

**UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

:
: No. 2:12-MD-02323-AB

:
: MDL No. 2323

:
: **HON. ANITA B. BRODY**

THIS DOCUMENT RELATES TO:
APPEAL OF SETTLEMENT CLASS
MEMBER [REDACTED] [REDACTED]
REGARDING DENIAL OF
MONETARY AWARD

INTRODUCTION

[REDACTED], 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. [REDACTED]'s Claim, determined that his Diagnosis was not generally consistent with the criteria for Level 1.5 Neurocognitive Impairment.

Mr. [REDACTED] appeals that Denial, and Class Counsel has filed a supporting statement. I grant his Appeal, finding that he has shown, by clear and convincing evidence, that the Claims Administrator erred in its determination.

CLAIM HISTORY

This is Mr. [REDACTED]'s first Claim. Doc. 284872. It results from evaluations by Qualified MAF neurologist Dr. [REDACTED] and Qualified BAP neuropsychologist Dr. [REDACTED]. Doc. 284795.

On February 14, 2022, Dr. [REDACTED] examined Mr. [REDACTED] and found that he "appear[ed] to have significant dementia." *Id.* at 3. Dr. [REDACTED] reported that Mr. [REDACTED]:

complains of memory problems. He states that he stopped driving 3 years ago because of shakiness, headaches, blurred vision, difficulty with directions and difficulty reading signs. He rides a bicycle.

He is essentially unemployed. He occasionally does yard work. He occasionally has 'gigs' as a security guard for night clubs. According to his friend . . . he occasionally

‘helps out’ at another friend’s carwash. He stopped doing construction work 3 years ago . . . [H]e worked for a construction company for approximately 6-7 months, and they ‘just never called him back.’

Id. at 1.

Dr. [REDACTED] also reviewed the Third-Party Sworn Statement from Mr. [REDACTED]’s childhood friend, [REDACTED]:

[Per Mr. [REDACTED], Mr. [REDACTED] was having problems with directions even 7-8 years ago. Mr. [REDACTED] states that the patient has not driven for 6-7 years . . . [h]e was previously very social, but now only interacts with a few friends. He rambles and repeats himself. Mr. [REDACTED] helps him with doctor’s appointments . . .

When he was working in construction ‘he’d always easily get off track,’ ‘just couldn’t stay on task’ and the company ‘didn’t want [REDACTED] to get hurt while on the job.’ Mr. [REDACTED] helps him with washing his clothes once or twice a week. Mr. [REDACTED] has had to remind him to shower and to change his clothes. Mr. [REDACTED] also helps him with cleaning his house. Mr. [REDACTED] states that recently Mr. [REDACTED]’s water and electricity were turned off, and he had to go ‘to the gym to take a shower.’

Id. (breaks added).

Dr. [REDACTED] extensively discussed Mr. [REDACTED]’s history of mental illness. He wrote that Mr. [REDACTED] “reports depression and suicidal thoughts.” *Id.* Additionally, he noted that Mr. [REDACTED] “had a fluctuating mood during the interview/exam: at times he seemed anxious and talked very rapidly with ‘flight of ideas,’ but during most of the interview/exam he was relatively calm with relatively normal paced speech.” *Id.* at 2.

He also reported that Mr. [REDACTED] “is apparently not under psychiatric care at present . . . has not taken Adderall or olanzapine for approximately 1 year . . . [and] needs psychiatric follow-up particularly in light of the suicidal thoughts.” *Id.* at 3. Ultimately, Dr. [REDACTED] concluded that Mr. [REDACTED] “appears to have significant dementia; however, he *also* has significant psychiatric illness.” *Id.* (emphasis added).

Dr. [REDACTED] then indicated that he needed to review Mr. [REDACTED]’s “previous neuropsychological evaluations from 2016 and 2019 . . . his previous BAP evaluation, [and] any neurological office records and the results of any previous brain imaging,” before certifying a diagnosis for this Settlement Program. *Id.*

On January 31, 2023, Dr. [REDACTED] conducted a neuropsychological exam and found that Mr. [REDACTED] displayed Level 1 Impairment in Complex Attention & Processing Speed, Level 1.5 Impairment in Learning and Memory, and Level 1.5 Impairment in Executive Functioning, for an overall impairment of Level 1.5. *Id.* at 16.

“In terms of Activities of Daily Living,” she wrote:

[H]e sometimes forgets to shower, shave or brush his teeth. He said that last year this happened for three days in a row. He does not feel that it is so bad that he has to be reminded by others, but he may skip a day or two of personal hygiene habits. In terms of chores, he needs help with cleaning and upkeep, and paying bills because he forgets to pay and mismanages money.

He said he was homeless for a couple of weeks. He lost his truck in a tornado in Louisiana as well. He has problems with organization and following through, i.e. saying he will take food out of the fridge and then forgets to cook it. He goes shopping by himself, but he will forget things, so it is better if someone else goes with him. He has lost interest in all hobbies except for going to the gym and he does that. He can see people socially on his own, though he tends to stay withdrawn.

He needs his GPS when he drives, and he does not trust himself to use power tools or weapons because he forgets the safety protocols. He is not able to work and has not been able to maintain jobs.

Id. at 7 (breaks added).

Describing Mr. [REDACTED]’s behavior during the examination, Dr. [REDACTED] reported that his:

[r]eceptive language skills appeared limited. He showed impatience with long instructions but then needed them repeated often . . . Thought processes were at times not logical, but there was no evidence of hallucinations. He reported feeling somewhat concerned others are watching him . . . His attention span was limited. His immediate, recent and remote memory appeared limited. His insight and judgment were limited. His reaction to perceived failure was to express concern about his mind, i.e. ‘I lost my damn mind!’

Id. at 11.

During the exam, Dr. [REDACTED] administered all five ACS tests, as well as the TOMM and the Victoria Symptom Validity Test. *Id.* at 16-18. Mr. [REDACTED] scored optimally on all. *Id.* at 19. She also completed a *Slick* criteria checklist and found none triggered. *Id.* at 18-19.

Overall, in concluding that Mr. [REDACTED]’s tests were valid, Dr. [REDACTED] wrote that he “appeared to put forth and maintain good effort. Occasionally, he would give the correct answer and then change his answer, but his overall effort appeared intact and he passed stand alone and embedded measures of effort. His profile was consistent with presentation and reported difficulties.” *Id.* at 20.

Dr. [REDACTED] also discussed Mr. [REDACTED]’s mental illness at length. She described Mr. [REDACTED]’s self-reported feelings:

Emotionally, he said, 'It's up and down.' . . . He reported feelings of sadness, crying/feeling more emotional, loss of interest, social withdrawal, loss of motivation, anxiety, panic attacks, and claustrophobia. He described manic episodes, saying he has racing thoughts and that his speech gets 'choppy and pressured.' He said he feels sped up at times.

During these times, he spends too much money on marijuana. He also said he became dependent on pornography. He has trouble sleeping, only obtaining about 4 hours a night, along with increased irritability, and some feelings of invincibility. This used to be followed by periods of depression so severe he would stay in a dark room and not leave the house. Now he said he is functioning with it and goes to the gym.

Id. at 6. (breaks added)

Dr. [REDACTED] also enumerated Mr. [REDACTED]'s psychiatric symptoms:

In terms of hallucinations, he said, 'I think I'm gifted.' He has internal conversations with himself, but denied auditory hallucinations. He feels concerned that people are watching him, saying he 'feel like eyes always on me.' He is always wondering what others are thinking, what their intentions are and what they could do to him. He stated he always has a knife or gun on him, because he wants to be able to defend himself. He feels he has to be aware and be vigilant. He tends to overthink things and said he gets tired of that.

When asked about social anxiety, he said he is not anxious around others, but said 'I'm the person people should be afraid of,' and said 'I can get boisterous' when it comes to expressing himself. He is convinced he will die of a self-inflicted gun shot wound or shooting by someone else, or death by cop. He denied any current suicidal and homicidal ideation, but admitted that he has had some in the past, as recently as three or four weeks ago.

In terms of suicide, he thinks about shooting himself or driving high speeds into a tree or traffic. He also said that at times he can understand the mind of a mass shooter. The homicidal thoughts come and go and he calls the NFL hotline a lot when he feels that way . . .

Id. at 6-7. (breaks added)

She took a comprehensive psychiatric history, relaying that:

When [Mr. [REDACTED]] was in Florida in 2016 and 2017, he said some things to a therapist and was involuntarily committed to the hospital for three days. He said he

was talking to a psychologist and said something about killing some racist cops and the police came and took him to the hospital. He had to tell people that he was not suicidal and not going to kill someone . . .

He stated that a doctor told him he had ADHD and bipolar and placed him on Abilify for 30 days. He gained weight and it increased his blood pressure, so he said he is not taking that medication again . . .

He was hospitalized in Jacksonville, Florida involuntarily in 2016, and in New Orleans. He has been in rehabilitation centers several times . . . [o]f note, he gave several different versions of the number of times he was hospitalized and when, which was demonstrative of his lack of clarity in thought and memory, and disorganized speech.

Id. at 7. (breaks added)

Dr. [REDACTED] also conducted the Mini International Neuropsychiatric Interview, finding that Mr. [REDACTED] met the criteria for 1) major depressive episode, recurrent, with melancholic features 2) high suicide risk; 3) current manic episode; 4) substance abuse and substance dependence, current; and 5) mood disorder with psychotic features. *Id.* at 20. She summarized these findings, concluding that:

Though the MMPI-2-RF is invalid, the profile is consistent with someone experiencing severe psychological distress, typical of bipolar and other psychotic/ thought disorders, and consistent with his self report. In the clinical interview, he expressed hallucinations, delusions, suicidal and homicidal thinking . . .

He has been involuntarily hospitalized before and became very angry at the therapist that called the police. He has thoughts of hurting people who he feels have wronged him. He refuses to take medication, but admits that he needs a therapist . . .

Id. at 21. (breaks added)

When describing limitations to testing, Dr. [REDACTED] noted that Mr. [REDACTED] has an “untreated psychosis/thought disorder, and uses marijuana on a regular basis.” *Id.* at 11.

Ultimately, Dr. [REDACTED] concluded that Mr. [REDACTED] displayed Level 1.5 Neurocognitive Impairment. *Id.* She immediately followed this diagnosis with another acknowledgment of his mental illness, concluding her report by writing:

The patient *also* has a severe thought disorder, with a history of suicidal and homicidal ideation, and repeated thoughts around his belief that he will die of a gun shot wound, either self-inflicted, or by someone else or even death by cop. He was

strongly encouraged to find a therapist now that he has moved to the Atlanta area. He refuses to take medications . . .

Id. (emphasis added). Dr. [REDACTED] then recommended a psychiatrist in the Atlanta area “who works with brain injured patients who have mood, thought, and behavioral disorders as a result of brain injury.” *Id.*

On May 28, 2023, Dr. [REDACTED] reviewed Dr. [REDACTED]’s neuropsychological evaluation and assigned Clinical Dementia Rating (CDR) scores of 1 in Community Affairs, 2 in Home and Hobbies, and 1 in Personal Care. *Id.* at 3. Dr. [REDACTED] also found that Mr. [REDACTED] displayed Level 1.5 Neurocognitive Impairment with a diagnosis date of January 31, 2023, the date of Dr. [REDACTED]’s exam. *Id.*

On August 9, 2023, an Appeals Advisory Panel (AAP) Consultant reviewed Dr. [REDACTED]’s neuropsychological evaluation to assess validity, given that Dr. [REDACTED] had not administered all performance validity tests. Doc. 287250. The AAP Consultant reported “no concerns about test validity,” noting that “the tests that were administered . . . are more than sufficient to indicate that the patient was trying his best.” *Id.* at 2.

On its own motion, the AAP Consultant then raised “concerns about the role of untreated psychosis as the basis for [Mr. [REDACTED]]’s cognitive and functional impairment.” *Id.* Acknowledging that mental illness does not invalidate a claim for benefits, the AAP Consultant nonetheless “recommend[ed] deferring neurocognitive diagnosis until such time as the patient’s mental illness is effectively treated.” *Id.*

On December 14, 2023, the Claims Administrator requested information from Mr. [REDACTED] during a sufficiency review of his Claim. Doc. 297353. It asked Mr. [REDACTED] to explain why his LinkedIn profile stated that he worked for a construction company between 2018 and 2021, when Dr. [REDACTED] and Mr. [REDACTED] reported that he only worked in construction for six to seven months. *Id.* The Claims Administrator also asked Mr. [REDACTED] to provide a “detailed description of [his] driving activities” and to explain an Instagram post of himself wearing an [REDACTED] shirt. *Id.*

Mr. [REDACTED] submitted his responses to these questions through counsel on December 19, 2023. Doc. 297467. He explained that he worked in construction seasonally, recounting that:

From what I can remember, I worked probably five months’ worth of work, give or take. Meaning, I could work 2 weeks one year and then not work again until the following year. When I worked, my duties were to assist with cleaning up the area . . . [a]lso, I would assist in passing one brick at a time while standing in line passing down the line and watching them on the conveyor belt go down the line. I also aimed a small water house in a bucket to harden cement then an operator would pick it up with [a] machine and place it in the hole.

Id.

As for his driving activities, Mr. ██████ replied:

At the time of my appointment with Dr. ██████, I was no longer driving and didn't have a car. I rode my bicycle everywhere . . . [i]n the beginning of 2023 . . . I moved to Atlanta . . . When I saw Dr. ██████, I had started driving but only a little bit here and there. I definitely use GPS while driving, I look for landmarks and use the GPS but I still miss my turns. I have no sense of direction anymore and I am a very slow driver because of this. I currently drive 4 days a week to and from work and to the gym. I go to the gym, so I don't blow my brains.

I do not have a valid driver's license and am trying to relearn how to take and pass the test. I have not been successful. I drive a Chevy Equinox that my brother signed for but that I pay for. I basically bought the car, so I have a place to live. I periodically become homeless and so I at least have a place to sleep and shower (the gym). I need help to get around and to drive whenever I try to drive. I'm trying to drive, just not that good anymore cause of issues with CTE and thinking while driving.

Id. (breaks added).

Finally, Mr. ██████ reported that, at the time he answered the questions (i.e., in late 2023), he worked for ██████ as a "security guy watching the cameras." *Id.* He added that he was "constantly getting help from [his] colleagues and coworkers on all duties." *Id.*¹

On March 23, 2024, the AAP Leadership Council conducted a consensus review of Mr. ██████'s Claim. Doc. 317997. The AAP Leadership Council agreed that Mr. ██████ had satisfied criterion (i) and (iv) for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. *Id.* But it simultaneously denied that he had fulfilled criterion (ii) or (iii). *Id.*

Regarding criterion (ii), the AAP Leadership Council took issue with Dr. ██████'s discussion of Mr. ██████'s mental illness in her report. *Id.* at 1. The AAP Leadership Council acknowledged that Dr. ██████ "indicated awareness of the Player's psychiatric problems" by reporting Mr. ██████'s "feelings of sadness, crying, anxiety, panic attacks, and manic episodes" as well as his history of psychiatric treatment and hospitalizations. *Id.* at 2.

But the AAP Leadership Council also found that:

Dr. ██████ . . . reported that the Player's thought process was not logical at times and listed untreated psychosis/thought disorder as a limitation of the testing. Additionally, in the 'Summary and Discussion' section, Dr. ██████ discussed that the

¹ Throughout, the AAP and others refer to this process as an audit. This is not exactly accurate. Rather, it was the Claims Administrator's normal process of establishing the sufficiency of Claims, which occasionally involves gathering information and clarifying otherwise confusing or inconsistent facts in the filed documentation.

Player had a severe thought disorder, a history of suicidal/homicidal ideation, was strongly encouraged to find a therapist, and refused to take medications; and Dr. [REDACTED] also noted that the Player could also see a psychiatrist . . . that the Player had been hospitalized 4-5 times without success, that the Player needed a treatment plan, and stated that the Player and his attorney would be given a list of names and that she hoped the Player would choose someone before his situation worsened.

Id. at 2. (breaks added)

The AAP Leadership Council went on:

Consequently, the examining neuropsychologist's consideration of the psychiatric symptoms seemed to indicate a current and ongoing severe thought disorder rather than indicate that the psychiatric condition had been excluded as a current etiology for the cognitive decline. Consequently, the AAPC recommendation that a neurocognitive diagnosis be deferred until such time as the patient's mental illness is effectively treated seems reasonable and prudent. Therefore criterion (ii) is not fulfilled based on the currently available information.

Id. at 2.

With regard to criterion (iii), the AAP Leadership Council first evaluated Dr. [REDACTED]'s consideration of Mr. [REDACTED]'s mental illness in his assignment of CDR scores, finding it adequate. *Id.* at 2-3. It noted that "the Settlement did not require the exclusion of psychiatric etiologies for functional loss and that a Diagnosing Physician's articulated consideration of confounding factors [i]s typically sufficient to establish the impairment . . ." *Id.* Since Dr. [REDACTED] "did indicate awareness of the Player's psychiatric symptoms," the AAP Leadership Council found that he met this standard. *Id.* at 3.

The AAP Leadership Council then went on to consider the impact of Mr. [REDACTED]'s responses to the audit questions.² *Id.* Here, it found issues, writing:

[T]he new/additional information from the audit . . . included descriptions of the Player's improved ability to work, drive, and exercise at a gym which would be consistent with a higher level of functioning for the CDR category of Community Affairs, such as a rating of 0.5 rather than 1.0.

Additionally, it is medically improbable that the improvement would be restricted to just Community Affairs or that someone could continue to function well enough to be employed and drive for several years while continuing to be so significantly impaired in the other relevant CDR categories (Home/Hobbies and Personal Care), and consequently it reasonable to assume that similar improvements in functioning

² Again, there was no noticed audit, merely the ordinary process of establishing the sufficiency of a claim. For purposes of expositional clarity, I'll preserve the references to an "audit" in the text, as others have in the claims process.

would also likely have affected the Player's abilities in Home/Hobbies and Personal Care. Consequently, criterion (iii) would no longer be fulfilled.

Id.

On April 25, 2024, the Claims Administrator largely adopted the AAP Leadership Council's conclusions and denied Mr. [REDACTED]'s Claim. Doc. 323395. In the Notice of Denial, the Claims Administrator reiterated the AAP Leadership Council's finding that criterion (ii) was not fulfilled because Dr. [REDACTED]'s "consideration of the psychiatric symptoms seemed to indicate a current and ongoing severe thought disorder rather than indicate that the psychiatric condition had been excluded as a current etiology for the cognitive decline." *Id.* at 2.

The Claims Administrator then found that Mr. [REDACTED] failed to satisfy criterion (iii), because the "later-arriving evidence . . . reveals a pattern of behavior inconsistent with a diagnosis of dementia, which, together with the absence of any explicit attempt to isolate the role of cognitive loss as opposed to other factors, materially undermines Dr. [REDACTED]'s conclusions about functional impairment." *Id.* at 3.

Mr. [REDACTED] timely appealed on July 3, 2024. Doc. 346810.

After the parties briefed this Appeal, I requested another AAP Consensus Review. Doc. 378763. I asked the AAP Leadership Council to reconsider its analysis again in light of my October 16, 2023 ruling. It now wrote:

In her discussion of the findings, Dr. [REDACTED] clearly articulates her considerations of the Player's psychiatric condition and its relationship to his performance on the cognitive tests. The Special Master's decision . . . includes the explicit notation 'The effects of mental illness on a Player's neuropsychological testing are not clear and convincing evidence of error when . . . the neuropsychologist has accounted for those effects in her thorough and . . . reasonable analysis.' The player's appeal appropriately asserts that the Settlement Agreement does not require a player to prove the cause of cognitive loss.

Id.

The AAP Leadership Council then argued that Mr. [REDACTED] had not sufficiently demonstrated that his tests were valid. Specifically, it found that:

[F]ollowing Dr. [REDACTED]'s and Dr. [REDACTED]'s evaluations, additional information was obtained regarding the player's mental health and its impact on his abilities. At the time of the clinical evaluations, the player was 'essentially unemployed' and 'stopped driving 3 years ago.' However, information obtained through audit . . . identified the player's condition had improved by 2023 to the degree that he was

able to work, drive independently, pay for a vehicle, and use a gym for both exercise and personal care . . .

[T]he settlement agreement requires that a ‘Player’s test data is a valid reflection of his optimal level of neurocognitive functioning.’ While the data collected by Dr. [REDACTED] were not associated with significant failures on performance validity tests, the differences in daily ability between what was reported to her and Dr. [REDACTED], and the information derived during audit, suggest that the tests did not reflect ‘his optimal level of neurocognitive functioning.’

Id.

Therefore, per the AAP Leadership Council:

Both Dr. [REDACTED] and Dr. [REDACTED] recommended treatment of the player’s psychiatric issues, and the improvements in cognitively mediated daily activity from July 2022 ([REDACTED]) and January 2023 ([REDACTED]) to the audit responses of December 2023 indicate that the findings from the earlier dates did not reflect the player’s ‘optimal level of neurocognitive functioning.’

Id.

RESOLVING THIS APPEAL

It’s evident from the medical records before me that Mr. [REDACTED] is very ill. He experiences memory loss and struggles to converse and follow directions. He is periodically homeless, strains to maintain his personal hygiene and works sporadically in rudimentary jobs. He drives illegally, because he has not passed a driver’s test. No one questions that his neuropsychological test scores, found valid by both his Diagnosing Physician and an AAP Consultant, support a finding of Level 1.5 Neurocognitive Impairment.

And yet the Claims Administrator, after an exhaustive and careful analysis, denied his Claim. It did so guided by independent medical reviewers convinced both that Mr. [REDACTED]’s mental illness could be responsible for his apparent cognitive losses, and that late arriving evidence of function was inconsistent with his doctors’ reports. I appreciate the fastidiousness of this approach.

Nevertheless, I conclude that it was in error. I will take criterion (ii) and criterion (iii) in reverse order.

1. Criterion (iii): Functional Impairment

The Claims Administrator denied that Mr. [REDACTED] had satisfied criterion (iii) because his audit responses revealed an “improved ability to work, drive, and exercise at a gym” consistent

with a level of functioning of 0.5, rather than 1.0, in Community Affairs, and it would be “medically improbable” that this improvement would be restricted to just this CDR category. Doc. 323395 at 3. It thus concluded that:

This later-arriving evidence, of which the Player has been given notice and opportunity to respond, reveals a pattern of behavior inconsistent with a diagnosis of dementia, which, together with the absence of any explicit attempt to isolate the role of cognitive loss as opposed to other factors, materially undermines Dr. [REDACTED]’s conclusions about functional impairment.

Id.

Ultimately, this conclusion rests too heavily on—and makes unwarranted inferences from—facts gathered after the Claim’s submission.

Overreliance on evidence that seems to indicate a post-diagnosis change in a claimant’s function does not promote accuracy, but, rather, threatens it. Of course it’s true that “the Settlement contemplates degenerative conditions,” and thus it’s natural that facts suggesting post-Claim functional improvement raise red flags about whether Diagnoses were accurate. But it’s important not to generalize from anecdotes of ambiguous import: “it is common sense that humans, even sick ones with increasingly limited cognitive function, may sometimes have better and worse days.”³

Within the Settlement’s system of claim verification, later-arriving evidence of function has less probative value than contemporaneous evidence. It “both raises problems of administrability (with layers of collateral briefing about what it ‘really’ shows) and probative value . . . the Settlement Agreement’s appeals process is not intended to be an inquisitorial one, designed to nitpick the BAP and MAF physicians’ clinical judgment. Rather, it is built around layered deference to expertise.”⁴

Moreover, unrestrained reliance on late arriving evidence would be at odds with one of my most important charges as Special Master: “to make sure that claims administration is both fair and efficient.”⁵ In fact:

[i]f applied indiscriminately, post hoc review threatens to open up every claim to indefinite inspection, with pernicious systemic effects which the drafters of the Settlement did not contemplate. Dignity, finality and efficiency are values that count alongside accuracy in this Program, which exists to remedy the harms of a class of vulnerable, proud, individuals.

³ Special Master Ruling on Post-Diagnosis Evidence, at 4 (June 8, 2020) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=post_diagnosis_evidence_sm.pdf.

⁴ Special Master Ruling on Pre-Diagnosis Evidence, at 4, 6 (Jul. 2, 2020) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=pre_diagnosis_evidence_sm.pdf.

⁵ Special Master Ruling on Validity Testing, External Evidence, and Functional Impairment, at 20 (Mar. 27, 2023) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_evidence_impairment_sm.pdf.

Privileging perfect processes to the detriment of good-enough ones leads to repeated, invasive, inconclusive audits, and multiple trips around the claim review round-about . . . [this] is not what the drafters of the Amended Class Action Settlement intended, nor is it what the Class deserves.⁶

Accordingly, late arriving evidence should be used to undermine (or buttress) a Diagnosing Physician's clinical judgment only rarely.

Here, Mr. ██████'s Claim was not sent into a formal audit. The Claims Administrator did not find that he materially misstated or omitted information. Rather, it used late arriving evidence to find Mr. ██████'s Claim insufficiently supported. It justified this action by noting that in a "March 27, 2023 ruling [the Special Master held that] it is permissible for the Claims Administrator to consider [late arriving evidence]." Doc. 323395 at 3.

My March 27, 2023 ruling offers an exception that illustrates the rule.⁷ There, the Claims Administrator learned that a Player diagnosed with Level 2 Neurocognitive Impairment hosted a weekly podcast for over seventy episodes.⁸ It also found that the Player "reported often golfing twice a week" and had petitioned a court for an occupational license after reporting he did not drive.⁹ During an audit, the Claims Administrator found that the Player "still golf[ed] regularly, participate[d] in charity basketball, and attend[ed] events in different states."¹⁰

When finding that the Podcast Evidence materially undermined the Diagnosing Physician's conclusions about functional impairment, I stressed that it was a "rare case."¹¹ It was only because his diagnosis of Level 2 Neurocognitive Impairment—suggestive of "profound" injury¹²—was so at odds with the late arriving evidence did I find it fair to question the Diagnosing Physician's contemporaneous clinical findings.¹³

I also addressed the use of the late arriving evidence to impeach the validity of the Player's neuropsychological testing, once again insisting that the practice was exceptional. "To be clear," I began, "simply because the record is open for later-arriving evidence does not mean that it has the same probative weight as information contemporaneous with the Diagnosis."¹⁴ I continued:

⁶ *Id.* at 24-25. (breaks added)

⁷ The NFL Parties argue that my concerns about later-arriving evidence should be ameliorated here because December 2023 is fairly close to January 2023, when Dr. ██████ completed her examination, and because Mr. ██████ himself provided the relevant information and had the opportunity to contextualize it. It's true that if there were significant differences in what he told the Claims Administrator and what he told Dr. ██████ in the same year, it would raise red flags. But as I explain above, having reviewed the record, I do not agree that's what happened here.

⁸ *Id.* at 4.

⁹ *Id.* at 11.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.* at 8.

¹³ *Id.* at 11.

¹⁴ *Id.* at 25.

Both the Claims Administrator and the AAPC should and do have a prior belief that any later-arriving evidence will not disturb the clinical impressions formed by examining physicians. They should and do defer to those examiners especially when they have considered evidence like it . . . And Reviewers should and do discount the probative value of evidence gathered post-Diagnosis—without a contextualized foundation—and are rightly wary of allowing a few pieces of evidence to be determinative.

Overall, the Claims Administrator should only second-guess a Diagnosis using later-arriving evidence if it generates a substantial and material update to the contemporaneously generated prior belief. Under my authority as Special Master, I have directed the Program’s reviewers publicly and privately that singular pieces of later-derived evidence should rarely, if ever, impeach a fully-articulated diagnosis by one of the Program’s clinicians or physicians.¹⁵

Accordingly, only because the Podcast Evidence created the “extraordinarily rare case[] where a pattern of behavior post-Diagnosis [was] so discrepant with the story told to the clinician” did I find it “fair to question if the test scores were valid estimates of functioning.”¹⁶

The record evidence here introduces no such discrepancy. In fact, Mr. ██████’s answers to the Claims Administrator’s questions were not (importantly) factually at odds with what he reported to his doctors.

First, addressing Mr. ██████’s work history. Dr. ██████ and Dr. ██████ both understood that Mr. ██████ sometimes worked, because Mr. ██████ had made fairly complete disclosures to them. Dr. ██████ found that Mr. ██████ “is essentially unemployed. He occasionally does yard work. He occasionally has ‘gigs’ as a security guard for night clubs.” Doc. 284795 at 1. Dr. ██████ found that “he is not able to work and has not been able to maintain jobs.” *Id.* at 7.

In his audit response, Mr. ██████ explained that he worked seasonally for a construction company “cleaning up,” “passing one brick” down a line, and aiming “a small water house in a bucket.” Doc. 297467. At the time of the audit, he was working as a “security guy watching the cameras.” *Id.* In briefing this Appeal, Mr. ██████’s counsel related that Mr. ██████ was terminated from this role after less than a year of employment. Doc. 346776 at 4.

These responses are not “so discrepant” with the picture painted in the clinical reports—indeed, just as Dr. ██████ indicated, Mr. ██████ works only sporadically. When he is employed, he completes rudimentary tasks. While Dr. ██████ reported that Mr. ██████ “is not able to work,” she attributed this to his inability to “maintain” jobs, which remains accurate—Mr. ██████ is consistently laid off. Accordingly, he “periodically become[s] homeless.” Doc. 297467.

Because this evidence is altogether consistent with Mr. ██████’s work history as reported by Dr. ██████ and Dr. ██████, it was improperly used to deny his Claim.

¹⁵ *Id.*

¹⁶ *Id.*

Second, turning to Mr. ██████'s driving activities. In his audit response, Mr. ██████ explained that he began driving after a six-to-seven-year break around when he saw Dr. ██████. *Id.* Per Mr. ██████, he must use a GPS when driving because he has “no sense of direction anymore.” *Id.* Mr. ██████ also disclosed that he drives without a valid license. *Id.*

Again, this evidence falls far short of the Podcast Evidence. Driving without a license hardly proves function—if anything, Mr. ██████'s failure to renew his license suggests he *cannot* safely drive a vehicle. Mr. ██████ also reported his driving activities to Dr. ██████, who specifically noted that Mr. ██████ “needs his GPS when he drives.” Doc. 284795 at 7. Dr. ██████, meanwhile, reviewed Dr. ██████'s report *before* assigning CDR scores. *Id.* at 3.

Third, addressing Mr. ██████'s ability to exercise at a gym. In Mr. ██████'s words, he joined a gym so he doesn't “blow his brains.” Doc. 297467. Moreover, when he is homeless, the gym provides a place to shower. *Id.*

The Claims Administrator found that this evidence undermined the level of functional impairment reported by Dr. ██████. I am not persuaded. Again, Mr. ██████'s later responses are mostly consistent with what he told his doctors. Dr. ██████ reported that “[h]e has lost interest in all hobbies except for going to the gym.” Doc. 284795 at 7. She also noted that Mr. ██████ copes with his depression by exercising at the gym. *Id.* at 6.

Furthermore, Dr. ██████ relayed Mr. ██████ report that when Mr. ██████'s water was turned off, “he had to go ‘to the gym to take a shower.’” *Id.* at 1. Thus, on a pure factual level, Mr. ██████'s audit responses do not contradict the contemporaneous clinical findings of his physicians and cannot serve as justification for undermining Dr. ██████'s assessment.

In sum, the later-arriving evidence is generally consistent with what he told his examining clinicians.¹⁷ Those clinicians concluded that he was nevertheless impaired, in reports that the independent medical reviews found to be thorough and carefully executed. My role, in review, is to “police the process, not its outcomes.”¹⁸ Here, that process has gone awry. It failed to defer to fully-articulated diagnoses about Mr. ██████'s functional loss, while allowing a few pieces of seemingly inconsistent later-arriving evidence to be determinative. This was an error.¹⁹

2. Criterion (ii): Valid, Qualifying, Test Scores

In its Notice of Denial, the Claims Administrator concluded that Mr. ██████ failed to satisfy criterion (ii) because “the examining neuropsychologist's consideration of the psychiatric symptoms seemed to indicate a current and ongoing severe thought disorder rather than indicate that the psychiatric condition had been excluded as a current etiology for the cognitive decline.” Doc. 323395 at 2.

¹⁷ To be clear, there were some inconsistencies and differences of emphasis. But the relative comprehensiveness of Mr. ██████'s disclosures to his clinicians, and their careful parsing of that evidence, is distinctive.

¹⁸ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 12 (Oct. 21, 2020) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=slick_validity_testing_sm.pdf.

¹⁹ I will follow the AAP Leadership Council, and not the Notice of Denial, in concluding that Dr. ██████ appropriately (and to the extent possible) established that Mr. ██████'s functional loss resulted from cognitive decline. The Notice of Denial's view entirely turned on apparent inconsistencies in what Dr. ██████ reported and the later-arriving evidence. I do not think those inconsistencies are significant and I conclude that the Denial erred here too.

In October 2023, I described the Settlement’s approach to the “difficult and sensitive problem” of concurrent mental illness.²⁰ Reiterating previous holdings, I explained that:

[T]he Settlement does not require the exclusion of psychiatric etiologies for functional loss.²¹ In parsing psychiatric symptoms from *cognitive and functional impairment* on appeal, as in many applications of the Settlement’s ‘layered deference to expertise,’ a diagnosing physician’s articulated consideration of confounding factors is typically sufficient to establish that a Player’s impairment is generally consistent with the Settlement’s requirements.²²

In the course of the Consensus Review I requested, the AAP found that Dr. [REDACTED]’s report meets this standard. I agree.

Indeed, as the AAP Leadership Council points out, she “clearly articulates her considerations of the Player’s psychiatric condition and its relationship to his performance on the cognitive tests.” Doc. 378763. She detailed his self-reported feelings, symptoms, psychiatric history and treatment records, conducted the Mini, and openly acknowledged Mr. [REDACTED]’s mental illness as a limitation to testing. Moreover, as in the October 2023 case, “there is no evidence that Mr. [REDACTED]’s] cognitive deficits occur exclusively in the context of delirium.”²³

It is true that the AAP Leadership Council, after finding Dr. [REDACTED] met this standard, went on to suggest that Mr. [REDACTED]’s mental illness raised validity concerns, since it may have had the “effect of limiting the required optimal level of cognition (and function) at the time of the MAF evaluations.” *Id.* In its briefing, the NFL Parties also followed this line of argument, contending that:

although Mr. [REDACTED] is correct that the Settlement Agreement does not require him to establish that his cognitive decline was caused by playing professional football in the NFL, he does need to have a compensable diagnosis, which requires

²⁰ Special Master Ruling on Validity Testing and Mental Illness, at 5 (Oct. 16, 2023) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_testing_mental_illness_sm.pdf

²¹ After reviewing the AAP Leadership Council’s pre-Denial Consensus Review, I wonder if it interpreted this ruling to only apply in the context of functional loss. *See* Doc. 317997 at 3 (“The Special Master’s ruling made clear that the Settlement did not require the exclusion of psychiatric etiologies for functional loss and that a Diagnosing Physician’s articulated consideration of confounding factors was typically sufficient to establish the impairment was generally consistent with the Settlement’s requirements. In this case, the Diagnosing Physician, Dr. [REDACTED], did indicate awareness of the Player’s psychiatric symptoms . . .”). This may explain the AAP Leadership Council’s finding that Dr. [REDACTED]’s consideration of Mr. [REDACTED]’s mental illness was sufficient, but Dr. [REDACTED]’s much more extensive analysis was not. To clarify, the Settlement does not require a Diagnosing Physician to *exclude* psychiatric etiologies for either functional or cognitive impairment. For both criteria, the Claims Administrator should normally defer to clinicians’ reasoned views.

²² Special Master Ruling on Validity Testing and Mental Illness, at 5 (Oct. 16, 2023) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_testing_mental_illness_sm.pdf (citations omitted, emphasis added).

²³ *Id.* at 6.

that his testing showing requisite levels of cognitive decline be a ‘valid reflection of his optimal level of neurocognitive functioning’ rather than a result of his severe psychiatric issues and refusal to take medications or seek treatment for those psychiatric conditions.

Doc. 360245 at 2.

I find this argument unpersuasive twice over. First, I have specifically held that the effects of mental illness do not render neuropsychological test results invalid, so long as “the neuropsychologist has accounted for those effect in her thorough and . . . reasonable analysis.”²⁴ According to the AAPC—holding apart concerns about later-arriving evidence—Dr. ██████’s report met that standard.

Second, I do not read the Notice of Denial as even making this kind of validity finding. The Denial states that Mr. ██████ failed to satisfy criterion (ii) because Dr. ██████ did not exclude Mr. ██████’s psychiatric condition as the current etiology for his cognitive decline. Doc. 323395 at 2. Claimants (and the NFL Parties) should be able to rely on these notices in deciding whether to appeal.

In all events, it may well be that if Mr. ██████ were effectively treated for his mental illness, he would be able to perform better on his neuropsychological testing.²⁵ But his examining clinician was convinced to the contrary, and wrote a thorough report to that end. The Claims Administrator should have deferred to that clearly articulated view.

The AAP Leadership Council raised a distinct set of validity concerns, turning on the late arriving evidence discussed above.²⁶ Per the AAPLC, because the later-arriving evidence showed Mr. ██████ more functional than his clinicians reported, he must have not performed optimally on his tests—otherwise, asks the AAPLC, how could he have improved?

Again, I appreciate the logic. But this case illustrates exactly why it is fraught to rely on temporally inconsistent evidence of function. For the reasons I’ve given above, there is nothing materially inconsistent between what Mr. ██████ told his doctors and what he later told the Claims Administrator, and therefore no reasonable basis for questioning those clinicians’ views that his testing provided a valid estimate of his abilities. Simply put, the contemporaneous records sufficiently support the claimed Qualifying Diagnosis, and the later-arriving evidence does not show that he miraculously improved, which would have otherwise impeached the prior conclusion.

²⁴ *Id.* at 7.

²⁵ The parties on appeal spend some of their briefing contesting whether treatment of his mental illness would improve his cognitive function. That kind of counterfactual question is a bad fit for a legalized appeals process built on deference.

²⁶ Again, I do not read the Notice to make this a validity finding. Rather, the Claims Administrator based its denial on the “pattern of behavior inconsistent with a diagnosis of dementia, which, together with the absence of any explicit attempt to isolate the role of cognitive loss as opposed to other factors, materially undermines Dr. ██████’s conclusions about functional impairment.” Doc. 323395 at 3.

I therefore find that Mr. [REDACTED] has successfully challenged the Claims Administrator's finding that he failed to satisfy criterion (ii).

CONCLUSION

This Settlement is "built around layered deference to expertise."²⁷ The Claims Administrator and AAP should usually defer to the expertise of diagnosing physicians. In this case, I am persuaded that the review process wrongly re-weighed evidence and consequently inappropriately discarded the articulated judgments of the doctors who met with Mr. [REDACTED] and evaluated the complex relationship between his mental health and his cognitive loss. They also wrongly concluded that he had not sufficiently demonstrated the required degree of functional impairment. He has therefore provided clear and convincing evidence of error in the review of his Claim.

I grant the Appeal, and direct the Claims Administrator to approve a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

Date: April 8, 2025



David A. Hoffman, Special Master

²⁷ Special Master Ruling on Pre-Diagnosis Evidence, at 6 (Jul. 2, 2020)
https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=pre_diagnosis_evidence_sm.pdf.