

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 terminated Dr. [REDACTED] as a MAF neurologist on October 7, 2018, after he conducted Mr. [REDACTED] evaluation but before his Claim was submitted. It notified Mr.

█████ counsel of the termination on March 6, 2019, and referred the Claim to the AAP for review. Doc. 202980. Following that review, on November 14, 2019, the Claims Administrator issued the first denial of Mr. █████ Claim, writing:

The Qualifying Diagnosis of Level 2 Neurocognitive Impairment was not made in a manner that is generally consistent with the Settlement criteria. On the MAF Diagnosing Physician Certification Form dated 10/7/18, Dr. █████ indicated that a neuropsychological evaluation was unnecessary “due to the severity of the neurocognitive impairment.”

However, there is documentation of functional abilities that would not be generally consistent with the presence of a moderate to severe dementia and would not indicate cognitive impairment of such severity that a neuropsychological assessment would be unnecessary, such as continuing to work as a general contractor, going to the gym in the morning to work out, and being able to drive. Additionally, Dr. █████ documented an MMSE score of 24 out of 30 in his evaluation note dated 10/24/17, which would not typically indicate the presence of a moderate to severe dementia or indicate severity of cognitive decline such that a neuropsychological assessment would either not be possible or medically unnecessary. Consequently, the diagnosis is not generally consistent with the Settlement criteria for Level 2 Neurocognitive Impairment.

Doc. 217202 at 1 (break added).

Appealing that Denial, Mr. █████ offered Dr. █████’s late-arriving explanation for his determination that neuropsychological testing was unnecessary. Doc. 230630. In a letter dated November 24, 2020, Dr. █████ wrote:

As a Board Certified Neurologist/Qualified MAF Physician, I determined that certain testing, including neuropsychological testing, was medically unnecessary because of the severity of this patient’s dementia which is an identified diagnosed condition currently developed in existence and experienced by the patient at the time of diagnosis.

The factual basis for said determination is based upon various factors, including his higher integrative function assessment, Mr. █████ completed the mini mental status examination whereby he, not only was unable to do a 3-step command completely without prompting, nor was he able to recall 3 of 3 objects at 5 minutes, he had difficulty registering the 3 objects to begin with. Also having difficulty with the intersecting pentagons, his overall score on the mini mental status examination was 24 out of 30. Scores between 10 and 19 traditionally indicate moderate dementia. However, people with early stage Alzheimer’s disease tend to score in the 19 to 24 range. Taking into account his scores, the rest of my examination, the

CDR, his diagnostic testing, age, education, and race/ethnicity, I found further Neuropsychological testing was unnecessary.

Said determination is further based upon his high field diagnostic Brain MRI with DTI (Diffusion-Tensor Imaging) and FT (Fiber Tractography), using 3D reconstruction technique accessing neural tracts which revealed the existence of abnormal and extensive white matter disease that actively involves the gray-white matter interface with micropechial hemorrhages, demonstrating axonal injury and shearing injury; and on 3D tractography, evidence of neuronal loss predominantly along the periinsular region on the left when compared to the right and in both frontal lobes. The leukoencephalomalacia seen in the right frontal lobe anteromedially shows decreased fractional anisotropy and hemosiderin; all of which identified as head trauma resulting in actual cognitive impairment.

Said determination and diagnosis is further supported by and based upon, my personal neurological assessment and examination, having performed the appropriate functional impairment evaluation specifically the criteria set forth in the National Alzheimer's Coordinating Center's Clinical Dementia Rating (CDR), the areas of Community Affairs, Home & Hobbies, and Personal Care, demonstrating this retired NFL player's functional impairment as referenced in my reports, herein, and having taken into consideration all of the documentary evidence necessary to corroborate his functional impairment, including either, prior records, and where required, third-party accounts by an independent person familiar with the patient's condition given to me under oath, and have determined the sufficiency of said aforementioned evidence to be satisfactory and qualifying pursuant to my Qualified MAF Physician Manual and Settlement Agreement Exhibit A-1 (subsection 1 (a)(i)-(iv) and 2 (a)(i)-(iv)).

Doc. 230631 at 38-39 (breaks added).

I remanded Mr. ██████ Claim for re-review; the Claims Administrator denied it a second time on February 17, 2021. Doc. 232953. Relying again on the AAP, the Claims Administrator concluded that Mr. ██████ Claim did not satisfy the Injury Definition for Level 2 Neuropsychological Impairment: he had neither satisfied criterion (ii) due to the lack of neuropsychological testing and inadequate explanation from Dr. ██████, nor criterion (iii) due to indicators that Mr. ██████ was functioning at a higher level than Level 2.0 Neuropsychological Impairment would allow. *Id.*

Mr. ██████ appealed again; I remanded a second time for review on September 9, 2021. Doc. 238273. This (third) review considered the import of new evidence: neuropsychological and neurological testing Mr. ██████ completed through the BAP in 2018. On February 6, 2018, during the pendency of his Claim's (first) review, Mr. ██████ completed a BAP neuropsychological evaluation with Dr. ██████. Doc. 238327. Dr. ██████ concluded that Mr. ██████ testing did "not indicate evidence of neurocognitive impairment," primarily because his suboptimal

performance validity “indicate[d] a high likelihood of invalid cognitive performance at the time of the evaluation.” *Id.* at 11. Dr. [REDACTED] also reviewed the testing conducted by Dr. [REDACTED]:

The patient submitted to this examiner records of a neurological evaluation conducted by [REDACTED], M.D. on October 24, 2017, as well as a brain MRI performed the following day. These evaluations were performed for the NFL Concussion Settlement MAF program. Dr. [REDACTED] opined that the patient had a Clinical Dementia Rating scale rating of 2.0 (moderate) in the areas of community affairs, home and hobbies, and personal care, although he did not report any details in his evaluation regarding what daily functional activities the patient can or cannot do, which is information that is necessary to assign a CDR rating. It is noted that as of the time of the present neuropsychological evaluation, the patient reportedly works 50 hours per week at his business, drives without difficulty, and performs all other ADLs assessed by these three CDR categories independently. Thus, the patient does not meet the definition of any functional impairment according to the CDR rating scale.

Dr. [REDACTED] reported that he made an overall diagnosis of level 2 neurocognitive impairment (which according to NFL Concussion Settlement guidelines equates to moderate stage dementia). However, the basis for Dr. [REDACTED]’s diagnosis of level 2 neurocognitive impairment (moderate dementia) is unclear, as there are numerous findings inconsistent with the presence of moderate stage dementia (e.g., full-time gainful employment; driving without major problem; ability to recall personal history including head injuries in great detail). An individual with moderate stage dementia is not able to work or drive and typically requires institutional care or 24-hour supervision to ensure their safety. Moreover, Dr. [REDACTED] reported that he administered a mini mental status exam to the patient, with the patient scoring 24 out of 30 possible points. A score of 24 on the MMSE is considered to be in the normal range and is inconsistent with the presence of moderate stage dementia. Finally, even if we ignored the findings from the present neuropsychological evaluation indicating the invalidity and non-credible nature of the patient’s cognitive test performance, his performance on the actual cognitive testing was largely in the normal range and demonstrates that he does not meet criteria for any level of neurocognitive impairment as defined by NFL Concussion Settlement guidelines.

Id. Dr. [REDACTED], a BAP neurologist, concurred with Dr. [REDACTED]’s conclusion that Mr. [REDACTED] “BAP level of disability is NONE at this time.” Doc. 238328 at 2. Like Dr. [REDACTED], Dr. [REDACTED] reviewed “the outside assessment” (Dr. [REDACTED]’s evaluation) and found “less neurological and psychological impairment at this time.” *Id.*

During the review, Mr. [REDACTED] Claim was placed into audit. Doc. 238488. The audit focused primarily on Mr. [REDACTED] employment history and covered his work history as a realtor and general contractor. The Claims Administrator ultimately concluded its audit on October 11,

2022, without making a finding of misrepresentation, omission, or concealment of material facts. Doc. 271013.

At the same time, an AAPC, reviewing Mr. [REDACTED] remanded Claim, considered Mr. [REDACTED] evaluations by Drs. [REDACTED], [REDACTED], and [REDACTED]. Doc. 239223. The AAPC concluded that Mr. [REDACTED] did not meet the criteria for a Qualifying Diagnosis on four grounds:

- a) Clear evidence of low effort and/or intentional poor performance on PVTs,
- b) Multiple Slick Criteria indicators of “malingered neurocognitive impairment”,
and
- c) Only one cognitive domain impaired at Level 1.5 or worse
- d) No functional impairment that can be attributed to dementia

Id.

Dr. [REDACTED]’s neuropsychological testing was rescored using the New Method on October 24, 2022. Doc. 271771. After rescoring, the (invalid) testing nominally demonstrated Level 1.5 impairment in Complex Attention and Level 2 impairment in Learning & Memory, Visual-Perceptual Processing, and Language, for an overall score of Level 2 impairment. *Id.*

The rescored neuropsychological testing and conclusion of the audit prompted yet another review by the AAPC on October 25, 2022. Doc. 271896. The AAPC reiterated the majority of conclusions from the 2021 AAPC report, with the exception of noting that four of five cognitive domains were ostensibly impaired after New Method rescoring. *Id.*

The AAPC identified three remaining reasons that Mr. [REDACTED] nevertheless did not meet the criteria for a Qualifying Diagnosis: “a) failure of multiple PVTs, indicating low effort to perform well or intentional poor performance, b) at least four *Slick* criteria for malingering being positive, and c) lack of convincing evidence of any functional impairment.” *Id.* at 1. The AAPC also elaborated on several specific issues raised during the audit and intervening appeals:

- 1) The patient’s attorneys argued that his “stuttering, stammering, and speech obstruction from his football related NCI are such that it is an impediment that would be a hinderance, invalidating any further neuropsychological testing, and it certainly made it medically unnecessary to diagnose his said NCI.” They also argued, based on statements by Dr. [REDACTED], that neuropsychological testing was inapplicable to this patient as he was incapable of undergoing the tests.

All of these statements are patently false.

- a) Dr. [REDACTED]’s own testing of the patient yielded a MMSE score of 24/30. This score is in the “borderline” range and clearly not indicative of an untestable patient.

- b) The patient's stuttering was described by Dr. [REDACTED] as "occasional," and did not interfere with testing. Furthermore, the patient reported that his stuttering began his sophomore year of college and he experienced no recent changes in his speech. The likelihood that it is a component of an acquired neurocognitive disorder as defined by this Settlement is negligible.
 - c) The fact that Dr. [REDACTED] was able to test the patient without any report of difficulty obviously invalidates Dr. [REDACTED]'s statement that he was incapable of undergoing cognitive testing.
- 2) Dr. [REDACTED]'s neuropsychological report makes no mention of any emotional "breakdown" during testing, as asserted by the patient's attorneys. In fact, Dr. [REDACTED] reports that the patient was able to stay on task, had no difficulty focusing, and had a generally positive mood and normal affect throughout the evaluation.
- 3) The patient scored below the cut-off for validity on multiple well-validated PVTs: the Medical Symptom Validity Test, Test of Memory Malingering, and three out of five ACS "effort" tests. This means that his low scores on the BAP neurocognitive test battery cannot be interpreted as reflecting brain impairment. It also means that his average or higher scores reflect abilities that are at least that strong.
- 4) The fact that the patient's responses on the 338-item MMPI-2-RF resulted in a valid and interpretable profile suggests strongly that his language skills (assessed as at Level 2 impairment by the New Method) are intact.
- 5) The Claims Administrator has uncovered extensive evidence of the patient's gainful employment as a general contractor, construction project supervisor/superintendent, and real estate agent over the past five years. This information came from his several previous employers as well as [REDACTED]. The specifics of the patient's earnings clearly contradict several of his responses to queries during the appeals and audit process (e.g., "In the last five years, I worked zero hours for [REDACTED]." "I didn't work as a contractor under my license in the last five years.")

In summary, this former player appears to have misrepresented some aspects of his work history as well as his neurocognitive abilities. He does not meet Settlement Program criteria for a neurocognitive disorder at the present time.

Id.

The Claims Administrator then denied Mr. ██████ Claim for a third time on October 31, 2022, citing the AAPC's report. Doc. 272505. After multiple extensions, Mr. ██████ appealed almost a year later. Doc. 289750.

RESOLVING THIS APPEAL

The Settlement Program's review of Mr. ██████ Claim has been attenuated and extensive: over five years have elapsed since the Claim's submission and over six since Dr. ██████ conducted his underlying neurological examination. The Claim's various denials, appeals, remands, and reviews have all stemmed from the inadequacy of that initial testing, in which Dr. ██████ asserted that neuropsychological testing was unnecessary and offered a plainly insufficient justification for doing so.

Despite the Claim's baroque history, this Appeal is the first to reach the merits. Though Mr. ██████ counsel argues with vigor, I conclude that there is not clear and convincing evidence that the Claims Administrator erred. Simply put, Dr. ██████'s 2017 examination, without attendant neuropsychological testing, did not provide sufficient evidence consistent with the Injury Definition criteria for Level 2 Neurocognitive Impairment. Doc. 289750.

The Settlement requires neuropsychological testing to establish a Diagnosis of Level 2 Neurocognitive Impairment and provides for waiver only when "the diagnosing physician can certify that... [it] is medically unnecessary because the Retired NFL Football player's dementia is so severe."¹ The diagnosing physician's judgment must be "reasonably determined," a standard that I have interpreted to mean that it must be "reasonable to have concluded that the testing would not generate valid results."²

Dr. ██████'s justification for the absence of neuropsychological testing, here and in other Claim submissions, falls well-short of what the Settlement requires.³ The Claims Administrator correctly evaluated his judgment using the customary two-pronged inquiry: "How severe was the impairment; and, Why does the impairment's severity make the testing unnecessary?"⁴ Neither Dr. ██████'s contemporaneous report nor his later explanation illustrate impairment so severe that it would preclude Mr. ██████ from completing neuropsychological testing. He scored a 24/30 on the MMSE; the AAPC opines that that score "is in the 'borderline' range and clearly not indicative of an untestable patient." Doc. 271896. I will adopt their expert judgment, which was echoed by

¹ Settlement Agreement, Exhibit 1, Section 2(b).

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.

³ Prior to his termination as a MAF physician, Dr. ██████ repeatedly insisted that neuropsychological testing attendant to his evaluations was unnecessary; independent reviewers have found those reasons wanting and consequently Dr. ██████'s testing has led to the denial of multiple claims. *See, e.g.*, Special Master Ruling on Absence of Neuropsychological Testing, at 1 n. 1 (March 29, 2023), https://www.nflconcussionsettlement.com/Docs/absence_np_testing_sm.pdf (noting numerous examples).

⁴ 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.

Dr. [REDACTED] in his evaluation, and conclude that Mr. [REDACTED] impairment is not so severe that it would make testing impossible.

Mr. [REDACTED] also argues that his later neuropsychological testing, which Dr. [REDACTED] found to be invalid after considering multiple *Slick* criteria, legitimates Dr. [REDACTED]’s judgment that Mr. [REDACTED] earlier neuropsychological testing was unnecessary. It does not. Dr. [REDACTED] explicitly decoupled Mr. [REDACTED] suboptimal performance from “genuine memory impairment” in his explanation of several performance validity measures:

The patient performed in the suboptimal range on the MSVT, with an “implausible” pattern of performance, which is suggestive of non-credible performance and is not consistent with being unable to pass the MSVT due to genuine impairment. He also performed in the suboptimal range on the TOMM. Additionally, he performed in the suboptimal range on 3 out of the 5 ACS effort measures, with overall ACS effort classification as suboptimal.

Notably, the patient’s performance on multiple PVTs in a memory paradigm cannot be attributed to genuine memory impairment, given that he performed in the normal range on an actual test of visual memory, and on two verbal memory tests he demonstrated normal performance on one and only a marginal weakness on the other. These latter findings demonstrate that he has grossly normal memory ability.

Doc. 238327 at 4.⁵ As I opined last year in a case with very similar facts, “The fact that the neuropsychological testing protocol served its intended purpose—detecting inconsistent, insufficient, task engagement—does not support the conclusion that testing could not have been completed at all.”⁶

Finally, Mr. [REDACTED] contests the Claims Administrator’s judgment that his documented functional impairment undermines his Diagnosis. Doc. 289750. Dr. [REDACTED] reported CDR scores of 2.0 in Community Affairs, Home & Hobbies, and Personal Care. Doc. 187261. But, as the Claims Administrator notes, Dr. [REDACTED]’s report also explained that Mr. [REDACTED] recently worked as a general contractor, went to the gym, and drove somewhat regularly: these are activities generally incompatible with the assigned CDR scores. *Id.* Dr. [REDACTED] and Dr. [REDACTED] assigned Mr. [REDACTED] scores of 0 in the same three CDR categories. Docs. 238327; 238328. The 2022 audit, while failing to conclude that Mr. [REDACTED] had misrepresented any material facts, did uncover more details of his employment history, which includes work as a general contractor and real estate agent. Given this

⁵ Mr. [REDACTED] explains in his Appeal that he experienced acute psychological distress during his neuropsychological evaluation by Dr. [REDACTED] and that ensuing disruptions may have led to his suboptimal performance validity testing. Doc. 289750. This is a hard claim to evaluate on Appeal, as it is presented through a letter from Mr. [REDACTED]’s wife to his lawyer. And even if it were easy to consider, the AAP does not accept that this distress, which is not evidenced in the contemporaneous medical records, would have led to the pattern of suboptimal validity testing Dr. [REDACTED] observed. I adopt the AAP’s view.

⁶ Special Master Ruling on Absence of Neuropsychological Testing, at 5-6 (March 29, 2023), https://www.nflconcussionsettlement.com/Docs/absence_np_testing_sm.pdf.

record evidence, I cannot conclude that there is clear and convincing evidence that the Claims Administrator's denial on the basis of functional impairment was in error.

Mr. [REDACTED] voluminous briefing on appeal, including more than two dozen exhibits and multiple cross-references in his briefs, documents his decline over the past several years, including updated third-party affidavits from 2020, which describe Mr. [REDACTED] withdrawal from social life and unwillingness to attend church, see friends, play card games, or watch football. Doc. 289752. Mr. [REDACTED]'s family describes a worsening domestic situation, and their struggles to assist him. *Id.* Dr. [REDACTED] enumerated some of that same post-2017 change in a 2020 addendum to his evaluation. *Id.* I have carefully reviewed this post-2017 documentation of cognitive and functional decline. It does not remedy the flaws at the heart of Dr. [REDACTED]'s initial evaluation: Mr. [REDACTED] Claim does not include testing that the Claims Administrator could have reasonably relied on as the basis for a Qualifying Diagnosis in 2018, nor reliable evidence consistent with a CDR of 2.0 at that time.

Mr. [REDACTED] remains eligible for a (free) Expanded BAP examination. Doc. 261370. Given the delays in his original Claim's resolution, some of which were not in his control, I extend by six months the time by which he can request that examination, if he has not already done so: from March 4, 2024, until September 24, 2024.

CONCLUSION

Mr. [REDACTED] has not offered clear and convincing evidence that the Claims Administrator erred in denying his Claim. I deny his Appeal.

Date: February 3, 2024



David A. Hoffman, Special Master