

IN RE: NATIONAL FOOTBALL LEAGUE
PLAYERS' CONCUSSION INJURY
LITIGATION

MDL No. 2323

Hon. Anita B. Brody

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

The Claims Administrator, accepting this determination, denied the Claim. Mr. [REDACTED] filed an Appeal, which I now deny.

Before the examinations that led to this Claim, Mr. [REDACTED] saw BAP neuropsychologist Dr. [REDACTED] on November 14, 2018. Doc. 268520 at 19. After conducting neuropsychological and validity testing, Dr. [REDACTED] found that “the overall cognitive validity findings from this evaluation are consistent with *Suboptimal* performance validity,” indicating “a high likelihood of invalid cognitive performance at the time of the evaluation.” *Id.* at 23. Therefore, Dr. [REDACTED] concluded that “the cognitive diagnostic findings from this evaluation indicate *No Diagnosis of Neurocognitive Impairment* according to the NFL-BAP program guidelines.” *Id.* at 31.

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disorder.” *Id.* at 34. Dr. [REDACTED] therefore concluded that Mr. [REDACTED] “does not meet BAP impairment criteria.” *Id.*

About four years later, on November 6, 2022, Mr. [REDACTED] filed a Claim asserting a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment dated October 18, 2021. Doc. 272790. His Diagnosing Physician, then MAF neurologist Dr. [REDACTED], evaluated Mr. [REDACTED] on March 7, 2022, and based his Diagnosis in part on a “neuropsychological assessment of Oct 18, 2021.” Doc. 268520 at 4.

Neuropsychologist Dr. [REDACTED] conducted that October 2021 assessment. *Id.* at 6. Dr. [REDACTED] met with Mr. [REDACTED] conducted a battery of neuropsychological and validity testing, and completed the following *Slick* checklist:

- Suboptimal scores on embedded and stand-alone performance validity measures – *on embedded measures, but not stand-alone measures*
- Pattern of performance markedly discrepant from accepted models of CNS dysfunction –*No*
- Discrepancy between test data and observed behavior –*No*
- Discrepancy between test data and reliable collateral reports –*No*
- Self-reported history discrepant with documented history –*No*
- Self-reported symptoms discrepant with known patterns of brain abnormality—*No*
- Self-reported symptoms discrepant with behavioral observations –*No*
- Self-reported symptoms discrepant with reliable collaterals’ descriptions of behavior – *No*

Id. at 11.

Finding only one *Slick* criterion triggered, Dr. [REDACTED] concluded that because “other indicators of validity appeared within normal limits [...] Mr. [REDACTED] test results are considered valid.” *Id.* Those results, once rescored under the New Method, purported to reveal Level 2 impairments in the complex attention and learning and memory domains, Level 1.5 impairment in the visual-perceptual processing domain, and no impairment in the executive functioning or language domains—for an overall cognitive impairment rating of Level 2. Doc. 274138.

But the AAP, reviewing the medical records on December 12, 2022, observed significant validity issues with Mr. [REDACTED] neuropsychological testing:

This former player has had two neuropsychological exams as part of the Settlement Program. The first was by Dr. [REDACTED] on 11/14/18. The then-35-year-old failed every performance validity test, triggered on two other *Slick* criteria (#3 and #4), and gave wildly exaggerated psychopathology responses on the MMPI-2-RF (5 validity scores at T>95). Dr. [REDACTED] appropriately diagnoses no neurocognitive impairment, per Exhibit 2 criteria.

The second exam was performed by Dr. [REDACTED] on 10/18/21. On this exam, the patient met criteria for Level 2 cognitive impairment (New Method) but, again, there are validity concerns. The patient passed the TOMM and the MSVT, but scored at or below the 5 percent base-rate score on 4/5 ACS performance validity tests. In addition, his symptom validity is still highly questionable, with 5 MMPI-2-RF validity scores at T>80 (i.e., >99th percentile).

Although Dr. [REDACTED] rates only Slick #1 as present, there are multiple other features that suggest disingenuous behavior. The patient told Dr. [REDACTED] that he had been diagnosed with ADAH in early life and treated with Adderall. There is no mention of this diagnosis in Dr. [REDACTED] report, only “a struggle with focus in class.” Dr. [REDACTED] apparently did not consider this at all in his formulation of the patient. This is sufficient for Slick criterion #6 to be judged present. In addition, on interview, the patient describes having numerous, very severe psychiatric symptoms but never receiving treatment. On the MINI, he met criteria for 7 separate psychiatric disorders, yet his behavior, language, and affect on interview were all normal. Criteria #6 (again) and #8 should be coded positive.

Overall, then, there are major concerns about the validity of this patient’s history, test performance, and symptoms. A qualifying diagnosis should not be made.

Doc. 274478.

The Claims Administrator reached out to Dr. [REDACTED] for his response to the AAP’s concerns. Regarding the AAP’s assessment of the validity testing, Dr. [REDACTED] wrote:

The reviewer is incorrect. Reliable Digit Span and ACS Word Choice were both above the 15th percentile, leaving 3/5 indicators falling at or below the 10th percentile. This is consistent with information presented in my original report.

Use of the MMPI-2-FR measures to validate/invalidate cognitive test validity is inconsistent with practice parameters in neuropsychology. “Invalid performance on a measure of personality does not allow for an a priori conclusion that the neurocognitive test results are also unreliable, and vice versa” (Bush et al. 2005. Symptom validity assessment: Practice issues and medical necessity. *Archives of Clinical Neuropsychology*, Vol. 20, p. 424).

Doc. 280681.

As for the AAP’s *Slick* criteria analysis, Dr. [REDACTED] wrote:

I am assuming the reviewer is indicating that Mr. [REDACTED] reported having been diagnosed with *ADHD* earlier in life. As “struggle with focus in class” is a

diagnostic criterion for ADHD, this certainly is consistent with Mr. [REDACTED] report, although potentially downplaying the history. As such, this does not appear sufficient to rate the Slick criterion #6 as present. As determination of the presence or absence of the Slick criteria is based on the examiner's judgment, it is my determination that the Slick criteria were correctly represented in the original report [...]

The reviewer's concern here is whether Mr. [REDACTED] had valid psychiatric symptoms. My original report addresses the invalidity of Mr. [REDACTED] psychiatric symptoms and the absence of valid psychiatric diagnoses. However, it is clearly possible that a person can present with invalid psychiatric symptoms while at the same time reporting valid neurocognitive symptoms that are confirmed with cognitive testing. For instance, persons who have Conversion disorder and show functional neurological signs can still have valid neurocognitive symptoms from other causes that are confirmed by neurocognitive test results.

Id.

Evaluating Dr. [REDACTED] response, the AAP noted the following, in relevant part:

Dr. [REDACTED] is correct in writing that 3/5, not 4/5, ACS performance validity tests (PVTs) were performed at or below 5% base-rate scores. I apologize for my error. Nonetheless, according to this Program's *Neuropsychologist's Handbook*, failure of 3 PVTs at this level is more than sufficient to indicate a "high likelihood of invalid performance."

Dr. [REDACTED] is correct in writing that symptom exaggeration is not a legitimate reason to question the validity of neurocognitive test performance. I never wrote or implied such. I simply wrote that *symptom validity* is also highly suspect.

In his response, Dr. [REDACTED] appears to acknowledge that the patient had ADHD since childhood and took medication for it. However, he downplays its significance and disagrees with me that Slick criterion #6 is present.

Finally, although the patient met criteria for seven psychiatric disorders on psychiatric interview (MINI), Dr. [REDACTED] apparently believes that these are invalidated by the MMPI-2-RF. He does not acknowledge that Slick criteria #6 and #8 are present.

In summary, Dr. [REDACTED] response does not alter my opinion in this case.

Doc. 305350.

The Claims Administrator also reached out to Dr. [REDACTED] for clarification on “the role noncognitive factors, such as mood state, sleep disorder, and physical limitations, had on Mr. [REDACTED] functional abilities and [...] the role the pre-NFL career diagnosis of ADHD had on his functional and cognitive abilities.” Doc. 282250. Dr. [REDACTED] responded on July 10, 2023, as follows:

[REDACTED] – Neuropsychological evaluation Oct 2021 level 1.5 impairment. Functional CDR sub-scores 1, 2, 1. Prior diagnosis of ADD (unlikely “ADHD” in an adult) not felt to be causal of his amnestic syndrome, and not a progressive multi-cognitive domain degenerative entity. BTW ADD is mentioned in 2 paragraphs on page 4. Please refer to detailed histories and affidavit and CDR. Also see neurology clinic visit note May 30 2023. Qualifying diagnosis still level 1.5

Doc. 286233.

The Claims Administrator asked for “a copy of the neurology clinic visit note, dated 5/30/23,” Doc. 286268, which Dr. [REDACTED] provided on November 14, 2023. Doc. 293673. The note described symptoms such as short-term memory issues, sleep and mood issues, and headaches. *Id.* Equipped with this report and Dr. [REDACTED] explanation, the AAP reviewed the record once more on February 23, 2024, with particular attention to “whether deference to the examining clinicians’ diagnoses might be appropriate.” Doc. 305350. The reviewer, in relevant part, documented a number of issues with Dr. [REDACTED] and Dr. [REDACTED] analyses:

2. On Dr. [REDACTED] October 2021 exam (including information he supplied later),
 - a. The patient’s diagnosis of ADD and his being treated with Adderall while in college is never mentioned. [suggests Slick criterion #6]
 - b. He is described as “essentially unemployed” since 2014, but Dr. [REDACTED] wrote that “he started a kettlebell training gym in 2012 and is still doing that now. ...He owned the gym for 7 to 8 years...” [suggests Slick criterion #6]
 - c. The patient complained of “problems with stuttering as well as forgetting words mid-sentence and mid-thought,” but Dr. [REDACTED] found that “speech was fluent and free of anomic or paraphrastic errors.” Dr. [REDACTED] also reported “good and rapid attempts to answer questions. Normal language.” [suggests Slick criterion #8]
 - d. The patient reported that “his wife took over handling the finances about 4-5 years ago,” but his wife reported that “he handles his bills and financial affairs without difficulties.” [suggests Slick criterion #6]
 - e. The patient reported that “he does not have leisure activities other than spending time with his children,” but his wife reported that “he has various hobbies and interests, and while he never completely lets such activities go, he may do it for a while and then switch to something else.” [suggests Slick criterion #6]
 - f. The patient scored at or below the 2% base-rate score on two ACS PVTs and below the 5% base-rate score on a third. As stated previously, this by itself may invalidate the neurocognitive testing. [Triggers Slick criterion #1]

- g. As on Dr. [REDACTED] neuropsychological exam, the patient produced extreme elevations (T>80) on all five MMPI-2-RF scales that assess exaggeration of physical, cognitive, behavioral and emotional symptoms. His MINI diagnoses are similarly noncredible. [suggests Slick criterion #7]
 - i. Dr. [REDACTED] acknowledges that “his personality inventory was invalid. As such, there is no support for the presence of these other mental disorders.”
- 3. Regarding Dr. [REDACTED] March 2022 MAF evaluation,
 - a. The patient was working as an insurance adjuster
 - i. Although he claims memory problems at work, his wife notes that he talks to her about cases that stand out and she has had “no direct or indirect feedback about his performance.” [suggests Slick criterion #5]
 - b. The patient reported weakness on the left side of his body. This was not found on the neurological exam. [suggests Slick criterion #8]
 - c. The patient displayed no abnormalities at all on the neurological exam, including the mental status portion. [suggests Slick criterion #2]
 - i. The patient’s MoCA score of 26/30 is normal for the patient’s age and education (Rosetti et al., 2011).
 - ii. This is incompatible with
 - 1. Dr. [REDACTED] finding of Level 1.5 overall cognitive impairment
 - 2. Dr. [REDACTED] diagnosis of early dementia (Level 1.5 Neurocognitive Impairment).

Although one or two of these issues might be overlooked in deference to Dr. [REDACTED] and Dr. [REDACTED] clinical judgment, taken together, they paint a picture that is utterly incompatible with a dementia syndrome. Exhibit 2 criteria for Level 1.5 Neurocognitive Impairment are not met.

Id.

Accordingly, the Claims Administrator denied Mr. [REDACTED] Claim on May 6, 2024. Doc. 324848. Referencing the Settlement’s diagnostic criteria for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, the Claims Administrator explained that while criteria (i), (iii), and (iv) were satisfied, criterion (ii)—evidence of moderate to severe cognitive decline in two or more cognitive domains—was not. *Id.* Noting the Program’s “standard of ‘layered deference to’ the clinician’s expertise, so long as their medical judgment is ‘thoroughly articulated’ and ‘reasonably determined,’” the Claims Administrator explained the AAP’s conclusion “that, although Dr. [REDACTED] explanation is thoroughly articulated, it is not reasonably determined because multiple issues with Dr. [REDACTED] and Dr. [REDACTED] reports taken together paint a picture that is incompatible with a dementia syndrome and therefore did not alter the prior AAPC determination that the neuropsychological testing results were invalid.” *Id.*

Mr. █████ appealed the Denial on July 3, 2024, arguing primarily that the Claims Administrator erred in not deferring to Dr. █████ findings on validity. Doc. 346870 at 4. The NFL Parties filed their response on October 7, 2024. Doc. 361503.

RESOLVING THIS APPEAL

The core problem with Mr. █████ Claim is the invalidity of his neuropsychological testing. Citing voluminous record evidence pointing to invalidity, the AAP determined that Dr. █████ insistence to the contrary was, though fully articulated, not reasonable. Doc. 305350. Dr. █████ reasoning suffered similar deficiencies in that he ignored facts indicating several *Slick* criteria. *Id.* The AAP found the clinicians' combined medical judgment to be "utterly incompatible with a dementia syndrome." *Id.*

The Claims Administrator, following this independent medical guidance, rejected Dr. █████ and Dr. █████ judgment when it denied Mr. █████ Claim. Doc. 324848. To prevail here, Mr. █████ must prove by clear and convincing evidence that this decision was in error. He has not met this burden.

The purpose of the *Slick* checklist is to "determine whether the Retired NFL Football Player's test data is a valid reflection of his optimal level of neurocognitive functioning."¹ Typically, the "AAP should defer to a clinician's *Slick*-criteria-based validity analysis when it results from reasoning completely articulated in contemporaneous reports, unless the analysis is clearly erroneous."² Where the clinician's medical reasoning is fully articulated, the "'clearly erroneous' bar for overriding a clinician's articulated reasoning is—appropriately—very high."³ A clinician's analysis must be more than merely "'wrong'" for deference to be inappropriate.⁴ It must instead contain errors "'so basic and foundational as to render his determinations unreasonable.'"⁵

These prudential standards urging deference have limited application here. The relevant diagnosing neurologist was Dr. █████ In July of this year, I determined that because of Dr. █████ diagnostic practices, as well as the unusual arrangements he made with Mr. █████ counsel, it would be inappropriate to give his views deference in the review process.⁶ Dr. █████ too, engaged in the same concerning billing practices, and consequently the Claims Administrator need not reflexively defer to his views either.

¹ Settlement Agreement, Exhibit A-2 (2).

² Special Master Ruling on *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

³ Special Master Ruling on Validity Testing and Deference, at 7 (Feb. 14, 2024), https://www.nflconcussionsettlement.com/Docs/validity_testing_deference_sm_2.pdf.

⁴ *Id.*

⁵ *Id.*

⁶ Special Master Ruling on Mixed Etiology for Alzheimer's Disease Diagnosis, at 6 n.9 (July 16, 2024), https://www.nflconcussionsettlement.com/Docs/alz_diagnosis_sm_3.pdf.

The review process in this case predated uncovering these facts, and the Claims Administrator afforded Dr. [REDACTED] and Dr. [REDACTED] views the layered deference which is the usual norm, assuming those views were completely articulated. Docs. 274478; 305350. This was a generous assessment of medical reports which were notably silent about key facts that undermined their conclusions.

Even applying this highly deferential standard, the AAP found so many basic, foundational errors in Dr. [REDACTED] and Dr. [REDACTED] analyses that the net result was “utterly incompatible” with the Settlement’s diagnostic criteria for Level 1.5 Neurocognitive Impairment. Doc. 305350. Specifically, the AAP observed striking discrepancies between Mr. [REDACTED] reported symptoms on the one hand, and his wife’s reports and his own behavior on the other. *Id.* For example, he reported being “‘essentially unemployed’ since 2014,” but during that time he ran a kettlebell training gym for “7 or 8 years” and is “still doing that now.” *Id.* Mr. [REDACTED] also claimed that his wife handles all the finances, and he denied having any hobbies. *Id.* Yet according to his wife, Mr. [REDACTED] “handles his bills and financial affairs without difficulties” and maintains “various hobbies and interests.” *Id.*

The clinicians simply neglected to grapple with these inconsistencies. *Id.* Mr. [REDACTED] displayed “no abnormalities at all on the neurological exam,” and the actual performance validity testing failures might have been sufficient *on their own* to invalidate the neuropsychological scores. *Id.* Where Dr. [REDACTED] only found one *Slick* criterion triggered, the AAP found five. Docs. 268520 at 11; 305350. These failures to engage with basic facts that undermined their analyses make the clinicians’ conclusions unreliable.

My role on appeal is to ask if there is clear and convincing evidence of error in the claims review process and in the Denial that it produced. It is easy to conclude that given the extensive factual evidence the AAP considered, and the assiduity with which it approached the question of deference, its determination was not erroneous. It follows that the Claims Administrator, relying on that advice in denying Mr. [REDACTED] Claim, did not err either.

CONCLUSION

Because Mr. [REDACTED] has not provided clear and convincing evidence of error in the Claims Administrator’s decision, I deny the Appeal.

Date: November 22, 2024



David A. Hoffman, Special Master