

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

The Claims Administrator placed Mr. ██████ claim in audit in October 2017. Doc. 135203. The audit resulted in adverse findings regarding Dr. ██████ testing, and that clinician was disqualified from participation in the Settlement Program. Doc. 151387. The Claims Administrator notified Mr. ██████ that “[a]ny Monetary Award claim that relies on neuropsychological testing performed by Dr. ██████ is disallowed and no claims may be submitted in reliance on her testing or opinions.” *Id.* The First Claim was thus denied.

On September 5, 2018, Dr. ██████, a board-certified neurologist and Qualified MAF Physician, re-evaluated Mr. ██████. Doc. 184817. In his report, Dr. ██████ discussed Mr. ██████ medical history, which included mention of a 2015 diagnosis of psychogenic nonepileptic seizures (PNES). *Id.* In addition to performing a neurological assessment of Mr. ██████, Dr. ██████ reviewed the results of two prior neuropsychological evaluations: “one was performed on August 3, 2016” (by Dr. ██████ “and the second one was on January 6, 2017” (performed by Dr. ██████, whose report was later filed by Mr. ██████ in support of this claim).¹ *Id.* Dr. ██████ concluded that Mr. ██████ qualified for Level 1.5 Neurocognitive Impairment. *Id.*

Mr. ██████ filed a Claim Form—his Second Claim—on September 18, 2018 based upon the Qualifying Diagnosis certified by Dr. ██████.² Doc. 185642; Doc. 185643. On October 4, 2018, the Claims Administrator provided notice of multiple documentary deficiencies in Mr. ██████ claim. Doc. 187055. On November 28, 2018, the Claims Administrator denied the Second Claim. Doc. 191771.

Mr. ██████ underwent another neuropsychological evaluation on January 16, 2019. Dr. ██████, a board-certified neuropsychologist, performed that new evaluation. Doc. 208776. Dr. ██████ found that due to suboptimal validity—specifically, “varied” scores on stand-alone performance validity measures, “significant intra-domain variability in test performance,” and “some test findings that were discrepant with observed behavior”—she could not reliably interpret Mr. ██████ test scores. She thus concluded that those scores did not support a Diagnosis within the Settlement. *Id.*

Dr. ██████ writing a supplemental report on May 12, 2019, responded to Dr. ██████ analysis. Doc. 206831. Dr. ██████ disagreed with Dr. ██████ conclusion about the etiology of Mr. ██████ functional impairment, stating: “rather than being separate, the psychological factors, e.g. depression, are more likely than not directly caused by the cognitive loss.” *Id.* Dr. ██████ did not discuss Dr. ██████ conclusions regarding test validity.

On May 14, 2019, Mr. ██████ submitted a new Claim Form—his Third Claim—again based on Dr. ██████ September 2018 Diagnosis. Doc. 206869. The Claims Administrator

¹ In November 2018, Mr. ██████ submitted the medical records for the neuropsychological evaluation performed by Dr. ██████ (and considered by Dr. ██████ Doc. 191021. The testing was part of an evaluation to determine eligibility for NFL Disability Benefits.

² Mr. ██████ counsel requested that three documents be disregarded from the most recent claim; specifically, the two prior Diagnosing Physician Certification Forms signed by Dr. ██████ (Doc. 63473; Doc. 138316), and Dr. ██████ report (Doc. 138315). Doc. 186446. However, Dr. ██████ original assessment draws support from Dr. ██████ report.

issued a Notice of Preliminary Review on October 28, 2019. Doc. 216364. It observed that the testing performed by Dr. [REDACTED] did not satisfy the criteria for a Level 1.5 diagnosis. *Id.* It also suggested that Dr. [REDACTED] evaluation did not include all of the tests listed in the BAP Test Battery and furthermore, that the neuropsychological testing was performed after the date of the Qualifying Diagnosis as stated in the Diagnosing Physician Certification Form. *Id.* The Claims Administrator noted that it had contacted Dr. [REDACTED] and requested further explanation in light of the neurocognitive testing issues, but he had withdrawn from the MAF Network by early 2020. *Id.*

Pursuant to the Special Master's request for additional expert input, several members of the AAP provided insight on the specific issues raised by the Claims Administrator. An AAP Consultant reviewed the neuropsychological evaluation conducted by Dr. [REDACTED] and concluded that it was generally consistent with the BAP neuropsychological test battery. Doc. 221902. However, the Consultant agreed with Dr. [REDACTED] that Mr. [REDACTED] test scores did not support a Diagnosis of Level 1.5 Neurocognitive Impairment given Mr. [REDACTED] suboptimal effort. *Id.* Additionally, the Consultant agreed with Dr. [REDACTED] assessment that "it is likely that psychological factors play a significant role in his functional difficulties." *Id.*

An AAP Reviewer, evaluating the entire file, agreed that the available documentation was insufficient to support a Level 1.5 Diagnosis. Doc. 223262.

The Claims Administrator, largely adopting these analyses, issued a comprehensive denial on June 3, 2020. Doc. 225285. After describing the Claim's procedural history, the Claims Administrator concluded:

The medical and neuropsychological assessments detailed above contain conflicting data concerning the documented progression of cognitive impairment, and there are documented concerns about the Player's performance on testing that argue against the presence of a dementia or Level 1.5 Neurocognitive Impairment as per the Settlement Criteria. For example, in 2016, Dr. [REDACTED] diagnosed moderate dementia, or Level 2 Neurocognitive Impairment, with a MoCA performance that was normal (26/30), and moderate impairment of function (CDR 2.0) without specific documentation for review. Also, there was no mention by Dr. [REDACTED] of the Player's significant neurologic diagnosis of psychogenic nonepileptic seizures (PNES), which does influence neuropsychological and daily functional abilities and could have been the (treatable) cause of the noted deficits. The next evaluation submitted by Dr. [REDACTED] gave a diagnosis of Level 1.5 Neurocognitive Impairment or mild dementia with a CDR fluctuating between 1.0 and 2.0 (mild to moderate impairment). However, it is not plausible to see a person diagnosed with moderate dementia and moderately impaired functioning (CDR 2.0) to improve over time to mild dementia with mildly impaired daily function (CDR 1.0), with no intervention.

In terms of the Slick Criteria, the Player's performance on his most recent neuropsychological testing in 2019 raises concerns with the ability to interpret the

testing results provided. Specifically, although the Player met cutoffs for embedded performance measures on Dr. [REDACTED] testing report, she reported that he gave less than optimal performances on Attention, Processing Speed and Language measures, which lead her to report performance discrepant with his observed behaviors. Dr. [REDACTED] also noted that the Player's documented self-reported symptoms were discrepant with known patterns of brain functioning. It is improbable that he needed to use his nondominant hand for testing that was dependent on speed and accuracy so as not to elicit a spell related to his PNES. Along with Dr. [REDACTED] concerns of suboptimal performance, this behavior, which is inconsistent with known patterns of brain functioning in neurological disease and is known to affect accuracy and speed, support her conclusions.

Lastly, both Drs. [REDACTED] and [REDACTED] documented the preexisting history of PNES, which existed prior to 2016. In 2019, the Player reported having three to four PNES episodes a week and had one during the trip to the appointment for testing and one during testing while doing the block design test. He disclosed to Dr. [REDACTED] that he was having daily spells in 2016. The documented frequency of the PNES episodes is such that these could account for any alterations in daily function and cognitive performance.

Based on the above, the diagnosis by Dr. [REDACTED] is not generally consistent with the Settlement criteria for Level 1.5 Neurocognitive Impairment.

Id. Mr. [REDACTED] timely appealed. Doc. 226265.

DISCUSSION

There are four diagnostic criteria that must be satisfied for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.³ The Claims Administrator identified a variety of bases for denying Mr. A [REDACTED] claim, arguably implicating all four criteria. Here, I focus on the crucial question of whether Mr. [REDACTED] has offered neuropsychological test results generally consistent with the requirements for criterion (ii).

For a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, the Retired NFL Player must provide “[e]vidence of a moderate to severe cognitive decline from a previous level of performance, as determined by and in accordance with the standardized neuropsychological testing protocol annexed in Exhibit 2.” Part of the testing protocol outlined in Exhibit 2 includes two required measures for evaluating performance validity: first, through the inclusion of performance validity tests within the neuropsychological test battery, and second, by requiring clinicians to complete the *Slick et al.* checklist of validity.⁴

³ Settlement Agreement, Exhibit A-1, Section (1)(a)(ii)-(iii).

⁴ Settlement Agreement, Exhibit A-2, Section 1-2.

Furthermore, for Diagnoses made by a Qualified MAF Physician, like Dr. [REDACTED] the neuropsychological testing used to support the Qualifying Diagnosis must ordinarily have transpired within one year of the diagnosing physician's evaluation.⁵

Mr. [REDACTED] file contains results from three neuropsychological evaluations: one by Dr. [REDACTED] from August 2016; another by Dr. [REDACTED] in January 2017, which was conducted as part of an assessment to determine Mr. [REDACTED] eligibility for NFL Disability Benefits; and lastly, an evaluation by Dr. [REDACTED] in January 2019. Doc. 138315; Doc. 191021; Doc. 208776. Dr. [REDACTED] who examined Mr. [REDACTED] on September 5, 2018, considered the first two neuropsychological evaluations in reaching a Qualifying Diagnosis. Doc. 184817. He then also reviewed the third testing and documented his findings in an addendum. Doc. 206799.

There is no dispute that the first evaluation cannot be used in support of this claim, given Dr. [REDACTED] disqualification from participation in the Settlement program. The major issue in this Appeal is whether the second or third evaluation sufficed, severally or together, to maintain Mr. [REDACTED] claim.

Mr. [REDACTED] counsel takes issue with the AAP's "inexplicable" failure to "acknowledge, or even reference" the older medical documentation in Mr. [REDACTED] file, including the second evaluation—performed by Dr. [REDACTED] Doc. 226265, at 6-7. But the neuropsychological testing performed by Dr. [REDACTED] (in January 2017) happened well more than a year before Dr. [REDACTED] evaluated Mr. [REDACTED] (in September 2018). Thus, Dr. [REDACTED] evaluation was not contemporaneous with the date of the Qualifying Diagnosis, and could not be used to satisfy criterion (ii). The AAP, and by extension the Claims Administrator, appropriately chose not give weight to this evaluation.

Dr. [REDACTED] performing the third neuropsychological evaluation, concluded that Mr. [REDACTED] test scores could not be reliably interpreted due to concerns about suboptimal effort. Doc. 208776. Her conclusion was based upon the considerations required by the Settlement Agreement: suboptimal scores on performance validity tests, and issues relating to several *Slick* criteria.⁶ *Id.* Dr. [REDACTED] also highlighted concerns about "significant intra-domain variability in test performance," which an AAP Consultant who later reviewed the file elaborated on, writing:

I concur entirely with Dr. [REDACTED] interpretation. The player's profoundly low scores on multiple tests, especially those of attention/processing speed and

⁵ Settlement Portal, *Frequently Asked Questions*, FAQ #110 ("If a Player's past neuropsychological testing was done more than a year before his MAF exam, or was done by anyone other than a Qualified BAP Provider in the BAP, the Qualified MAF Physician may use it as a baseline assessment to compare against contemporaneous neuropsychological testing but cannot use it to measure impairment unless the Claims Administrator approves the Qualified MAF Physician to use it in that manner.").

⁶ Specifically, Mr. [REDACTED] received suboptimal scores on several of the stand-alone performance validity tests (ACS Word Choice and Victoria Symptom Validity Test [VSVT]). Dr. [REDACTED] additionally noted concerns in line with *Slick* criteria 3—namely, that some of the test findings were discrepant with Mr. [REDACTED] observed behavior.

language comprehension, are not credible.⁷ There are extensive objective indicators that the player was not entirely forthcoming in his symptom reporting, nor trying his best to perform well on neurocognitive tests.

Doc. 221902 (footnote added).

Mr. [REDACTED] counsel argues that pursuant to Rule 10(d) of the Rules Governing MAF Physicians, “Dr. [REDACTED] had the authority to determine how much weight to give Dr. [REDACTED] findings ... Dr. [REDACTED] [] conducted his own examination and presented his diagnosis in September, 2018,” and in a “supplemental report . . . he addressed his disagreement with Dr. [REDACTED] findings.” Doc. 226265.

Rule 10(d) clarifies the proper practice for the diagnosing physician in the event that she disagrees with the conclusions of the examining neuropsychologist. It does *not* state that the Claims Administrator must simply defer to the opinion of the MAF Physician in the face of such a disagreement. Moreover, Dr. [REDACTED] supplemental report only addresses his disagreement with Dr. [REDACTED] assessment of Mr. [REDACTED] functional impairment. Doc. 206831. Thus, even if the Claims Administrator were to have deferred to Dr. [REDACTED] reasoned opinion that cognitive loss—rather than “possible depressive disorder”—caused Mr. [REDACTED] functional decline, the separate and critical issue of test validity remained unaddressed.

Invalid neuropsychological test results cannot support a Level 1.5 Qualifying Diagnosis. Here, the examining neuropsychologist denied the validity of Mr. [REDACTED] test performance. Two members of the AAP reviewed and supported the neuropsychologist’s assessment about suboptimal validity. The Claims Administrator thus did not err in its determination that Mr. [REDACTED] has not provided sufficient documentation to support the Qualifying Diagnosis.

CONCLUSION

To be eligible for a Monetary Award, Mr. [REDACTED] must provide evidence generally consistent with the criteria put forth in the Settlement Agreement injury definitions. The Claims Administrator found that he failed to meet that burden in relevant part because he had failed to provide valid, contemporaneous, neuropsychological test results. Because he has not provided clear and convincing evidence that the Claims Administrator’s decision on that ground was erroneous, his Appeal is denied.

Date: September 29, 2020



David A. Hoffman, Special Master

⁷ On three of six tests administered to evaluate Complex Attention and Processing Speed, Mr. [REDACTED]—compared against a group of demographically similar individuals—obtained scores lower than 99% of test takers. Of the three Language tests administered, he obtained one score lower than 99% of test takers, yet on another test he scored much higher—in 42nd percentile.