

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

On September 6, 2018, MAF Neurologist Dr. [REDACTED] evaluated Mr. [REDACTED]. Doc. 228318. During that evaluation, Mr. [REDACTED] received a Montreal Cognitive Assessment (MoCA) score of 16/30 and an overall Clinical Dementia Rating (CDR) score of 1.0. *Id.* Mr. [REDACTED] subsequently underwent neuropsychological testing with Dr. [REDACTED] on October 18, 2018, and Dr. [REDACTED] on February 25, 2019. Doc. 223114 at 1-8, 14. Both rounds of testing produced invalid results. *Id.*

On October 17, 2019, Dr. [REDACTED] evaluated Mr. [REDACTED] for a second time. Doc. 223109. Mr. [REDACTED] received a MoCA score of 20/30 and an overall CDR score of 1.0. *Id.* at 3. In light of Mr. [REDACTED]'s invalid neuropsychological test results, Dr. [REDACTED] recommended repeat testing one year from the February 2019 evaluation with Dr. [REDACTED]. *Id.* at 5.

Dr. [REDACTED] again tested Mr. [REDACTED] on March 19, 2020. Doc. 223114 at 12-17. Mr. [REDACTED]'s test scores revealed Level 2 Impairment in four neurocognitive domains—Complex Attention, Learning and Memory, Visual-Perceptual, and Language—and no impairment in Executive Functioning. *Id.* at 16. Dr. [REDACTED] determined that “Mr. [REDACTED]'s performance was . . . valid according to the Slick criteria checklist” and therefore his performance was “consistent with Level 2.0 Neurocognitive Impairment.” *Id.* at 15, 17.

Having received these test results, Dr. [REDACTED] certified a Diagnosis of Level 1.5 Neurocognitive Impairment, dated April 3, 2020. Doc. 223115. In her accompanying report, she explained her downward deviation from the neuropsychological test results:

Although the neuropsychological profile is consistent with Level 2.0 impairment, the patient's history, mental status exam, and CDR are more generally consistent with Level 1.5 impairment. Therefore, as per diagnostic criteria set forth by the settlement guidelines, the patient's degree of cognitive impairment correlates most appropriately with a Level 1.5 impairment.

Doc. 223109 at 5.

Mr. [REDACTED] immediately filed his second Claim for a Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 223134. The Claims Administrator initially denied that Claim on October 19, 2020 after an Appeals Advisory Panel (AAP) Consultant disagreed with Dr. [REDACTED], concluding that Mr. [REDACTED]'s neuropsychological testing in March 2020 was invalid. Doc. 229570. Mr. [REDACTED] timely appealed. Doc. 230198. As part of his appeal, he provided a detailed explanation from Dr. [REDACTED] as to his findings on validity. Doc. 230197. I remanded Mr. [REDACTED]'s Claim for re-review. Doc. 230350. After reviewing Dr. [REDACTED]' explanation, the AAP Consultant reversed course, writing:

Although I disagree with some of Dr. [REDACTED]'s conclusions, he provides thoughtful, reasoned explanations for his clinical decision making. That is, he engaged in the *process* that is required of BAP neuropsychologists under the settlement agreement.

For these reasons, I will defer to him as the examining clinician (as is required) and support his diagnosis of Level 1.5 Neurocognitive Impairment.

Doc. 230509 at 4 (emphasis in original).

On December 8, 2020, the Claims Administrator approved Mr. [REDACTED]'s Monetary Award for a Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 231012. The NFL Parties did not appeal.

Roughly two years later, Mr. [REDACTED] began the process of pursuing a Supplemental Claim for benefits.

On January 12, 2023, then MAF neurologist Dr. [REDACTED] examined Mr. [REDACTED] as part of “an initial MAF evaluation.” Doc. 320287 at 10. Mr. [REDACTED] saw Dr. [REDACTED] on five additional occasions in 2023 for telemedicine visits: on March 28, May 23, July 6, September 7, and November 9. *Id.* at 5-9. Dr. [REDACTED] did not offer any Diagnosis, nor did he prepare any formal report beyond his visit notes.¹ *Id.*

On March 28, 2024,² Dr. [REDACTED] evaluated Mr. [REDACTED]. Doc. 320294. She conducted a neurological examination, a motor examination, and summarized Mr. [REDACTED]'s previous medical records. *Id.* During this evaluation, Mr. [REDACTED] received a MoCA score of 16/30 and an overall CDR score of 2.0. *Id.* at 2-3. In her report, Dr. [REDACTED] offered a Diagnosis of Level 2 Neurocognitive Impairment:

In summary, Mr. [REDACTED] is a 54 year-old male presenting for evaluation of cognitive complaints. He has illustrated progressive cognitive decline over the years, as documented by previous evaluations. Additionally, there is also noted evidence of a progressive decline over the years by his wife, whom he has known for several years. His MoCA score has decreased from 20/30 in 2019 to 16/30 per my evaluation. Though there was previous mention of possible sleep apnea, Mr. [REDACTED] notes that he does not snore as often as before. Thus, it is in my opinion that sleep

¹ The records that Mr. [REDACTED] uploaded to the Claim Portal on April 7, 2024 include handwritten MoCA and CDR assessments, which appear to have been completed on January 12, 2023, presumably during Dr. [REDACTED]'s initial in-office examination. Doc. 320287 at 12-27. The handwritten scoring of these two assessments is largely illegible and Dr. [REDACTED] did not memorialize them in any of his visit notes. *Id.* Dr. [REDACTED] entered into arrangements with medical funders whereby he purported to assign his right to collect from his patients, at marked-up rates, in return for immediate payments from those funders. He also maintained a practice of repeated visits after a Diagnosis, purportedly secured by liens on any resulting award. Lien Rules Implementation Opinion Regarding Asserted Attorney Costs, at 4-6 (June 24, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=2024.06.24_asserted_attorneys_costs.pdf. “Because of Dr. [REDACTED]'s diagnostic practices, as well as the unusual arrangements he made with [third-parties] it would be inappropriate to give his views deference in the review process . . . consequently the Claims Administrator need not reflexively defer to his views.” Special Master Ruling on Neuropsychological Testing, at 7 (Nov. 22, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=np_testing_sm_4.pdf.

² One of Dr. [REDACTED]'s CDR Assessment Forms incorrectly lists the date of Mr. [REDACTED]'s exam as March 27, 2024. Doc. 320285.

apnea, though it may be present to some degree, does not fully account for the patient's present cognitive deficits or decline. The patient was notably awake, alert, and interactive during the entire time of our evaluation. The patient also notes a prior history of depression. However, this seems to be adequately managed with medications. He was awake, alert, and very pleasant during our visit. He does not show any evidence of a mood disorder or side effects from medication that could account for his cognitive deficits. Thus, in my neurologic opinion, he has a qualifying diagnosis of Level 2 neurocognitive impairment.

Id. at 4.

On her MAF Diagnosing Physician Certification Form, Dr. [REDACTED] responded affirmatively to the question of whether she “determine[d] that certain tests in the BAP testing protocol were medically unnecessary because of the severity of the Retired NFL Football Player's dementia.” Doc. 320482 at 6. She explained:

Mr. [REDACTED] previously underwent neuropsych testing in March 2020 [conducted by Dr. [REDACTED]], and was found to have Level 2.0 neurocognitive impairment at that time. Additionally, he was noted to have progression of his cognitive dysfunction, as illustrated by the decrease in MoCA score from 20/30 in 2020 to 16/30 from my evaluation. There is evidence of decline from previous cognitive function. Thus, in my professional medical opinion, repeating neuropsych testing is not necessary.

Id.

Mr. [REDACTED] submitted his Supplemental Claim for a Diagnosis of Level 2 Neurocognitive Impairment on August 9, 2024. Doc. 352424.

The Claims Administrator requested review by the Appeals Advisory Panel Leadership Council (AAPLC) of Dr. [REDACTED]'s Qualifying Diagnosis. Doc. 356964. On September 22, 2024, the AAP Consultant expressed concern as to whether Dr. [REDACTED] could use Dr. [REDACTED]'s neuropsychological test results from 2020 to support her Diagnosis in 2024, over four years later:

A central question in this case is whether we can combine Dr. [REDACTED]'s 2020 neuropsychological exam results Dr. [REDACTED]'s 2024 neurological findings to confer the qualifying diagnosis of Level 2 Neurocognitive Impairment. I believe we should not, for the following reasons:

- 1) Neuropsychological test scores are not immutable characteristics of the person. They are a snapshot of the person's cognitive performance and emotional state at a single point in time.
- 2) We cannot assume that the patient will only get worse over time. Signs and symptoms of dementia may progress, but they may also remain the same or even

remit. Therefore, we cannot assume that a patient whose test scores were at Level 2 impairment in 2020 would be equally impaired in 2024.

- a. Test scores are affected by a very wide range of physical health factors (e.g., sleep deprivation, medications, blood pressure), emotional factors (e.g., depression, test performance anxiety, suspiciousness), and environmental factors (e.g., physical comfort, examiner characteristics, time of day), in addition to primary neurocognitive disorders.
 - b. This is entirely separate from the issues of cooperation and test score validity, which are themselves suspect in this case.
- 3) Even a neuropsychological evaluation that is entirely valid by the criteria specified in this Settlement Program is not applicable or relevant forever. To use an analogy from medicine, if a patient injures his leg and goes to a hospital, a perfectly good x-ray taken a year ago to assess osteoarthritis would never be used to assess for a fracture. Similarly, if a patient went to his primary care physician complaining of fatigue and lethargy, no competent physician would base her diagnosis on blood tests that were performed a year ago.
 - 4) In conditions with insidious onset in adulthood and slow progression, like the degenerative dementias, test scores older than one year – even if they were perfectly valid at the time – are not very useful. For this reason, most Alzheimer’s Disease Research Centers (ADRCs) and Clinical Centers (ADCCs) examine patients every six months.
 - 5) It has been the general practice of this Settlement Program to consider neuropsychological and neurological assessments performed within one year of each other to be contemporaneous. This is an entirely reasonable, and even liberal, standard.

For all these reasons, I believe that the available evidence does not support the qualifying diagnosis of Level 2 or Level 1.5 Neurocognitive Impairment. A new, entirely valid neuropsychological assessment is necessary.

Doc. 359399 at 2-3.

In an addendum on November 2, 2024, the AAP Consultant addressed Dr. [REDACTED]’s opinion that repeat neuropsychological testing was medically unnecessary:

The MAF diagnosing physician, [REDACTED], MD, has opined that neuropsychological reassessment is not necessary because 1) the patient was determined to have level 2 impairment in March 2020, and 2) his MoCA scores have declined from 20/30 in 2020 to 16/30 in 2024, providing “evidence of decline

from previous cognitive function” (Doc ID 320482). A member of the AAP Leadership Council has requested my input regarding this explanation.

According to Settlement Program documents, including the Special Master’s decision of May 27, 2020, neuropsychological testing can be considered “medically unnecessary” only when it is “reasonably determined” that patient’s cognitive impairment is “so severe” that he could not engage meaningfully in testing and therefore the results would be worthless. Dr. [REDACTED]’s documentation has not fulfilled this requirement. In fact, she obtained a MoCA score of 16/30 in 2024, a score in the range of mild dementia. Such patients are absolutely testable.

This failure to meet the criterion for “medically unnecessary,” together with outright invalidity on 4 of 5 neuropsychological evaluations and the age of the most recent exam (four years prior to Dr. [REDACTED]’s MAF neurological evaluation), makes neuropsychological reassessment mandatory if a qualifying diagnosis is to be pursued.

Doc. 365504 at 3.

On November 27, 2024, the Claims Administrator asked Dr. [REDACTED] to respond to the AAPLC’s feedback and “provide [her] input on whether new neuropsychological testing would be helpful in supporting the Level 2 diagnosis [she] gave the Player.” Doc. 368468. It wrote:

Dr. [REDACTED] indicated (Doc ID# 320482) that because the Player’s cognitive deficits had progressed, as measured by the MoCA (the MoCA score decreased from 20/30 in 2020 to 16/30 at the current evaluation), that additional neuropsychological testing was not necessary. The Special Master has adopted a two-pronged analysis to determine whether the determination that certain testing is medically unnecessary is reasonably determined: (1) how severe was the impairment, and (2) why does the severity of the impairment make the testing unnecessary.

Regarding the first prong, the severity of the impairment is best estimated by the MoCA score of 16/30 (Doc ID# 321232) which would indicate mild to moderately severe dementia.

Regarding the second prong, the Player was described as being awake and alert, as well as being able to participate in testing well enough to complete the MoCA, score 16/30, and to provide a detailed history during the examination with Dr. [REDACTED], so it would not appear that the cognitive deficits were so severe as to prevent a new neuropsychological evaluation from being performed or would be so severe as to prevent valid/optimal participation in testing.

However, Dr. [REDACTED] proposes to use the decline in the MoCA score to establish progression of the cognitive deficits over time, which would mean the MoCA would

effectively be used as a surrogate for a new neuropsychological evaluation. Unfortunately, the MoCA test does not contain any assessment of performance validity and so it should not be assumed that progression on the MoCA would definitely equate to progression on a more detailed neuropsychological evaluation, indicating that the MoCA test is not an adequate substitute or surrogate for a new neuropsychological evaluation. AAPC review concluded that the MoCA score of 16/30 would not indicate that the Player was unable to meaningfully engage in neuropsychological testing and consequently this would not fulfill the Special Master's decision of May 27, 2020 that neuropsychological testing should be considered medically unnecessary only when it is reasonably determined the cognitive impairment is so severe that the Player could not meaningfully engage in testing.

Additionally, the AAPC review also pointed out that the prior neuropsychological evaluation from 2020 was invalid. Consequently, the Diagnosing Physician's use of the decline on the MoCA as a surrogate to indicate decline from the prior neuropsychologically determined state of impairment in 2020 would be flawed since the neuropsychological evaluation in 2020 was invalid and so could not be used to indicate a previously determined level of cognitive impairment.

Therefore, based on the available information, it appears the second prong of the Special Master's analysis has not been fulfilled, and a new neuropsychological evaluation would be necessary to support a Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

Id. (breaks added).

Dr. [REDACTED] responded to the AAPLC's feedback on December 27, 2024. Doc. 371784. She correctly noted that "the AAPLC reviewer mistakenly stated that [Dr. [REDACTED] 2020 neuropsychological] evaluation was invalid."³ *Id.* Next, she justified her reliance on the 2020 test results in lieu of requiring Mr. [REDACTED] to be retested:

Given that the evaluation was significant for Level 2.0 cognitive impairment, it is my medical opinion that unique circumstances are present that indicate repeat testing would be futile. Specifically, given that Mr. [REDACTED] was already diagnosed with Level 2.0 Cognitive Impairment during the 2020 neuropsychological evaluation, it is highly unlikely that repeating a neuropsychological evaluation at this time would change the diagnosis. Specifically, the current settlement criteria do not recognize cognitive impairment diagnosis levels more clinically severe than

³ The validity of Dr. [REDACTED] 2020 neuropsychological test results has been the subject of significant discussion throughout Mr. [REDACTED]'s various Claims and Appeals. As I previously noted, the Claims Administrator (relying on AAP Consultant guidance) ultimately accepted Dr. [REDACTED] test results as valid in December 2020. Docs. 230509 at 4; 231012. I accept that determination, as the relevant question is not validity but rather whether they can support a different Diagnosis four years later.

Level 2.0, i.e. there are no Level 2.5, Level 3, Level 3.5, etc. cognitive impairment diagnoses recognized by current settlement criteria guidelines. Based on these circumstances in which repeating a neuropsychological evaluation would not likely change the diagnosis, it is my medical opinion that utilization of the 2020 neuropsychological evaluation is more than reasonable to measure impairment.

To summarize, the diagnosis of Level 2.0 Neurocognitive Impairment was not based solely on Mr. [REDACTED]'s worsening MoCA scores. When reviewing Mr. [REDACTED]'s previous records, there was also noted worsening of his cognitive abilities as per previous evaluations and Mr. [REDACTED]'s CDR assessments. Based on the evidence of progression of cognitive decline as noted by Mr. [REDACTED], Mr. [REDACTED]'s wife, and previous evaluations, which include the valid neuropsychological evaluation completed in 2020, it is still my medical opinion that Mr. [REDACTED]'s history and testing are consistent with a qualifying diagnosis of Level 2.0 Neurocognitive Impairment, with a date of diagnosis 03/28/2024. Furthermore, it is highly unlikely that a repeat neuropsychological evaluation would illustrate any notable improvement, thus making it unnecessary to repeat neuropsychological evaluation at this time.

Id.

Upon review, the AAP concluded (as summarized by the Claims Administrator in the Notice of Denial) that under the Settlement's diagnostic criteria for Level 2 Neurocognitive Impairment,⁴ criteria (i), (iii), and (iv) were fulfilled. Doc. 378610. However, it denied that criterion (ii)—which “requires evidence of severe cognitive decline in accordance with the standardized neuropsychological protocol”—was fulfilled. *Id.* In explaining that determination, the AAP first addressed the use of Dr. [REDACTED] non-contemporaneous neuropsychological test results:

In 2020, Dr. [REDACTED] reported the Player had suboptimal performance on one performance validity test, only one Slick criterion was positive, overall valid performance, average premorbid intellectual functioning, Level 2 impairment in the domains of Complex Attention, Learning and Memory, Visual-Perceptual Processing, and Language, and no impairment in Executive Functioning, for overall Level 2 cognitive impairment. After application of the New Method using below average reading level, the Player continued to have Level 2 impairment in all domains except Executive Functioning and overall Level 2 cognitive impairment.

We cannot rely on Dr. [REDACTED] 2020 neuropsychological test results in supporting Dr. [REDACTED]'s 2024 diagnosis of Level 2 Neurocognitive Impairment because the testing already qualified the Player for a Monetary Award for a diagnosis of Level 1.5 Neurocognitive Impairment, and the impairment level did not change after application of the New Method. In his 8/6/2023 decision, the Special Master

⁴ See Settlement Agreement, Exhibit A-1 (2)(b).

articulated potential factors the Claims Administrator may consider when using its discretion to allow testing performed more than one year prior and that consideration of whether the testing was being used for two different claims was appropriate. Additionally, the testing was completed four years before the MAF evaluation by Dr. [REDACTED] upon which the current claim is based.

Id.

Next, having concluded that it cannot rely on Dr. [REDACTED] 2020 testing, the AAP addressed whether Dr. [REDACTED] had reasonably determined that additional neuropsychological testing was medically unnecessary:

In her Diagnosing Physician Certification Form, Dr. [REDACTED] certified that additional neuropsychological testing was medically unnecessary because of the severity of the Player's dementia. In supporting this certification, Dr. [REDACTED] explained, "Mr. [REDACTED] previously underwent neuropsych testing in March 2020, and was found to have Level 2.0 neurocognitive impairment at that time. Additionally, he was noted to have progression of his cognitive dysfunction, as illustrated by the decrease in MoCA score from 20/30 in 2020 to 16/30 from my evaluation. There is evidence of decline from previous cognitive function. Thus, in my professional medical opinion, repeating neuropsych testing is not necessary."

In his 5/27/2020 opinion on a Qualified MAF Physician's certification that testing was medically unnecessary, the Special Master adopted a two-pronged analysis to analyze whether the certification that certain testing is medically unnecessary is reasonably determined: (1) how severe was the impairment, and (2) why does the severity of the impairment make the testing unnecessary. In this case, the severity of the impairment is best estimated by the MoCA score of 16/30, which would indicate moderately severe dementia. While the decline in the MoCA score from 2020 to the current evaluation would suggest progression of the cognitive deficits, the MoCA test does not contain any assessments for performance validity, and so it should not be assumed that progression on the MoCA would definitely equate to progression on a more detailed neuropsychological evaluation. However, Dr. [REDACTED]'s determination that this would likely indicate progression of the cognitive deficits is reasonable, and clinically, patients are commonly followed with MoCA examinations over time to monitor progression. Consequently, Dr. [REDACTED]'s reasoning does not appear to be obviously flawed at face value or otherwise unreasonable, but the MoCA test may still be an inadequate substitute for a new neuropsychological evaluation. AAPC review concluded that the MoCA score of 16/30 would not indicate that the Player was unable to meaningfully engage in testing and consequently this would not fulfill the second prong of the Special Master's analysis.

In response to a request from the Claims Administrator to address these concerns, Dr. [REDACTED] provided an addendum dated 12/27/2024, in which she clarified that

Dr. ██████ indicated the 2020 evaluation was valid and that indication of progression included not only the MoCA score, but also previous records and statements by the Player and his wife, and again reiterated that a repeat neuropsychological evaluation was not necessary. However, the information in the records and statements from the Player and his wife would not supersede the lack of a recent and valid neuropsychological evaluation. Therefore, Dr. ██████'s certification that additional neuropsychological testing is medically unnecessary is not reasonably determined, so criterion (ii) is not fulfilled, and a new neuropsychological evaluation is needed.

Id.

Relying on the AAP's findings, the Claims Administrator denied Mr. ██████'s Supplemental Claim on February 17, 2025. *Id.* Mr. ██████ timely appealed. Doc. 383448.

RESOLVING THIS APPEAL

On appeal, Mr. ██████ attacks the Claims Administrator's determination that he failed to fulfill diagnostic criterion (ii). He argues that (1) Dr. ██████ properly relied on Dr. ██████ non-contemporaneous and previously-used neuropsychological testing, and (2) Dr. ██████'s certification that additional neuropsychological testing was medically unnecessary was reasonably determined and thus owed deference. To succeed, Mr. ██████ must show by clear and convincing evidence that the Claims Administrator erred in either one of its findings to the contrary.

First, the Claims Administrator found that Dr. ██████ neuropsychological test results from 2020 could not be used to support Dr. ██████'s Diagnosis dated March 28, 2024. Doc. 378610. That was a reasonable choice. Indeed, Mr. ██████ does not even attempt to attack it. Nor could he, given the Program's established rules.

As I explained in a similar case earlier this year: "Under the Program's rules, neuropsychological testing must have occurred within a year of the Diagnosis. . . . The Claims Administrator has discretion to relax the contemporaneous testing requirement, but, as I have repeatedly held, its decision not to exercise that discretion is not itself clear and convincing evidence of error."⁵ Dr. ██████ neuropsychological testing, over four years old at the time of Dr. ██████'s Diagnosis, did not meet the one-year contemporaneous testing requirement. When deciding whether to make an exception for Mr. ██████, the Claims Administrator was well within its authority to consider that he had previously used Dr. ██████ test results to support his

⁵ Special Master Ruling on Neuropsychological Testing, at 6 (Apr. 25, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=np_testing_sm_5.pdf (citing *Frequently Asked Questions: FAQ #109* (What must the medical records show for Level 1.5 and Level 2 Neurocognitive Impairment diagnoses made outside the BAP for living Retired NFL Football Players?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>; see also Special Master Ruling on Validity and Historical Testing, at 6 (Feb. 20, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_historical_testing_sm.pdf).

successful Claim for Level 1.5 Neurocognitive Impairment.⁶ Because Mr. [REDACTED] was “pressing to reuse the same [testing] battery for two different Claims”—that previous Claim and this Supplemental Claim—the Claims Administrator rightfully declined to exercise its discretion and grant an exception.⁷

Second, the Claims Administrator found that Dr. [REDACTED]’s certification that repeat testing was medically unnecessary was not reasonably determined. *Id.* Mr. [REDACTED] has not offered clear and convincing evidence that this judgment was an error.

The Settlement requires that a Diagnosis of Level 2 Neurocognitive Impairment include neuropsychological testing *in addition to* documented functional impairment.⁸ That is as true for Supplemental Diagnoses as it is for Claimants’ original ones. Given that Dr. [REDACTED] could not reuse Dr. [REDACTED] non-contemporaneous testing, her Diagnosis was plainly deficient. There is, however, a “narrow . . . exception to the testing requirement”⁹ that applies if “the diagnosing physician can certify in the Diagnosing Physician Certification [Form] that [neuropsychological] testing . . . is medically unnecessary because the Retired NFL Football Player’s dementia is so severe.”¹⁰ Dr. [REDACTED] did just that, certifying that additional neuropsychological testing was medically unnecessary. Doc. 320482 at 6.

But Dr. [REDACTED]’s certification was the beginning, not the end of the inquiry, because to be given deference, her articulated judgment must be “reasonably determined.”¹¹ In other words, Dr. [REDACTED] must show that “it was reasonable to have concluded that the [additional] testing would not generate valid results.”¹² If Dr. [REDACTED]’s judgment was indeed reasonably determined, then “the Claims Administrator should accept [her] Certification even if it would have made a different choice.”¹³ If not, “[her] Certification is not entitled to deference.”¹⁴

To verify whether a diagnosing physician’s judgment is reasonably determined, the Program employs a now-familiar two-pronged test: (1) how *severe* was the impairment, and (2) why does the impairment’s severity make the testing *unnecessary*.¹⁵ Dr. [REDACTED]’s discussion of Mr. [REDACTED]’s cognitive decline—his worsening MoCA scores, his CDR results, and information from

⁶ Special Master Ruling on Validity and Historical Testing, at 4 (Aug. 6, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_testing_12_sm.pdf (specifically calling out this basis as reasonable).

⁷ *Id.*

⁸ See Settlement Agreement, Exhibit A-1 (2)(a)(ii)-(iii).

⁹ Special Master Ruling on Qualified MAF Physician’s Certification that Testing is Medically Unnecessary, at 3 (May 27, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=physician_certification_testing_sm.pdf.

¹⁰ Settlement Agreement, Exhibit A-1 (2)(b).

¹¹ Special Master Ruling on Qualified MAF Physician’s Certification that Testing is Medically Unnecessary, at 3 (May 27, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=physician_certification_testing_sm.pdf.

¹² *Id.*

¹³ *Id.* at 6.

¹⁴ Special Master Ruling on Neuropsychological Testing, at 8 (Apr. 25, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=np_testing_sm_5.pdf.

¹⁵ Special Master Ruling on Qualified MAF Physician’s Certification that Testing is Medically Unnecessary, at 4 (May 27, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=physician_certification_testing_sm.pdf.

his wife—satisfies the requirement that she describe the severity of Mr. [REDACTED]'s illness. Doc. 371784. But it does not show how that severity made testing unnecessary.

Crucially, Dr. [REDACTED] did not deem Mr. [REDACTED] unable to complete additional testing due to his cognitive decline. *Id.* Rather, she argued that additional testing was unnecessary because “it was highly unlikely that [such testing] would change the diagnosis.” *Id.* This misunderstands the Settlement’s narrow exception to the testing requirement, which is reserved for Claimants who cannot produce valid results *because* their condition “is so severe.”¹⁶ Even if Dr. [REDACTED] was correct, and new neuropsychological testing would have revealed the same results, it does not follow that the testing is *medically* unnecessary. While it may be inconvenient for Mr. [REDACTED], so long as he is medically capable of undergoing additional testing, he must do so to gain financial benefits under the Settlement.

If anything, Mr. [REDACTED]'s ability to complete a MoCA with Dr. [REDACTED] suggests that he can obtain new, contemporaneous, and valid test results. If these new test results reveal Level 2 Impairment—as Dr. [REDACTED] is certain that they will—then Mr. [REDACTED] may file another Supplemental Claim.

CONCLUSION

The Claims Administrator concluded that Mr. [REDACTED] had failed to satisfy diagnostic criterion (ii) and thus denied his Supplemental Claim. Since Mr. [REDACTED] has not shown that this determination was in error at all, let alone by clear and convincing evidence, I deny his Appeal.

Date: July 23, 2025



David A. Hoffman, Special Master

¹⁶ Settlement Agreement, Exhibit A-1 (2)(b).