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IN RE: NATIONAL FOOTBALL	:	No. 2:12-md-02323-AB
LEAGUE PLAYERS' CONCUSSION	:	
INJURY LITIGATION	:	MDL No. 2323
	:	
	:	Hon. Anita B. Brody
THIS DOCUMENT RELATES TO:	:	
APPEAL OF REPRESENTATIVE	:	
CLAIMANT [REDACTED]	:	
REGARDING DENIAL OF MONETARY	:	
AWARD	:	
	:	

After reviewing [REDACTED] medical records, I have concluded that the Claims Administrator's decision to deny the Claim was not wrong. In this Opinion, I will explain why that is, and address the questions [REDACTED] raised in her Appeal Form and supporting letters.

The [REDACTED] filed three Claim Forms in this case in short succession, based on medical evaluations by multiple sets of clinicians, and contributing to a complex procedural history. First, on March 23, 2018, [REDACTED] filed a Claim Form for Level 1.5 Neurocognitive Impairment, based on a Diagnosis from [REDACTED] that Claim Form dates to February 9, 2016. Doc. 163254. The Diagnosing Physician Certification Form, however, indicated the date of Diagnosis was November 29, 2016. Doc. 163326. On April 4, 2018, [REDACTED] filed a new Claim Form, again for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, and again certified by [REDACTED]. Doc. 165121. This updated form indicated the date of Diagnosis remained November 29, 2016.

The Claims Administrator subsequently issued a Notice of Preliminary Review, highlighting several apparent deficiencies with the Claim. Doc. 165411. [REDACTED] then filed a third Claim Form on May 31, 2018. Doc. 173827. This time, the Form indicated that [REDACTED]

██████ was the diagnosing physician—though the date of Diagnosis, November 29, 2016, remained the same. ██████ filed a new Diagnosing Physician Certification Form, signed by ██████. Docs. 173829-173846. The medical records submitted in support of the Diagnosis included a report from ██████ (Docs. 173847-173853), and results of a neuropsychological evaluation performed on November 29, 2016, by neuropsychologist ██████ (Docs. 173854-173866).

On September 24, 2018, the Claims Administrator denied ██████ Claim, and provided the following explanation:

The Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment was not made in a manner that is generally consistent with the settlement criteria. Specifically, while there is concern for a significant cognitive decline affecting memory and other cognitive functions, including a MOCA score of 15/30 reported by the Diagnosing Physician (Doc ID#’s 173847-173853), the reported functional abilities indicate too high a level of independent functioning to be generally consistent with the Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. For instance, the Diagnosing Physician reports the Retired NFL Football Player is able to work, run his own concrete business (requires some extra preparation for jobs compared to the past), and drive independently (Doc ID#’s 173847-173853). This is corroborated in the neuropsychology note (Doc ID#’s 173854-173866) which also reports continued ability to work and be self employed in the concrete business. Additionally, the neuropsychological testing performed by ██████ on 1/3/2017 and addendum dated 1/3/2017 (Doc ID#’s 173854-173866) are also not generally consistent with the settlement criteria. Specifically, based on the performance on the WAIS and WTAR there is no indication of a moderate to severe cognitive decline, validity testing was insufficient, and there was a pattern of performing too well on complex tasks and too poorly on simple tasks that was not generally consistent with a mild dementia syndrome. Consequently, the overall picture is not generally consistent with the settlement criteria for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

Doc. 186222.

The claims file does not contain an official appeal filed in response to that Notice. However, ██████ subsequently submitted numerous documents under the label “Evidence in Support of Appeal” in December 2018, and the Claims Administrator treated that documentation as an appeal. Docs. 192700-193628. The documents consist of medical records related to ██████ physical condition—in particular, his heart health. There are bloodwork results (Docs. 193614; 193615; 193623); results of a right heart catheterization (Doc. 193613); echocardiogram results (Docs. 193616; 193618); exercise oxygen titration test results (Doc. 193619); pulmonary function test results (Docs. 193625; 193626); and other tests of physical and heart health (Docs. 193627; 193628). There is also a document that contains a combination of medical records—including a

highlighted version of [REDACTED] already-filed report (including an addendum), as well as speech language pathology records from 2017. Doc. 192700.

In June 2019, Special Master Pritchett remanded the Claim for review of the new evidence. After reviewing the documentation, the Claims Administrator issued a new Notice of Denial on August 14, 2019, which stated:

A member of the Appeals Advisory Panel reviewed your Qualifying Diagnosis based on principles generally consistent with the diagnostic criteria set forth in Exhibit A-1 (Injury Definitions), as set forth in Section 6.4(b) of the Settlement Agreement, and determined that the Retired NFL Football Player does not have the Qualifying Diagnosis indicated on the Diagnosing Physician Certification Form. The Appeals Advisory Panel member provided this explanation: I have reviewed the new/additional information in Doc ID# 192700, and it does not change my determination that the diagnosis of Level 1.5 Neurocognitive Impairment is not generally consistent with the Settlement criteria. The new/additional information includes a letter from [REDACTED] dated 12/5/18, which confirms the continued functional activities of operating a business and driving, which suggest a higher level of functioning than would be generally consistent with the presence of dementia or the Settlement criteria for Level 1.5 Neurocognitive Impairment. The new/additional information also includes a clinic note by [REDACTED] dated 11/30/16, which describes concern for cognitive decline, including reports of forgetting how to drive to places he has been to frequently in the past, forgetting the names of objects, worsening memory, forgetting his medications, being irritable and more easily frustrated, but does not include a diagnosis of dementia. Additionally, [REDACTED] describes a mental status examination that includes normal psychomotor activity, speech that is articulate with normal volume and rate, thought process that is linear and logical, thought form that notes some circumstantiality but good continuity, no auditory/visual hallucinations, being alert and oriented x4 with fair attention and fair-poor concentration, being able to demonstrate simple abstraction, average intelligence, average fund of knowledge, fair insight, average judgement, and limited impulse control, which is not suggestive of a moderate to severe decline in cognition. [REDACTED] makes a diagnosis of adjustment reaction with mixed disturbance of emotions and conduct but does not make a diagnosis of dementia. The new/additional information also includes speech pathology assessments dated 1/11/17, 7/27/17, 10/24/17, which included an Arizona Battery for Communication Disorders of Dementia (ABCD) that identified a total score of 20.1, which is consistent with the presence of cognitive impairment, and a MOCA score of 25/30 (there appears to be some confusion on the total score for the MOCA in the note, the total score is first listed as 25/30, but the sum of the individual scores would equal 21/30, and then in the impressions section of the note the score is reported as 18/30), which is higher than would be typical for dementia. However, while these tests (ABCD and MOCA) would indicate concern for cognitive decline, they would not replace the neuropsychological testing, which was

not generally consistent with the Settlement Criteria for Level 1.5 Neurocognitive Impairment for the reasons previously stated (based on the performance on the WAIS and WTAR there is no indication of a moderate to severe cognitive decline, validity testing was insufficient, and there was a pattern of performing too well on complex tasks and too poorly on simple tasks that was not generally consistent with a mild dementia syndrome). Consequently, the diagnosis is not generally consistent with the Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

Doc. 212845.

In September 2019, [REDACTED] filed a request for an extension of time, which was granted—pushing his September 2019 Appeal deadline back to January 2020. Doc. 214133.

On December 12, 2019, [REDACTED] passed away due to heart failure. Doc. 219134. [REDACTED] filed a Petition to be appointed as his Representative Claimant, which Special Master Pritchett granted in January 2020. Doc. 219487. [REDACTED] then filed a series of three extension requests, all of which were granted—pushing her final Appeal deadline back to May 2021. Docs. 219161; 225633; 231558.

On May 7, 2021, [REDACTED] appealed. Doc. 235322. In it, she questioned whether the Claims Administrator had considered all of the evidence in the file before issuing the Notice of Denial. She also submitted supporting documentation, consisting of both records already provided (including reports from [REDACTED]), as well as new evidence in support of the Claim. The documentation falls in four general categories.

First, there are neurology records dating back to 2015 that address various conditions, including a partial seizure disorder and a slow-growing brain tumor (meningioma). Read together, these records document [REDACTED] worsening neurological condition. In 2015, [REDACTED], a neurosurgeon, addressed the seizure disorder and ordered a brain MRI, resulting in the meningioma diagnosis. Doc. 235325. In 2016, [REDACTED] ordered new brain MRIs to reexamine [REDACTED] tumor diagnosis. Docs. 235328; 235329. [REDACTED] referred [REDACTED] for a neuropsychological exam, carried out by [REDACTED] in January 2017. Docs. 235330; 235331. That same month, [REDACTED] conducted a neurological exam, assessing [REDACTED] seizure disorder as well as his cognitive impairment. Docs. 235326; 235327.

Second, there are more recent neurology and neuropsychology records from the year 2019—comprising a portion of the new evidence submitted with this Appeal. [REDACTED] underwent a BAP examination performed by [REDACTED] (a neuropsychologist) in July 2019 and by [REDACTED] (a neurologist) in August 2019. Doc. 235336. In late 2019, he was referred to [REDACTED] (a neurologist) for treatment of his seizure disorder and evaluation of progressing cognitive decline. Doc. 235332 (identical to Docs. 238094 and 238099). [REDACTED] referred [REDACTED] for a neurocognitive assessment, which was conducted by [REDACTED] (a nurse practitioner) in November 2019. Doc. 238099.

Third, there are new records related to sleep apnea. Specifically, there are results from a diagnostic polysomnogram (sleep study), and a corresponding report from [REDACTED] providing a diagnosis of sleep apnea. Doc. 235333 (identical to Docs. 238095; 235335).

Finally, [REDACTED] submitted new post-mortem medical records. There is a post-mortem autopsy report from December 2019. Doc. 235334. And there is a post-mortem diagnosis of stage III chronic traumatic encephalopathy, based on a brain autopsy conducted by [REDACTED] (a neurologist and neuropathologist). Doc. 238096.

Given the new evidence described above, I remanded the Claim to the Claims Administrator for re-review. Doc. 235562. The Claims Administrator sought input from the Appeals Advisory Panel, the Settlement's group of expert medical reviewers, who assessed both the existing and new documentation and concluded that the Claim still failed to meet the Settlement's requirements. Doc. 235887. The AAP Member agreed and relying on this review the Claims Administrator then issued a third Notice of Denial, writing:

A member of the Appeals Advisory Panel reviewed your Qualifying Diagnosis based on principles generally consistent with the diagnostic criteria set forth in Exhibit A-1 (Injury Definitions), as set forth in Section 6.4(b) of the Settlement Agreement, and determined that the Retired NFL Football Player does not have the Qualifying Diagnosis indicated on the Diagnosing Physician Certification Form. The Appeals Advisory Panel member provided this explanation: The Retired NFL Football Player was diagnosed with Level 1.5 Neurocognitive Impairment with a diagnosis date of 11/29/2016 by two different diagnosing physicians, [REDACTED], who certified the diagnosis on 7/31/2017, and [REDACTED], who certified it on 5/24/2018. [REDACTED] performed a neuropsychological evaluation on 11/29/2016, and [REDACTED] evaluated the player on the same day. [REDACTED] evaluated the player on 11/30/2016 and followed up with him in 2017.

Other records in the file include: (1) a 10/8/2015 office visit with [REDACTED]; (2) a BAP neuropsychological evaluation performed on 7/9/2019 by [REDACTED]; (3) a BAP neurological evaluation performed on 8/6/2019 by [REDACTED]; (4) evaluations dated 11/4/2019 and 12/5/2019 by [REDACTED]; (5) a neurocognitive assessment dated 11/26/2019 by [REDACTED]; and (6) an autopsy report that indicates the presence of CTE stage III.

A diagnosis of Level 1.5 Neurocognitive Impairment rendered outside of the BAP must be generally consistent with these four diagnostic criteria: (i) concern of severe decline in cognitive function; (ii) evidence of moderate to severe cognitive decline . . . in two or more cognitive domains; (iii) functional impairment; and (iv) not exclusively in the context of delirium, acute substance abuse, or medication side effects.

The AAP member reviewed the entire file and noted the following:

Regarding criterion (i): [REDACTED] reports memory problems that have been getting worse for three years, that concentration and attention are somewhat diminished, and [REDACTED] 11/29/2016 note indicates a MoCA score of 15/30. Therefore criterion (i) is fulfilled.

Regarding criterion (ii): There are several neuropsychological evaluations, including one by [REDACTED] dated 1/3/2017 with an addendum, and another neuropsychological evaluation by [REDACTED] dated 7/9/2019. An Appeals Advisory Panel Consultant (AAPC) neuropsychologist reviewed the reports and concluded that the testing showed only Level 1 impairment in a single domain (Executive Function) with no other domains impaired, as well as failure of multiple performance validity tests. Because the Settlement Class Member raised this as a potential issue on appeal, the AAPC also verified there was no indication that using test norms specific to African Americans was responsible for the Player failing to meet the Settlement Program's cognitive criteria for Level 1.5 Neurocognitive Impairment. Therefore criterion (ii) is not fulfilled.

Regarding criterion (iii): Both [REDACTED] reported memory problems, short temper, forgetting food on the stove, forgetting how to drive places, forgetting names of objects, using wrong words for objects, and being irritable. The 2019 neuropsychological testing by [REDACTED] indicated scores of 0.5 for the CDR categories of Community Affairs and Home/Hobbies, and 0.0 for the CDR category of Personal Care. The 2019 note by [REDACTED] indicated scores of 0.5 for Community Affairs, 1.0 for Home/Hobbies, and 0.0 for Personal Care. [REDACTED] described the functional abilities as the Player was independent for ambulation, bathing, hygiene, feeding, grooming, toileting, and dressing; needing assistance with driving due to fatigue and respiratory insufficiency, that the Player was no longer cooking and his wife now managed the finances, and the Player no longer fished due to other health issues, no longer went to Church for one year due to other health issues, and that his wife does the cooking and shopping. Therefore, while there is some indication of functional decline in the Community Affairs and Home/Hobbies categories, overall the information would not be generally consistent with the Settlement criteria for Level 1.5 Neurocognitive Impairment and criterion (iii) is not fulfilled.

Regarding criterion (iv): There is no report that the cognitive deficits occurred exclusively due to delirium or acute substance abuse or due to medication side effects. Additionally, the records indicate no alcohol or illicit substance use, and the current medications listed in the neuropsychological testing (sensipar, plavix, prorenal + D with Omega 3, sodium bicarbonate, auryxia, coreg, zetia, lasix, calcitriol, caltrate, and aspirin) would not be expected to cause significant cognitive impairment. Therefore criterion (iv) is fulfilled.

There is an autopsy report that indicates the presence of CTE stage III, but this is not part of the Settlement criteria for Level 1.5 Neurocognitive Impairment.

Because of the issues cited above regarding criteria (ii) and (iii), the diagnosis is not generally consistent with the Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

Doc. 237421. [REDACTED] now appeals that decision. Doc. 237819.

DISCUSSION

The Claims Administrator, reviewing the 2016 Diagnosis and a variety of later-arriving documents, determined that the records supported only two of the four requirements for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. In her Appeals Form, [REDACTED] disputed that conclusion, arguing that the claim package did contain evidence generally consistent with a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment—specifically, regarding criterion (ii) and criterion (iii). She also raised the following points and concerns in her Appeal and in a later letter:

1. She asked why [REDACTED] evaluations (on 11/4/19 and 12/5/19) were not considered or mentioned in the Denial of Monetary Award Notice;
2. She questioned whether she can or should file a new Claim on behalf of her late husband for Level 2 Neurocognitive Impairment;
3. She flagged newly-submitted evidence for consideration—including a post-mortem diagnosis of CTE from [REDACTED], and a sleep apnea study and report from [REDACTED]; and
4. She raised concerns about use of race-based demographic adjustments for the neuropsychological test scores [REDACTED] received through his Baseline Assessment Program examination (on 7/9/2019).

No lawyer represented [REDACTED] in bringing her Appeal, and neither the NFL Parties nor Class Counsel responded to her filing.

I now will analyze the correctness of the Claims Administrator’s decision to deny the Claim, and then address [REDACTED] remaining questions directly.

1. Review of Claims Administrator’s Decision

To be paid through the Settlement, each of the criteria for the asserted Qualifying Diagnosis must be satisfied.¹ Here, the Claims Administrator concluded that two of the four criteria for the claimed Diagnosis, Level 1.5 Neurocognitive Impairment, had not been met:

¹To satisfy any given criterion in Claims like the [REDACTED] there must be evidence that is “generally consistent” with the required elements of that criterion. FAQ #103, available [here](#), provides an explanation of what “generally consistent” means.

criterion (ii), which requires specific neuropsychological testing and results, and criterion (iii), which relates to “functional impairment” in certain categories. After carefully reviewing the records in this claim file, I conclude that the Claims Administrator was not wrong in either of the above determinations.

Neuropsychological Testing.

Criterion (ii) requires that there is “[e]vidence of a moderate to severe cognitive decline from a previous level of performance, *as determined by and in accordance with the standardized neuropsychological testing protocol* annexed in Exhibit 2.” In other words, this criterion requires the Retired Player to have undergone a specific neuropsychological testing regimen outlined in the Settlement, *and* that the Retired Player’s results from that testing meet designated score thresholds.

The claim file contains results from (at least) two different instances of neuropsychological testing.² First, ██████ underwent testing with ██████ in January 2017. That testing did not conform with the testing protocol that is outlined in the Settlement. Specifically, the Settlement requires the neuropsychological examination to include at least seven tests that evaluate whether the patient is putting forth adequate effort. The set of tests administered by ██████ included only one of the seven required measures. Because of this, the examination is not “generally consistent” with the requirements for criterion (ii).

Second, there are test results from the BAP exam performed by ██████ in July 2019. In this case, the testing protocol was correct, but ██████ scores did not meet the levels required to satisfy Level 1.5 Neurocognitive Impairment. A Level 1.5 Diagnosis requires the Retired Player to have scores that meet designated thresholds in “two or more [of five] cognitive domains” that are outlined in the Settlement.³ As ██████ explained in her report, and as the Claims Administrator reiterated in its most recent Notice of Denial, ██████ did not meet the score thresholds in any of the five domains. Additionally, he failed on five out of seven tests that measured whether he was putting forth adequate effort. The Settlement provides that failure on two or more effort tests is indicative of suboptimal effort—meaning the results are not reliable enough to support a Qualifying Diagnosis.

██████ raised concerns about the use of race-based demographic adjustments in the scoring of ██████ BAP examination. In late 2021, I asked the Settlement’s panel of expert

² ██████ also submitted records from a “neurocognitive assessment” performed by ██████ a nurse practitioner, in November 2019. Neither the Claims Administrator nor ██████ has suggested that this evaluation could support criterion (ii)—and it could not. The assessment consisted of a six-item test battery, which does not come close to the thirty-item battery required by the Settlement. Additionally, testing must be performed by a licensed neuropsychologist with particular certifications defined in the Settlement. (FAQ #84, available [here](#), provides more information about these requirements.) ██████ did not have the requisite qualifications. For these reasons, this assessment cannot support criterion (ii).

³ Specifically, the Retired Player must meet designated score thresholds in “two or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual-spatial), provided one of the cognitive domains is (a) executive function, (b) learning and memory, or (c) complex attention.”

medical reviewers to rescore this BAP exam using race-neutral adjustments, and the Claims Administrator has uploaded a copy of those updated results to the claims file. [REDACTED] scores changed slightly after the rescoring diagnosis: they now met the cutoff for Level 1.5 Impairment in one domain, executive function. But the scores must meet the cutoffs in *two* domains to satisfy criterion (ii). Additionally, the issue regarding adequate effort (that is, [REDACTED] failure on five of seven metrics) is not affected by the rescoring. To put it differently: race-based demographic adjustments were not the reason that [REDACTED] claim failed to satisfy the Settlement's requirements.

Because the Claims File does not contain results from neuropsychological testing that meet the Settlement's requirements, the evidence does not satisfy criterion (ii), and the claim must be denied.

Functional Impairment and the Clinical Dementia Rating (CDR) Scale.

Criterion (iii) requires evidence of a decline in functioning measured using the Clinical Dementia Rating (CDR) scale. For a Level 1.5 diagnosis, there must be evidence of impairment that is consistent with a CDR score of 1.0 in three specific categories: Community Affairs, Home & Hobbies, and Personal Care. For Community Affairs, this means the individual was "[u]nable to function independently [in job, shopping, volunteer and social groups], although may still be engaged in some; appears normal to casual inspection." For Home & Hobbies, it means "[m]ild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned." For Personal Care, it means "[n]eeds prompting" with respect to self-care (including dressing, hygiene, and keeping of personal effects).

The most recent Notice of Denial from the Claims Administrator summarizes the available evidence related to functional impairment:

Regarding criterion (iii): Both [REDACTED] reported memory problems, short temper, forgetting food on the stove, forgetting how to drive places, forgetting names of objects, using wrong words for objects, and being irritable. The 2019 neuropsychological testing by [REDACTED] indicated scores of 0.5 for the CDR categories of Community Affairs and Home/Hobbies, and 0.0 for the CDR category of Personal Care. The 2019 note by [REDACTED] indicated scores of 0.5 for Community Affairs, 1.0 for Home/Hobbies, and 0.0 for Personal Care. [REDACTED] described the functional abilities as the Player was independent for ambulation, bathing, hygiene, feeding, grooming, toileting, and dressing; needing assistance with driving due to fatigue and respiratory insufficiency, that the Player was no longer cooking and his wife now managed the finances, and the Player no longer fished due to other health issues, no longer went to Church for one year due to other health issues, and that his wife does the cooking and shopping. Therefore, while there is some indication of functional decline in the Community Affairs and Home/Hobbies categories, overall the information would not be generally

consistent with the Settlement criteria for Level 1.5 Neurocognitive Impairment and criterion (iii) is not fulfilled.

Doc. 237421. I conclude that evidence of [REDACTED] functional impairment in Community Affairs and Home & Hobbies is generally consistent with required thresholds. However, that is not the case for Personal Care. In the “early” medical records from [REDACTED], who evaluated [REDACTED] in 2016 and 2017, there is no mention of difficulty with self-care tasks. In the examination records from 2019, multiple providers affirmatively reported a score of 0.0 impairment in the category of Personal Care. I have not identified evidence that contradicts those findings. For this reason, the Claims Administrator was not wrong in deciding that criterion (iii) had not been fulfilled.

2. Addressing Outstanding Questions

To the extent that I have not addressed [REDACTED] questions above, I will respond to the specific inquiries she raised in her Appeals Form and communications.

a. Consideration of [REDACTED] Reports

[REDACTED] reports do not change the outcome of this claim because they do not support any of the specific injury criteria. The language in [REDACTED] reports that is most related to the Settlement injury criteria reads: “Cognitive Testing showed moderate to severe dementia with primary impairments in mental flexibility, executive function, language fluency, attention, and visual spatial skills.” This does not support either of the two injury criteria in question. Since [REDACTED] was referring to the testing performed by [REDACTED], which did not meet the Settlement’s requirements (as discussed above in footnote 1), there is no support for criterion (ii). And because she did not discuss functional impairment in the required CDR categories (Community Affairs, Home & Hobbies, and Personal Care), the report does not support criterion (iii).

b. New Evidence from [REDACTED]

[REDACTED] reports provide a diagnosis of sleep apnea. This does not bear on any of the injury criteria in this case.

c. New Evidence from [REDACTED]

[REDACTED] provided a post-mortem diagnosis of CTE following examination of a brain autopsy. This does not bear on any of the Level 1.5 injury criteria, so it does not provide support for the present claim.

The Settlement does have a Qualifying Diagnosis of “Death with Chronic Traumatic Encephalopathy (CTE),” and the documentation from [REDACTED] plainly supports the diagnosis. However, the CTE Qualifying Diagnosis is only available for Retired Players who passed away on

or before April 22, 2015 (the “final approval date” of the Settlement). Due to this limitation that the Parties included in the Settlement Agreement, [REDACTED] would not be successful in filing a claim for Death with CTE.

d. Whether [REDACTED] Can or Should File a Level 2 Claim

The criteria for Level 2 Neurocognitive Impairment mirror the Level 1.5 criteria, except that Level 2 generally requires evidence of more severe impairment. The evidence does not support a Level 2 diagnosis.

CONCLUSION

To be paid through the Settlement, a Claimant must meet the specific requirements outlined for any of six “Qualifying Diagnoses.” These six Diagnoses were decided upon by agreement of the NFL and the lawyers representing the original group of Retired Players after extensive negotiation, and they are the only Diagnoses that can qualify for a Monetary Award.

The Parties created the Diagnosis asserted in this Claim—Level 1.5 Neurocognitive Impairment—specifically for use in this Settlement. In other words, it is not a diagnosis that exists in ordinary clinical practice; instead, it is a mixture of four different *components* of real-world practice. Each of the components—listed in the Settlement Injury Definitions as criteria (i), (ii), (iii), and (iv)—must be fulfilled for the overall Claim to succeed.

The available records demonstrate that [REDACTED] experienced a prolonged and severe decline in his health following a prolific career as an NFL linebacker. He suffered from many real-world diagnoses, including numerous significant neurological conditions. There is documentation of progressive cognitive decline, and un rebutted evidence that he suffered from CTE at the time of his death. But those diagnoses, and the supporting medical records, do not fit into the Settlement’s prescribed boxes for the claimed Qualifying Diagnosis.

This Claim’s determination has been delayed too long. And the Claims Administrator’s Notices should have been clearer in addressing the [REDACTED] concerns. But because the Claim failed to satisfy the Settlement’s particular requirements to qualify for Level 1.5 Neurocognitive Impairment, I deny [REDACTED] Appeal.

Date: January 25, 2022



David A. Hoffman, Special Master