

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

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

1

In July 2017, Dr. [REDACTED] conducted a retrospective review of Mr. [REDACTED] medical records from a 2010 research study. Doc. 146276. The study, in which Mr. [REDACTED] was one of a hundred participants, took place at the [REDACTED] in [REDACTED], California, and examined [REDACTED]

[REDACTED] Doc. 148166 at 2. The research entailed questionnaires, a “Mental Skills Test” to test memory, a SPECT scan of the brain, an EEG, and a “computerized concentration task.” *Id.* at 2–3. The examination was unpaid—although participants received a copy of the results of all tests and procedures—and participation was optional. *Id.* at 3–4.

After reviewing those records, Dr. [REDACTED] provided a summary report in which he concluded that “[f]rom all these findings, the evaluator is of the opinion that Mr. [REDACTED] did suffer from Neurocognitive Disorder secondary to a Medical Condition (Head Trauma), Level 1.5 (i.e. ‘early dementia’).” Doc. 146294. Based on that review, in October 2017, Dr. [REDACTED] certified a pre-Effective Date Diagnosis of Level 1.5 Neurocognitive Impairment dated back to April 2, 2010. Doc. 146276.

One year later, in October 2018, Dr. [REDACTED] (of the [REDACTED], where the research study took place) certified the same Diagnosis, also dated back to 2010. Doc. 197906. In February 2019, Mr. [REDACTED] submitted a Claim Form relying on Dr. [REDACTED] Level 1.5 pre-Effective Date Diagnosis.¹ Doc. 198968. He also submitted a Third Party Sworn Statement of Functional Impairment from [REDACTED], a long-time family friend. Doc. 198970.

In May 2019, after performing a thorough review of the research study medical records, an Appeals Advisory Panel Consultant determined that the cognitive testing Mr. [REDACTED] underwent did not satisfy the Settlement Program’s requirements for a Level 1.5 Diagnosis. Doc. 230244.

The Claims Administrator issued a Notice of Request for Additional Documents on October 10, 2019, explaining that Mr. [REDACTED] needed to provide a neuropsychological evaluation to support his Claim. Doc. 215119. However, by that time, Mr. [REDACTED] had already begun the process of being evaluated through the Baseline Assessment Program.

On July 23, 2019, several months before the above Notice had been issued, Mr. [REDACTED] underwent neuropsychological testing with Dr. [REDACTED], a board-certified neuropsychologist and Qualified BAP Provider. Doc. 223950. Dr. [REDACTED] performed a comprehensive examination, including a detailed review of Mr. [REDACTED] medical history, and concluded that “[t]he objective test scores, behavioral observations from today’s exam, CDR ratings, and reports from family/friends all converge to indicate a major neurocognitive disorder. . . . The current findings are consistent with a Level 2 neurocognitive impairment [diagnosis].” *Id.*

Mr. [REDACTED] was next evaluated on October 7, 2019 by Dr. [REDACTED], a Qualified MAF Physician and BAP Provider. Doc. 215150. Following a thorough examination, Dr. [REDACTED] determined: “Based upon the history provided, and the neuropsychometric testing, it is my

¹ Because of the backdating to 2010, Mr. [REDACTED] 2016 stroke had no bearing on that Claim.

opinion that he would qualify for [Level] 2.0, neurocognitive deficits. I indicated to his wife that I would need to see a sworn third-party corroboration of the changes and deficits [REDACTED] has experienced over the years. His wife indicated she would get the documentation to me.” *Id.* After reviewing documentary evidence of Mr. [REDACTED] functional impairment, Dr. [REDACTED] certified a Qualifying Diagnosis of Level 2 Neurocognitive Impairment dated October 11, 2019, and supported by Dr. [REDACTED] examination. Doc. 215151 (MAF Diagnosing Physician Certification Form, dated October 11); Doc. 223953 (BAP Diagnosing Physician Certification Form, dated October 7); Doc. 237792 (identical BAP Diagnosing Physician Certification Form).

Because Mr. [REDACTED] strokes took place before the Qualifying Diagnosis, they are noted (as required) on the Claim Form. *Id.* Mr. [REDACTED] checked a box indicating that he believed the strokes were *not* causally related to the Qualifying Diagnosis—meaning that the stroke offset should not apply. He later submitted a Stroke or Traumatic Brain Injury Explanation Form, and attached a medical opinion letter from Dr. [REDACTED] followed by supporting records, explaining why the Qualifying Diagnosis was not causally related to Mr. [REDACTED] stroke. Doc. 237891.

In his letter, Dr. [REDACTED] attested to reviewing medical records and affidavits from multiple parties, including Dr. [REDACTED] long-time family friend [REDACTED], and Dr. [REDACTED]—Mr. [REDACTED] family physician of 34 years at the time of writing. Dr. [REDACTED] letter (formally, a Third Party Sworn Statement of Functional Impairment) explained the history of Mr. [REDACTED] medical care—including details pulled from reviewing medical records. Doc. 237891. “As [Mr. [REDACTED]’s physician,” he concluded, “I have seen him evidencing signs of chronic traumatic brain injury long before his strokes in 2016 and 2018.” *Id.* Dr. [REDACTED] explained that, based on his own examination of Mr. [REDACTED] and his review of the medical records, he was of the opinion “that Mr. [REDACTED] cognitive difficulties predated his stroke history,” leading him to conclude that the Qualifying Diagnosis was not causally related to Mr. [REDACTED] prior strokes. Doc. 237891.

Between February 24, 2020, and July 30, 2020, the Claims Administrator engaged in ongoing correspondence with Mr. [REDACTED] attorney, first trying to obtain the records from the BAP neuropsychological testing in July 2019—which were eventually submitted in April 2020 (Docs. 223950; 223952)—and later trying to establish whether Mr. [REDACTED] wanted to proceed with the pre-Effective Date or the BAP Claims. Doc. 230246. Based on the information in the Claim file, it appears that Mr. [REDACTED] counsel never gave a definitive answer to this question.

On December 2, 2020, the Claims Administrator issued a Notice of Denial addressing the pre-Effective Date Diagnosis certified by Dr. [REDACTED] Doc. 230682. The Notice relied on an evaluation from the AAP Member, who explained that “based on the currently available information, especially regarding criteria (ii) and (iii), the diagnosis is not generally consistent with the Qualifying Diagnoses of Level 1.5 Neurocognitive Impairment,” and additionally, that Dr. [REDACTED] was not eligible to certify a Qualifying Diagnosis because he was not board certified in a neuro-specialty as required under Section 6.3(d) of the Settlement Agreement. *Id.* Mr. [REDACTED] did not challenge that determination.

As noted at the outset of this discussion, however, the present Appeal relates to the *second* Claim that Mr. ██████ filed, which was based on the Level 2 Qualifying Diagnosis obtained through the BAP—certified by Dr. ██████ and Dr. ██████ Doc. 223953. Mr. ██████ filed a Claim Form for that Diagnosis on August 25, 2021. Doc. 237893.

On September 8, 2021, an AAP Consultant reviewed the file because “[a] question ha[d] been raised as to whether [the] neuropsychological evaluation by ██████, PsyD, ABPP conforms to the requirements described in Exhibit 2 of the Settlement Agreement, especially as it relates to performance validity assessment and an incomplete BAP test battery.” Doc. 238333. The Consultant concluded:

Dr. ██████ did an admirable job evaluating this very impaired patient. He attempted to adhere to the requirements of the BAP protocol, but he demonstrated appropriate clinical flexibility in adapting to the patient’s unambiguous language deficits.

Id. The Consultant then added:

It is impossible to determine what portion of the patient’s impairments are due to his two strokes and what are due to his pre-stroke neuropsychiatric condition. Affidavits from a long-time family friend (Ms. ██████) and the patient’s long-time primary care physician (Dr. ██████) describe significant psychiatric symptoms and changes in the patient’s habits, activities and behavior prior to his 2018 stroke. However, we have no evidence of cognitive impairment at this time. There is no question that the patient met [the Settlement Program’s] criteria for Level 2 Neurocognitive Impairment at the time of his neuropsychological assessment (July 2019).

Id.

The Claims Administrator then requested global review of the file from the AAP, apparently seeking input on the question of whether the stroke offset should apply. An AAP Member, having both independently reviewed the file and also read the Consultant’s report, provided the following explanation:

The Player was evaluated by the BAP neuropsychologist, Dr. ██████, on 7/23/2019, and by the BAP neurologist, Dr. ██████, on 10/7/2019, and was given a diagnosis of Level 2 Neurocognitive Impairment with a diagnosis date of 10/7/2019.

Medical records show that the Player suffered two Strokes, in July of 2016 and November of 2018. The 2016 Stroke left the Player globally aphasic. Dr. ██████ adapted the BAP test battery in an attempt to compensate for the Player’s aphasia and noted severe cognitive deficits in multiple domains.

In a Stroke Explanation Form dated 6/28/2021, Dr. [REDACTED] explained that the Player's Qualifying Diagnosis was not causally related to Stroke. He summarized evidence that the Player's cognitive difficulties predated the Stroke. Part of that evidence is a report dated 3/27/2017 by another neurologist, Dr. [REDACTED] who reviewed a prior evaluation of the Player done in April 2010 by his group and concluded that the Player had a diagnosis of Level 1.5 Neurocognitive Impairment at that time. However, Dr. [REDACTED] conclusion is not consistent with the actual records of that 2010 evaluation, which do not support a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

The Player's longtime primary care physician, Dr. [REDACTED], provided a letter dated 11/20/2020 in support of the statement that the cognitive difficulties were not caused by Stroke, stating that his 2011 note reported difficulties in memory, cognitive slowing as well as attention deficit disorder, anxiety and depression. Limited information is provided regarding the Player's level of function in the years prior to his 2016 Stroke. In 2008 he was working for the [REDACTED] but gave up his job doing color broadcast on radio. There are no comments from any provider regarding the severity of the Player's cognitive difficulties during that period. The most detailed description of the Player's functioning comes from a statement, dated 2/4/2019 and addended 8/23/2020, by Ms. [REDACTED] a family friend who has known the Player since 2003. She describes clear behavioral changes in the 6-7 years prior to the Stroke, including pathological levels of obsessiveness, paranoia, delusions and emotional lability.

An AAP Consultant reviewed the neuropsychological testing report and determined that Dr. [REDACTED] had made an excellent effort to evaluate this Player and that the Player met Settlement criteria for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment at the time of his testing in July 2019, but that it is impossible to determine what portion of the Player's impairments are due to his two Strokes. The Player was clearly severely impaired by both cognitive difficulties and other neurological deficits, such as aphasia and right sided weakness, at the time of his evaluation. The medical records indicate that worsening cognitive and behavioral changes were noted before the first Stroke in 2016, although most of the symptoms described during that period appear to be psychiatric. The records do not provide sufficient evidence that the severity of either the cognitive deficits or related functional impairment were at a level of any Qualifying Diagnosis before the 2016 Stroke.

Although some cognitive changes preceded the Stroke, the available medical records support the opinion that the majority of the cognitive impairment noted at the time of diagnosis was due to the Stroke in 2016. Therefore, there is no clear and convincing evidence in the Claim file to indicate that the Qualifying Diagnosis was not causally related to the Stroke.

Doc. 239929.

On November 4, 2021, the Claims Administrator issued a Notice of Monetary Award Claim Determination, finding Mr. [REDACTED] to be eligible for an Award for his Level 2 Qualifying Diagnosis. Doc. 239924. However, it decided to apply the stroke offset, thus reducing Mr. [REDACTED] Monetary Award by 75%. *Id.*

Mr. [REDACTED] now appeals that determination. Doc. 240794.

DISCUSSION

Mr. [REDACTED] has met the requirements for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment based on his BAP exams from July and October 2019. And there is no dispute that prior to receiving that Diagnosis, Mr. [REDACTED] suffered strokes within the Settlement’s precise definition of the term.² At issue is whether the Claims Administrator’s decision to apply the Settlement’s stroke offset, thereby reducing Mr. [REDACTED] Monetary Award by 75%, was correct.

The Settlement provides that if a Retired Player receives a Qualifying Diagnosis after suffering a medically diagnosed stroke, the 75% stroke offset will *not* apply “if the Settlement Class Member demonstrates, by ***clear and convincing evidence***, that the Qualifying Diagnosis was ***not causally related*** to the Stroke.”³ It is thus clear that the Player who suffered a stroke pre-diagnosis bears the initial burden of establishing that the offset should not apply. But several interpretive questions remain: What constitutes “clear and convincing evidence” in this context? And what does it mean for a Qualifying Diagnosis to be “causally related” to a stroke?

“Clear and convincing evidence” is generally recognized as an intermediate standard of proof—more demanding than preponderance of the evidence, but less demanding than beyond a reasonable doubt.⁴ Here, in the context of a stroke, it is the responsibility of the Player—and by extension, his doctors—to offer evidence that meets this standard. Stepping back, this is no easy conceptual task: how can a doctor know (and with what certainty) if an earlier stroke did not cause

² See Settlement Agreement § 2.1(www); see also Special Master Decision Regarding Stroke Definition (July 15, 2020), https://www.nflconcussionsettlement.com/Docs/stroke_sm.pdf (discussing the meaning of “stroke” within the Settlement).

³ Section 6.7(d) (emphasis added).

⁴ *In re Fosamax Alendronate Sodium Prods. Liab. Litig.*, 852 F.3d 268, 285-86 (3d Cir. 2018) (“Black’s Law Dictionary defines clear and convincing evidence as ‘evidence indicating that the thing to be proved is highly probable or reasonably certain.’”).

Mr. [REDACTED] counsel cites *Rivera v. Minnich*, 483 U.S. 574 (1987), specifically quoting the Supreme Court’s statement that: “[A]s we have said in explanation of the need for clear and convincing evidence in certain proceedings, rights once confirmed should not be lightly revoked.” I am not persuaded of the case’s relevance. *Rivera* itself concerns paternity proceedings, and the quoted language originates from *Schneiderman v. United States*, 320 U.S. 118 (1943), dealing with immigration and citizenship. In the present proceedings there has been no conferral or confirmation of rights. Application of the stroke offset would not be a “revocation” of any right belonging to a Player; instead, by the plain language of the Settlement, the burden is on the Player to establish that he should be exempt from the offset.

a later Diagnosis? The evidence must be circumstantially derived.⁵ Because this burden is placed in the first instance on the Player, I am persuaded that it is appropriate to look to the Third Circuit’s Model Jury Instructions, cited by Mr. ██████ attorney, for additional clarity about application of this standard. The instructions provide that “[c]lear and convincing evidence is evidence that produces in your mind a firm belief or conviction that the allegations sought to be proved by the evidence are true.”⁶

This brings us to our next inquiry: what does “causally related” mean? The Settlement does not provide guidance beyond the language in the offset provision itself, and it is seemingly susceptible to various meanings, ranging from narrow to broad. However, Judge Brody’s Final Order and Judgment approving the Settlement provides a key interpretative guide. As explained in that Order, the 75% offset—which applies in the event of either a stroke or severe traumatic brain injury unrelated to football—simply targets instances in which either of these distinct medical events *causes a Qualifying Diagnosis*.⁷ As the Order explains, “any Retired Player has an opportunity to demonstrate by clear and convincing evidence that the Stroke he suffered did not cause his Qualifying Diagnosis.”⁸

Thus, in this case, the Claims Administrator’s task was to evaluate whether the available evidence produced a firm belief or conviction—in other words, that it is highly probable or reasonably certain—that Mr. ██████ strokes did not cause his Qualifying Diagnosis. To succeed on appeal, Mr. ██████ must show that there is a high degree of probability that the Claims Administrator was wrong in determining he had not met that burden, and therefore in applying the 75% stroke offset. This doubled standard presents a challenge for Mr. ██████ appeal, but one which I conclude he has surmounted.

The Claims Administrator’s decision to apply the offset resulted from input from the AAP. Doc. 239929. Mr. ██████ counsel challenges that reliance both procedurally and substantively—first, arguing that it was improper for the Claims Administrator to request AAP review on whether the stroke offset should apply. Doc. 240794. Next, he asserts that even *if* AAP review was proper, the AAP Member’s analysis—which was ultimately adopted by the Claims Administrator—was inconsistent with the Settlement’s evidentiary requirements regarding the stroke offset. *Id.* Notably, the NFL Parties oppose only the first argument—asserting that the Claims Administrator’s request for AAP review was proper—but take “no position on the question of whether the stroke offset was properly applied to Mr. ██████ claim.” Doc. 242548. I will consider each argument in turn.

⁵ In a discussion about “middle-level” burdens of proof, the Supreme Court has indicated that “clear and convincing” evidence need not be “unequivocal,” especially in a context where proof is “based on medical ‘impressions’ drawn from subjective analysis and filtered through the experience of the diagnostician.” *Addington v. Texas*, 441 U.S. 418, 430, 432-33 (1979). This caution to be modest about what we can know in the face of inconsistent evidence is particularly apt given the counterfactual nature of the stroke offset inquiry.

⁶ MODEL CIV. JURY INSTRUCTIONS § 1.11 (U.S. CT. APPEALS 3D CIR. 2020), <https://www.ca3.uscourts.gov/model-civil-jury-table-contents-and-instructions>.

⁷ See Memorandum and Final Order and Judgment Approving Settlement, 307 F.R.D. 351, 409 (“Like severe TBI, Stroke is a well-known cause of the Qualifying Diagnoses.”).

⁸ *Id.* at 409 (emphasis added).

Among other tasks vital to the Settlement’s administration, the Claims Administrator is responsible for processing and reviewing Claim Packages and determining whether Claimants are entitled to Monetary Awards.⁹ Having entrusted the Claims Administrator with this central responsibility, the Parties to the Settlement incorporated language granting it broad authority to take the steps necessary to do its job: “The Claims Administrator will have the discretion to undertake or cause to be undertaken further verification and investigation, including into the nature and sufficiency of any Claim Package or Derivative Claim Package documentation, including, without limitation, as set forth in Section 10.3 [regarding audit procedures].”¹⁰

As such, it simply cannot be the case that the Claims Administrator—tasked with reviewing the sufficiency of complex medical documentation, and authorized to “undertake or cause to be undertaken further verification and investigation, including into the nature and sufficiency of any Claim Package”—does not have authority to request assistance from the Settlement’s appointed expert medical reviewers.¹¹ The AAP’s very purpose is to provide advice regarding the “medical aspects” of the Settlement—for which non-medical professionals will, at times, necessarily need assistance in understanding and interpreting.¹² Limiting the Claims Administrator’s ability to ask for the AAP’s assistance in making particular, nuanced, medical determinations would unquestionably run contrary to the goals and purpose of the Settlement.

The Claims Administrator’s request for AAP input for this particular claim was appropriate, and well within its authority. But whether reliance on that input—and the substantive decision itself—was proper is a separate question.

To begin, as Mr. █████ counsel points out, there are specific circumstances in which the Settlement delegates decision-making authority to the AAP—for example, in review of pre-Effective Date Diagnoses.¹³ But apart from these (limited) instances, the AAP serves an advisory, not an authoritative, role. As I have explained in multiple previous opinions, this Program is grounded on a fundamental presumption that the Claims Administrator—and by extension, the AAP—*should defer to the articulated medical judgments of examining clinicians and physicians*.¹⁴ When the AAP provides input, it generally should not seek to substitute its own judgment for that of the

⁹ Settlement Agreement §§ 10.2(b)(5)-(6).

¹⁰ *Id.* § 8.6(b).

¹¹ Notably, the AAP Consultant’s review verifying the adequacy of Mr. █████ neuropsychological testing—review which was *at the request of the Claims Administrator*—is an indispensable factor in my decision to grant this Appeal. Because of that review, there is no question that Mr. █████ has satisfied the requirements for a Level 2 Qualifying Diagnosis.

¹² See Settlement Agreement § 2.1(g) (defining “Appeals Advisory Panel”); see also *id.* § 2.1(h) (defining “Appeals Advisory Panel Consultants”).

¹³ Settlement Agreement § 6.4. For a complete summary of who reviews each Qualifying Diagnosis and what standard of review applies, see *Frequently Asked Questions: FAQ #130* (Who reviews my claim for a monetary award?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

¹⁴ See, e.g., Special Master Decision Regarding Clinical Judgment on Generally Consistent Standard, at 3 (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_judgment_sm.pdf; Special Master Decision Regarding Functional Impairment/Cognitive Decline (Sept. 7, 2021), https://www.nflconcussionsettlement.com/Docs/functional_impairment_sm_5.pdf.

examining doctor. Instead, it is to ascertain if the front-line doctor's judgment was well-reasoned and medically sound.¹⁵ That is because many of the foundational decisions for Claim Awards are incapable of being reduced to numerical scores but instead result from complex medical judgments.

Sometimes, that reviewing task will uncover facts that the examining clinician or physician missed, or errors in carrying out complex calculations. Correcting such mistakes (and making sure they do not recur) is one of the essential roles for the Settlement's advisory medical experts. But there will inevitably be other instances—in which a reviewing AAP Member or Consultant's own judgment will differ from that of the examining clinician. And in these instances, the Settlement asks its experts to perform a different, but vital and admittedly extremely challenging task: to advise the Settlement's non-medical-expert decisionmakers on whether *another* medical professional's articulated conclusion resulted from the exercise of a reasonably determined medical judgment. This is the core deferential standard which applies to so much of the Program's review processes. Clearly, the degree of (and justification for) deference will wax with the carefulness of the underlying reasoning. cursory reports will fairly provoke more skepticism than thoughtful assessments. And the AAP Member and Consultants should be particularly hesitant to overturn judgments reached through the Settlement's own carefully monitored medical programs and by its own doctors, at least when they carefully explain themselves.

Sometimes, the Settlement itself delegates authority to the diagnosing physician, further strengthening the presumption of deference. In the case of pre-Diagnosis strokes, the Settlement provides a specific form—the Stroke or Traumatic Brain Injury Explanation Form—which “is to be used by a diagnosing physician . . . where the diagnosing physician determined the Qualifying Diagnosis was not causally related to the Stroke or TBI.”¹⁶ The Form includes the following instructions for the diagnosing physician:

Explain why the Retired NFL Football Player's Qualifying Diagnosis was not causally related to the Stroke or TBI. Your explanation must provide clear and convincing evidence that the Stroke or TBI is not a reason for the Qualifying Diagnosis. Attach any medical records or diagnostic tests that support this explanation. If you need more space, attach supplemental pages to this Form.

The Parties could have delegated authority to the AAP, as they did in many other places, to determine the sufficiency of evidence regarding whether a Diagnosis is “causally related” to a pre-Diagnosis stroke. But the Settlement's text (that is, the language of the stroke provision) and the corresponding (required) Form make clear that the Parties intended the diagnosing physician to bear this burden. This is quite analogous to the physician's certification that neuropsychological testing was medically unnecessary.¹⁷ And, as with the question of certification, if asked to advise

¹⁵ See Special Master Decision Regarding Neuropsychological Testing: *Slick* Criteria and Validity, at 10-11 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

¹⁶ The Form is available on the NFL Concussion Settlement website: https://www.nflconcussionsettlement.com/Docs/fillable_stroke_tbi_form.pdf.

¹⁷ See Special Master Decision Regarding Neuropsychological Testing (Sept. 23, 2021), https://www.nflconcussionsettlement.com/Docs/np_testing_sm.pdf; *Frequently Asked Questions: FAQ* 363

on whether the stroke offset should apply, the reviewing AAP Member’s task is to evaluate the sufficiency of the *reasoned judgment of the diagnosing physician*—not to offer their own, independent judgment as a substitute. That is, for this question, the AAP Member should not ask if the diagnosing physician was right, but rather whether he or she was reasonable.

Turning to the record in this case, it is first worth noting that both the examining BAP neuropsychologist, Dr. [REDACTED] and diagnosing BAP/MAF neurologist, Dr. [REDACTED] provided exemplary reports from their evaluations of Mr. [REDACTED] Docs. 223950; 223952. Both offered complete, well-reasoned, and thorough explanations that address Mr. [REDACTED] medical history. And both reached clearly articulated conclusions about his level of cognitive impairment and its relationship to his strokes.

Following submission of those initial reports, Dr. [REDACTED] completed a Stroke Explanation Form, detailing the basis of his determination that Mr. [REDACTED] Qualifying Diagnosis was not causally related to his strokes. Doc. 237891. Dr. [REDACTED] first noted that his conclusion was based on his own personal evaluation of Mr. [REDACTED] through the BAP, in which he determined that “many of the [cognitive] changes [preceded] the strokes.” He next detailed his review of additional records, including a letter from Dr. [REDACTED] regarding the results obtained through the 2010 research study, his opinion that Mr. [REDACTED] demonstrated Level 1.5 Impairment in 2010; a letter from Dr. [REDACTED] Mr. [REDACTED] family physician of thirty-four years, attesting to having observed signs of cognitive impairment long before the strokes; and a letter (including a supplemental addendum) from Mr. [REDACTED] longtime family friend, [REDACTED], detailing a specific timeline of changes in Mr. [REDACTED] daily functioning, personality, decision-making skills, reasoning, planning, and task-completion, all of which predated the strokes. He ultimately concluded that the stroke offset should not apply.

As explained above, the Claims Administrator’s task was to evaluate whether Dr. [REDACTED] provided “clear and convincing evidence”—that is, whether his explanation and the supporting records produced a firm belief, making it highly probable—that Mr. [REDACTED] strokes did not cause his Qualifying Diagnosis. By extension, the AAP—when asked to review the Claim—had the same charge. But the AAP did not approach Dr. [REDACTED] report with this standard in mind. The AAP’s review instead seems to have held him to a higher form of proof, amounting to counterfactual certainty.

The reviewing AAP Member offered numerous criticisms. Doc. 239929. First, the AAP stated, “Dr. [REDACTED] conclusion is not consistent with the actual records of that 2010 evaluation, which do not support a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment”—but provided no further explanation about why Dr. [REDACTED] conclusion was inconsistent. Next, regarding the letter and medical records from Dr. [REDACTED] the AAP noted that “[l]imited information is provided regarding the Player’s level of function in the years prior to his 2016 Stroke,” and further highlighted the lack of “comments from any provider regarding the severity

(regarding deference to diagnosing physician’s determination that neuropsychological testing is medically unnecessary), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

of the Player's cognitive deficits." Finally, the AAP Member addressed the Consultant's report, reiterating the Consultant's stance that "it is impossible to determine what portion of the Player's impairments are due to his two Strokes," and that "[t]he records do not provide sufficient evidence that the severity of either the cognitive deficits or related functional impairment were at a level of any Qualifying Diagnosis before the 2016 Stroke."

This analysis supplants, but does not address, Dr. ██████ explanation. Taking the criticisms in order, first, even assuming that Dr. ██████ conclusion about a Level 1.5 Diagnosis was incorrect, the proper inquiry was whether Dr. ██████ report (and the corresponding research study records) constitute evidence that could reasonably support Dr. ██████ conclusion that Mr. ██████ 2019 Qualifying Diagnosis was not caused by his strokes. Importantly, Dr. ██████ did not adopt Dr. ██████ conclusion; rather, those records were part of the broader swath of evidence he considered in reaching his ultimate conclusion about causation. The AAP provided no basis on which to conclude that such consideration was improper.

Next, the AAP mentioned a lack of "comments" regarding the severity of Mr. ██████ cognitive difficulties in the records from Dr. ██████ Here too, this question does not address whether those records support Dr. ██████ conclusion that Mr. ██████ strokes did not cause his Qualifying Diagnosis. Much like Dr. ██████ letter and the 2010 research study evaluation, the AAP's task was to determine if Dr. ██████ opinion and records lent support sufficient to deem Dr. ██████ conclusion "highly probable."

Finally, the Consultant wrote that "it is impossible to determine what portion of the Player's impairments are due to his two Strokes." The AAP Member adopted this view. But this is the wrong criterion. Claimants need not prove what precise fraction of their current impairment is caused by a previous stroke. (And how could they?) Rather, the question is simply this: did the claimant offer sufficient evidence to produce a firm belief or conviction that the stroke did not cause the Qualifying Diagnosis. And the *sufficiency* of the evidence is to be determined, in the first instance, by reference to the report of the diagnosing physician.

The diagnosing physician—after a conducting a careful personal examination of Mr. ██████ reviewing numerous other records, and providing a thoughtful explanation of his process and reasoning—concluded that the stroke offset should not apply. The AAP, in rejecting that conclusion, gave no deference to Dr. ██████ views, interrogating them for error rather than assuring itself of their carefulness and reasonableness. Given this inappropriate level of scrutiny, the Claims Administrator's decision to apply the Stroke Offset cannot stand.

In considering whether to remand for application of the appropriate standard, or to grant the Claim, I have carefully considered both the record and the AAP's comments on Dr. ██████ report. There is no evidence that Dr. ██████ articulated judgment was medically unsound—indeed, the AAP both praised it and relied on it in part. Given that, I find that the available evidence affirmatively meets Mr. ██████ "clear and convincing" burden to avoid the offset: taken as a whole, the record supports a determination that it is highly probable that Mr. ██████ strokes did not cause his Qualifying Diagnosis. There is more than sufficient proof that he had suffered

significant cognitive decline before 2016. I therefore conclude that there is a high degree of probability that the Claims Administrator's decision to apply the stroke offset was wrong.

CONCLUSION

Mr. [REDACTED] Appeal is granted. I direct the Claims Administrator to reissue his Monetary Award for a Qualifying Diagnosis of Level 2 Neurocognitive Impairment, to be paid in full, without application of the 75% stroke offset.

Date: April 25, 2022



David A. Hoffman, Special Master