

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

His deficits in executive functioning make it difficult for him to plan and organize information. He also has cognitive rigidity and has difficulty reasoning using concepts framed in words. His deficits in learning and memory make it difficult for him to recall the specifics of information that he has heard, whether the information is related or not. His deficits in visual memory make it difficult for him to recall nuances in maps, pictures, or designs. His language deficits affect his semantic fluency. He also has problems understanding what others say [too]. His deficits in spatial-perceptual functioning make it hard for him to accurately copy simple drawings or correctly space and form common shapes. He also has difficulty with abstract visual-spatial analysis, abstract visual reasoning, and the analysis and synthesis of abstract visual stimuli.

Id. at 12.

Dr. [REDACTED] also administered six performance validity tests, writing that:

Mr. [REDACTED]'s scores on effort and performance validity tests reflect good effort, with the exception of his performances on the ACS Word Choice and Logical Memory II Recognition. The results from these tests suggest the possibility of poor effort. However, Mr. [REDACTED]'s performance on these subtests is the result of his cognitive deficits in visual memory and attention and concentration and in logical verbal memory, respectively. . . . The results of the present evaluation are considered to be a valid assessment of Mr. [REDACTED]'s current functioning.

Id. at 4–5.

In Dr. [REDACTED]'s subsequent evaluation of functional impairment, he observed:

Symptomatically, [Mr. [REDACTED]] suffers from memory impairments so advanced as to limit his independent function at home He cannot manage complex or intermediate ADL's such as balancing a checkbook or keeping a schedule. He will often leave the burner on at home if he cooks as he forgets. . . . He also struggles with basic ADLs affecting his ability to gain meaningful work and fully function at home without assistance or cues. He cannot maintain his household without assistance from his high school age son at this time. He meets criteria outlined in the National Alzheimer Coordinating Center's Clinical Dementia Rating Scale as having Category 2 (moderate) impairment.

Doc. 66378 at 4.

Mr. [REDACTED] also submitted October 4 and 5, 2016 evaluations from neurologist [REDACTED] and neuropsychologist [REDACTED] for the NFL Player Benefits Disability Plan. Docs. 144999; 145000.

In contrast to Drs. [REDACTED] and [REDACTED], Dr. [REDACTED] (the neurologist) opined that Mr. [REDACTED] was substantially able to engage in an occupation for remuneration or profit, explaining that “intermittent headaches” and “decreased mental focus” are “not expected to be disabling.” Doc. 144999 at 2. Dr. [REDACTED] also marked “independent” for all functional activities of daily living (eating, bathing, dressing, toileting, walking, and continence) and wrote “independent” for five out of ten instrumental activities of daily living: (1) shopping alone for clothes, household necessities, or groceries; (2) playing a game of skill or working on a hobby; (3) heating water, making a cup of coffee, and turning off the stove; (4) preparing a balanced meal; and (5) traveling out of the neighborhood, driving, and arranging to take public transportation. *Id.* at 4. He concluded that although “a mild cognitive disability cannot be excluded, [Mr. [REDACTED]]’s reported symptoms are not expected to be disabling.” *Id.* at 13.

Regarding Mr. [REDACTED]’s level of neurocognitive impairment, Dr. [REDACTED] (the neuropsychologist) observed that Mr. [REDACTED] demonstrated a “pattern of performance . . . consistent with a deficit in executive function,” and that in spite of Mr. [REDACTED]’s likely “significant level of depression that contributes to his subjective symptoms,” his “objective performance abnormalities cannot be attributed to depression. Perseveration and problems with semantic organization would not be expected as the manifestations of depression . . . these results are indicative of acquired neurocognitive impairment that cannot be attributed to depression or substance abuse.” Doc. 145000 at 7. However, Dr. [REDACTED] also concluded that Mr. [REDACTED] “performed within normal limits in most areas of higher cognitive function.” *Id.*

On December 5, 2017, the Claims Administrator initiated an audit of seventy Claims that relied on Dr. [REDACTED]’s neuropsychological reports. One was Mr. [REDACTED]’s. Doc. 146177. After issuing a Report of Adverse Finding in Audit on March 30, 2018, the Claims Administrator referred the report to the Special Masters for additional consideration. Doc. 171861.

While this audit was ongoing, Mr. [REDACTED] submitted a second Claim Form, on October 15, 2018. Doc. 187934. [REDACTED], a then-Qualified MAF Physician, evaluated Mr. [REDACTED] on November 8, 2017. Doc. 187265. No licensed neuropsychologist assisted Dr. [REDACTED]. *Id.* After reviewing Mr. [REDACTED]’s prior neuropsychological tests and performing his own examination, Dr. [REDACTED] diagnosed Mr. [REDACTED] with Level 2 Neurocognitive Impairment after assigning him a CDR score of 2.0 in the categories of Community Affairs, Personal Care, and Home and Hobbies. *Id.* at 1. Dr. [REDACTED] stated that Mr. [REDACTED] was:

[Q]uite frustrated with his daily routine. He tends to get up at approximately 6 am. He [goes] about his activities initially with an exercise bicycle session and then moves about the house readily and does do some yard work and cleaning up in general. He is presently not working on a regular basis. He has been involved in some coaching track and field but has not been able to follow through on this. He tends to forget the coaching plays as well as the names of the children that he is coaching. He is prone to road rage, frustration, and even depression.

Id. at 3. Dr. [REDACTED] certified, pursuant to Exhibit A-1 of the Settlement Agreement, that neurological testing was medically unnecessary because of the severity of Mr. [REDACTED]'s dementia. Doc. 187264.

Meanwhile, after reviewing the Claims Administrator's report, the Special Masters did not agree that the claims relying on Dr. [REDACTED]'s diagnoses necessarily resulted from misrepresentations, omissions, or concealment of material facts. Doc. 203226. They closed the audit on March 14, 2019. *Id.*

At that point, Mr. [REDACTED] had two concurrent diagnoses under review: the first based on testing from Dr. [REDACTED] and made by Dr. [REDACTED], and the second made by Dr. [REDACTED] without neuropsychological testing.

Because Section 6.4 of the Settlement requires the AAP to review certain Qualifying Diagnoses made before the January 7, 2017 Effective Date, on May 23, 2019, an AAP Consultant reviewed the September 2016 reports from Doctors [REDACTED] and [REDACTED], the October 2016 reports from Doctors [REDACTED] and [REDACTED], and the November 2017 report from Dr. [REDACTED]. Docs. 83984; 237978. The Consultant raised several concerns about the doctors' reports and highlighted various discrepancies between them before concluding that "the available reports do not adequately support the claim for the qualifying diagnosis" Doc. 237978 at 2.

The Claims Administrator subsequently denied Mr. [REDACTED]'s Claim on June 19, 2019. Doc. 209483. The Notice stated (in part):

The Qualifying Diagnosis of Level 2 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria. There is documentation of concern for cognitive decline (including MOCA scores of 19/30 on 9/16/16, and 22/30 on 10/4/16; not working, problems remembering names, dates, new information, and computer passwords, not being able to maintain the household without assistance, and not being able to help his son get ready for the day, problems controlling anger, worsening ability to manage money or shop independently, struggling with basic ADL's, not being able to work or fully function at home without assistance or cues, and with worse ability to properly dress, wash, or eat). However, there is an assessment of [Mr. [REDACTED]'s] functional abilities that was performed on 10/4/16, which indicated that he was able to independently balance the checkbook, shop alone for clothes, household necessities, or groceries, play a game of skill or work on a hobby, heat water, make a cup of coffee, turn off the stove, prepare a balanced meal, pay attention to and understanding discussing a TV show, book or magazine, independently travel out of the neighborhood, drive, or arrange to take public transportation; and was independent in activities of daily living, including eating, bathing, dressing, toileting, transferring, and continence

[T]here were discrepancies between the two neuropsychological assessments completed only one month apart, Dr. [REDACTED]'s exam on 9/15/16, and Dr.

■■■■■'s exam on 10/4/16. The current Full-Scale IQ on Dr. ■■■■■'s administration of the WAIS-IV was 65, but this rose to 81 on Dr. ■■■■■'s exam just a month later. The Player's premorbid IQ obtained with the TOPF was estimated to be 83 by Dr. ■■■■■ and 86 by Dr. ■■■■■, which would not indicate a severe cognitive decline compared to the current Full-Scale IQ obtained by Dr. ■■■■■. On the testing performed by Dr. ■■■■■ there was underperformance detected on several tests, including the ACS Word Choice, WMS-IV Logical Memory Recognition, Reliable Digit Span, and BDAE Complex Ideational Material tests. Additionally, on Dr. ■■■■■'s evaluation, the Player displayed only some mild executive function difficulties, and there was evidence of learning with improvement on several tests with small practice effects that showed significant improvement (Reliable Digit Span, WAIS-IV Arithmetic), which calls into question the validity of Dr. ■■■■■'s findings. Dr. ■■■■■'s administration of the MMPI-2-RF identified significant exaggeration of symptoms, calling into question some of the reported information regarding performing functional activities. Consequently, the diagnoses made by Dr. ■■■■■ and Dr. ■■■■■ are not generally consistent with either Level 1.5 Neurocognitive Impairment or Level 2 Neurocognitive Impairment.

Id.

After seeking and receiving multiple extensions, Mr. ■■■■■ appealed on December 1, 2020. Doc. 230624. In support of his Appeal, his counsel asserted, among several other arguments, that the only discrepancy in Mr. ■■■■■'s neuropsychological testing stemmed from the NFL Disability assessment, and that the NFL Disability test battery:

[W]as not, and was not intended to be of the caliber, quality, and specificity of the BAP testing protocol for the NFL concussion settlement, nor focused on the discrepancies bullet-pointed in the [Claims Administrator and AAP Consultant's] Denial Determination. This is clearly because testing was conducted for purposes different from that of the NFL concussion settlement's BAP protocol.

Id. at 5.

I remanded Mr. ■■■■■'s Appeal for re-review by the Claims Administrator on December 8, 2020. Doc. 231008. On January 25, 2021, the Claims Administrator began another audit of Mr. ■■■■■'s Claim. After a prolonged back-and-forth, throughout which Mr. ■■■■■ provided a substantial amount of additional information about his retained function and daily activities, the Claims Administrator concluded the audit on August 26, 2021. Doc. 237906.

On August 29, 2021, the AAP Consultant re-reviewed Mr. ■■■■■'s Claims and Appeal. Doc. 237978. The Consultant stated that although patients with dementia do sometimes (normally) display practice effects, "they tend to be much smaller in magnitude. . . . if this patient learned so

much from his first assessment that his Digit Span rose from 7 to 12 . . . that would be difficult to reconcile with a Level 2 Neurocognitive Impairment (moderate dementia).” *Id.*

The Claims Administrator denied both of Mr. [REDACTED]’s Claims (again) on October 28, 2021. Doc. 239639. With respect to the first Claim, it explained that:

The AAPC determined either adequate effort was not devoted on [Dr. [REDACTED]’s] tests or there was intentional underperformance on some tests, that [REDACTED] administered many more tests than are recommended in the BAP test battery, and even when the substituted tests were included, there was Level 2 impairment in only two domains (Executive Function and Complex Attention). The AAPC concluded that the results did not adequately support the diagnosis of dementia or satisfy the Settlement criteria for Level 2 or Level 1.5 Neurocognitive Impairment.

The evaluation by Dr. [REDACTED] reported the Player performed within normal limits in most areas of higher cognitive function There was concern that Dr. [REDACTED]’s evaluation was not reliable due to inflation of scores from the practice effect, because it took place just a few weeks after Dr. [REDACTED]’s evaluation. However, the AAPC opined that practice effects are much smaller in patients with degenerative dementias, and the magnitude of the improvement between the two evaluations would be difficult to reconcile with the presence of the Level 2 Neurocognitive Impairment. Therefore, criterion (ii) is not fulfilled. . . .

Dr. [REDACTED] reports the Player is no longer working, is not able to manage complex or intermedia ADLs such as balancing a checkbook or keeping a schedule, will often leave a burner on at home if he cooks . . . and is not able to maintain his household without assistance from his son. . . . There is additional information from an audit which indicated the Player was involved with Uber and Amazon deliveries, but that his son and a friend actually performed the job duties, although he would ride along and leave some packages on doorsteps. The audit also reported the Player had difficulty driving, did act as a volunteer Team Chaplain around 2016, stopped public speaking around 2016-2017, does not shop, had to stop speaking engagements for the Ministry around 2017-2018, received an honorary deputization after speaking at a juvenile detention center, and received a Master’s degree in 2016 but his sister-in-law actually did the course work. . . . While Dr. [REDACTED] did not explain the medical reasoning for excluding effects of depression as causing or contributing to the functional decline, he did state that the above in all medical probability is related to sustained concussions Consequently, the information is mixed, somewhat inconsistent, and incomplete with very little information about Personal Care activities (dressing, grooming, bathing, eating, toileting) in particular. Therefore, while there is report of functional decline, criterion (iii) is not fulfilled for a diagnosis of Level 2 Neurocognitive Impairment.

Id. With respect to Mr. [REDACTED]’s second Claim, the Claims Administrator concluded (in part) that:

Dr. [REDACTED] provides a very lengthy discussion of the neuropsychological testing results in his letter dated 9/1/[2020], including that Dr. [REDACTED]'s evaluation was not reliable due to inflation of scores from the practice effect and that further neuropsychological evaluation would be useless or medically unnecessary and would lead to invalid results. However, the AAPC indicated that practice effects are much smaller in patients with degenerative dementias and that the magnitude of the improvement between the two evaluations would be difficult to reconcile with the presence of a Level 2 Neurocognitive Impairment. Regarding Dr. [REDACTED]'s determination that further neuropsychological evaluation would be medically unnecessary, the Special Master has adopted a two-pronged analysis to determine whether this determination is reasonably determined: (1) how severe was the impairment, and (2) why does the severity of the impairment make testing unnecessary. In this case, the severity of the impairment is difficult to determine due to the conflicting neuropsychological reports and the issues with the insufficient effort in the testing by Dr. [REDACTED]. . . . [T]he assertion by Dr. [REDACTED] that a neuropsychological evaluation is medically unnecessary is not supported, both by the AAPC review and for the reasons stated above. Therefore criterion (ii) is still not fulfilled.

Id.

Again, Mr. [REDACTED] successfully sought and received multiple extensions, and ultimately appealed on August 1, 2022. Doc. 267679.

DISCUSSION

As this somewhat convoluted history details, Mr. [REDACTED]'s Appeal challenges the result of one Denial notice, which itself separately addressed both a 2017 Pre-Effective Date Claim and a 2018 Post-Effective Date Claim. The 2017 Claim's denial results from failures of both validity and insufficient functional impairment; the 2018 Claim's Denial focuses on functional impairment and the absence of neuropsychological testing without a reasonably articulated excuse.

Mr. [REDACTED]'s appeal of the 2017 Claim's denial is both general and specific. At the general level, he points to the number of doctors who have diagnosed him with cognitive dysfunction. By way of example, he writes:

Appellant's May 2017 PED Claim for NCI award determination supported by Dr. [REDACTED] and Dr. [REDACTED]; and/or (2) Appellant's May 2017 PED Claim for NCI award determination supported by Dr. [REDACTED], Dr. [REDACTED], and Dr. [REDACTED]; and/or (3) Appellant's MAF Claim (post-PED), supported by Dr. [REDACTED], also based on Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED], Dr. [REDACTED], Ms. [REDACTED], Dr. [REDACTED], Workers' Compensation medical professionals, Team physicians, Mr. [REDACTED], Mr. [REDACTED], etc., the law and the totality of the record evidence.

Doc. 267676, at 3.

This general appeal to authority does not satisfy Mr. [REDACTED]'s burden on appeal, which is to identify, by clear and convincing evidence, any errors in the Claims Administrator's determination. The fact that many different doctors have determined that Mr. [REDACTED] suffers from impaired cognition isn't determinative of his satisfying the Injury Definitions.

Mr. [REDACTED] also argues that the AAPC did not sufficiently defer to Dr. [REDACTED]'s validity finding. But Dr. [REDACTED]'s analysis was not at all articulated—he does not even mention Mr. [REDACTED]'s symptom validity testing. Additionally, as the NFL Parties point out, while Dr. [REDACTED] did administer more tests (and different ones) from the Settlement's battery, he only administered three ACS measures, and Mr. [REDACTED] scored below the 15% percentile on each. Overall, the AAPC concluded that the resulting test scores from 2016 offered invalid measures of Mr. [REDACTED]'s cognitive functioning, a factual finding which I adopt.

Separately, the Denial noted an absence of information about personal care in concluding that there was insufficient information to justify a CDR score supporting Level 2 neurocognitive impairment. There is essentially no contemporaneous evidence from Dr. [REDACTED]'s examination about personal care—only a single line that Mr. [REDACTED]'s friends and family prompt him to pay his bills and take his medication. Dr. [REDACTED]'s nearly contemporaneous October 2016 report observed that Mr. [REDACTED] was then independent in this area. Doc. 144999. (Dr. [REDACTED]'s 2022 somewhat inconclusive comments that it was then “[his] understanding” that Mr. [REDACTED] required prompting to dress, wash and groom can't be imputed backward to 2016. Doc. 267677, at 96.)

Mr. [REDACTED] argues that the other evidence of functional loss was so compelling as to require a finding that he had established a CDR consistent with Level 2 in a generally consistent manner to the injury definitions. But that is not what the AAPC observed. Instead, as I read the record, the evidence supporting a Level 2 award in home and hobbies and community affairs was mixed (at best). Mr. [REDACTED] received a master's degree in the Fall of 2016: this is inconsistent with the “no pretense of independent function outside the home” required by Community Affairs. And while home and hobbies dysfunction at the asserted level requires “very restricted interests,” Mr. [REDACTED] continued to golf at the time of his diagnoses, as well as to exercise and do yard work.

The Post-Effective Date Claim

The Denial of the 2018 Claim rests on two grounds: missing neuropsychological test scores (where they were required) and insufficient evidence of functional impairment.

On Appeal, Mr. [REDACTED] offers correspondence from Dr. [REDACTED] explaining his reasoning in concluding that testing was unnecessary. I have read that letter with care, and I appreciate Dr. [REDACTED]'s thoughtful recitation. But this late-arriving reasoning cannot substitute for the actual

reasons that Dr. █████ offered at the time of his determination, which rested entirely on Dr. █████'s testing.¹ That testing, as I have just explained, was invalid.

In all events, Dr. █████'s conclusion must have been reasonably determined. As FAQ #363 explains:

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

Enforcing the Settlement Agreement, I have applied two factors when determining whether the "reasonably determined" standard was met:

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

The AAPC, informed by this standard and following it, determined that Dr. █████'s explanation—supplemented by the later letter—was not reasonably determined. Having read the file with care, I cannot conclude that the Claims Administrator erred.

¹ As I have repeatedly written, no deference is due to clinician's letters produced on Appeal. Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 11 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

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

Nor did it err in concluding that Dr. [REDACTED]'s examination, which did not apparently formally use a CDR worksheet, insufficiently documented a qualifying level of functional impairment. The Denial Notice stated:

Criterion (iii): Dr. [REDACTED] describes the Player's daily routine as tending to get up at approximately 6am, does his activities initially with an exercise bicycle session and then moves about the house readily and does some yard work and cleaning up in general, not working on a regular basis, has been involved in some coaching and track & field but has not been able to follow through on this and forgets the coaching plays and the names of the children he is coaching. Dr. [REDACTED] also reports road rage. Dr. [REDACTED] provided a physician letter certification of diagnosis which states that the Qualifying Diagnosis is being made with the criteria set forth in the CDR category 2.0 in the areas of Community Affairs, Home/Hobbies, and Personal Care.

Dr. [REDACTED] provides additional information about the functional abilities in his letter dated 9/1/[2020], including that the Player is struggling with anger issues, review of reports from Dr. [REDACTED] dated 8/7/2013 that indicate difficulty with shopping, misplacing items, forgetting names, and loss of interest in hobbies, as well as review of other records which indicated social withdrawal, shaking people's hands repeatedly, lack of pleasure in playing golf and riding a bike, difficulty managing his son's affairs, balancing a checkbook, keeping a schedule, often leaving the burner on if he cooks, and needing reminders to pay bills and take medications. Consequently, considering the information obtained in audit described above, the information is somewhat mixed and incomplete. In particular, there is not much information about Personal Care abilities (dressing, grooming, bathing, eating, and toileting). Additionally, the fact that the Player was awarded a Master's degree in 2016 would indicate at least the appearance of the ability to function independently outside the home, which would not be generally consistent with a score of 2 for the CDR category of Community Affairs (should indicate no pretense of independent function outside the home). Therefore, while there is report of functional decline, criterion (iii) is still not fulfilled for a diagnosis of Level 2 Neurocognitive Impairment.

Doc. 239693.

I found this aspect of the Denial somewhat confusing. It (and the underlying reports) mix information that pre- and post-dates the relevant 2017 examination. (Thus, the fact that Mr. [REDACTED] obtained a master's degree in 2016 is relevant to the denial based on the 2017 Claim, but not the 2018 Claim.) But Mr. [REDACTED]'s briefing does not shed significant light in describing exactly the state of the documentary record regarding functional impairment *in 2017*. Dr. [REDACTED]'s 2020 and 2022 letters are probative of what he more recently recalls about what he thought in 2017, but they do not substitute for contemporaneous reports which make sense of the conflicting pieces of information in the file, including Mr. [REDACTED]'s limited driving, golfing, yard work, and 2017 public speaking.

I do not agree with the NFL Parties that Mr. [REDACTED] engaged in 2017 in activities which are “unambiguously inconsistent with” a CDR of 2 in any of the relevant categories. There is considerable evidence in the record documenting Mr. [REDACTED]’s reduced level of function. And yet, Mr. [REDACTED] has not offered clear and convincing evidence of error in the Claim Administrator’s decision that he did not sufficiently support a loss of function consistent with a Level 2 Award.

CONCLUSION

Mr. [REDACTED] has seen many doctors over the last decade, and most of them believe that he is suffering cognitive decline (along with other physical and emotional ills). Unfortunately, the two examinations he defends in this Appeal were conducted in ways so inconsistent with the Settlement’s Injury definitions that they provide insufficient foundations for an Award. One describes invalid test scores; the other relies on those very exams to excuse a failure to administer additional testing. And though there is record evidence of some level of functional impairment, there are contradictions both within the medical records and between those records and later arriving audit information. No contemporaneous clinical reports help contextualize those inconsistencies.

I therefore must deny Mr. [REDACTED]’s Appeal. Mr. [REDACTED] remains eligible for a BAP Examination, which I would hope he schedules in the near future.

Date: March 17, 2023



David A. Hoffman, Special Master