058, Judge

¹⁷ Russell, E.W. (2001). Toward an explanation of Dodrill's observation: High neuropsychological test performance does not accompany high IQs. *The Clinical Neuropsychologist*, 15, 423-428; Diaz-Asper, C.M., Schretlen, D.J. & Pearlson, G.D. (2004). How well does IQ predict neuropsychological test performance in normal adults. *Journal of the International Neuropsychological Society*, 10, 82-90.

Brody wrote last year that “deference is not the same thing as blind and automatic acceptance.”¹⁸ One can put a thumb heavily on the scale and still find a treating clinician’s medical judgment wanting.

The AAPC, following my explicit direction, asked itself if there were errors in Dr. [REDACTED]’s views that were so basic and foundational as to render his determinations unreasonable.¹⁹ That is, not (as the singular Consultant loosely put it) was Dr. [REDACTED] “wrong,” but did he reach a conclusion that fell within a wide, reasonable, span. This “reasonably determined” criterion is the most deferential standard of review outside of automatic acceptance.

Applying that heavily deferential standard, the AAPC advised me that by assuming equivalence between testing results which are not expected to produce the same levels of deficiency, Dr. [REDACTED] made a fundamental, logical error, which made it impossible to conclude that his opinion was a reasonably determined medical judgment. And they warned that adopting Dr. [REDACTED]’s logic could lead to perverse outcomes for Claimants with low Test of Premorbid Functioning scores. I take that concern for equitable treatment across Claimants seriously—it advances the core purpose of the generally consistent test—and appreciate that the AAPC made it explicit in its review.

Having reviewed the record with care, it appears undeniable that Mr. [REDACTED] is experiencing real illness and dysfunction. But as his treating physician, Dr. [REDACTED], put it, there is a difference between a “clinical diagnosis” and what can satisfy the “criteria of legal proceedings.” Doc. 275145. The question for this Appeal is narrow and technical: do Mr. [REDACTED]’s medical records sufficiently support his second Claim—of a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment—so as to demonstrate that its denial was wrong, by clear and convincing evidence?

I adopt the AAPC’s view that Dr. [REDACTED]’s articulated judgment was not reasonably determined, and that therefore Mr. [REDACTED]’s medical records do not sufficiently support his Diagnosis. For that reason, I cannot agree with Mr. [REDACTED] that there is clear and convincing evidence of error in his second Claim’s denial.

CONCLUSION

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

Date: November 30, 2023



David A. Hoffman, Special Master

¹⁸ ECF No. 11931, Explanation and Order Denying 11813 Motion for Relief (Dec. 27, 2022), at 6.

¹⁹ As Dr. [REDACTED]’s note endorsed Dr. [REDACTED]’s reasoning, the two rise and fall together.