

IN RE: NATIONAL FOOTBALL
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

██████████ is the Representative Claimant for her late brother ██████████. Mr. ██████████ was alive when his Claim was first filed in 2020 based on a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, but he passed away in March 2021. On his behalf, Ms. ██████████ now appeals the Claims Administrator's denial of his Claim.

After reviewing Mr. [REDACTED] medical records, I have concluded that Ms. [REDACTED] has not demonstrated by clear and convincing evidence that the Claims Administrator's denial of Mr. [REDACTED] Claim was in error. Her Appeal is denied.

This case has a complex and convoluted history.

On May 10, 2017, Mr. [REDACTED] filed a Claim for benefits based on a pre-Effective Date Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Doc. 67706. Dr. [REDACTED], a neuropsychologist, had conducted neuropsychological testing on July 13, 2016. Dr. [REDACTED] a neurologist, performed a neurological evaluation two days later. Docs. 67709–67713.

Subsequently, the Claims Administrator began an audit of seventy Claims, one of which was Mr. ██████ that relied on Dr. ██████ neuropsychological reports. Docs. 151827; 171858. Although the Special Masters did not ultimately confirm an adverse finding, Mr. ██████ withdrew his first Claim on July 15, 2018.¹ Doc. 179488.

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Mr. ██████ then sought another evaluation through the BAP. He underwent testing with two BAP Providers—neuropsychologist Dr. ██████ and neurologist Dr. ██████ —who, in the years that followed, reached different conclusions about Mr. ██████ level of impairment, while repeatedly altering their respective diagnoses. Only selected portions of Dr. ██████ and Dr. ██████ communications with each other and the Claims Administrator are in Mr. ██████ file. The following is what I can piece together.

Dr. ██████ first performed a neuropsychological evaluation of Mr. ██████ on September 25, 2018. Doc. 223882. Reviewing affidavits from ██████, Mr. ██████ then-girlfriend, and ██████, Mr. ██████ longtime friend, Dr. ██████ determined that Mr. ██████ satisfied the criteria for Level 2 Neurocognitive Impairment in the categories of Complex Attention and Processing Speed and Language, but not in the remaining categories of Executive Functioning, Learning and Memory, and Visual-Perceptual Processing. *Id.* Dr. ██████ finding that “Mr. ██████ showed Level 1 impairment in [the CDR categories of] Community Affairs, Personal Care, and Home and Hobbies,” concluded that he met “criteria for Level 1.5 [Neurocognitive Impairment] as he met Level 2 impairment in the areas of Complex attention and processing speed [and Language] and Level 1 impairment on the CDR scale . . .” *Id.*

Notably, Dr. ██████ reached this conclusion despite his acknowledgement that Mr. ██████ neuropsychological test results were invalid: Mr. ██████ had “failed the TOMM, MSVT, and ACS Word Choice. Overall, Mr. ██████ appeared to have difficulties as a result of his constant pain and fatigue.” *Id.* Nevertheless, Dr. ██████ justified a Level 1.5 Diagnosis, writing:

[Mr. ██████ performance on the effort tests would be described as suboptimal by the criteria set up under the rules established by the settlement, but it is [my] strong opinion that the client did make his maximum effort although his ability to focus and concentrate over an exam was compromised by his attentional and physical issues.

Id.

Mr. ██████ subsequently underwent a neurological evaluation with Dr. ██████ in January 2019. Doc. 223883. Dr. ██████ CDR analysis was conclusory. She noted that Mr. ██████ “CDR score totals 1 with subscores of 1 in Memory, Judgment and Problem Solving, Community Affairs, and Home and Hobbies.” *Id.* At the same time, Dr. ██████ stated that she was “particularly concerned with regard to the patient’s reported psychiatric manifestations including auditory and visual hallucinations,” and recommended “neurologic and/or psychiatric evaluation.” *Id.* Dr. ██████ nevertheless certified a Level 1.5 Qualifying Diagnosis, essentially adopting Dr. ██████ neuropsychological assessment. *Id.*

On July 24, 2020, Mr. ██████ submitted a new Claim for benefits based on that Diagnosis, dated to January 22, 2019. Doc. 226856.

The Claims Administrator issued a Notice of Request for Additional Documents on July 30, 2020. Doc. 226982. The Notice highlighted two deficiencies. First, Mr. [REDACTED] “medical records do not indicate evidence of moderate to severe cognitive decline from a previous level of performance in two or more cognitive domains . . . one of which must be executive function or learning and memory because you are relying solely on a third-party affidavit to corroborate functional impairment.” *Id.* The Claims Administrator requested that Mr. [REDACTED] upload “medical or employment records that corroborate the functional impairment. If no such records exist and you must rely on a third-party affidavit, you may provide additional neuropsychological testing . . .” *Id.* And, although Mr. [REDACTED] “received a Qualifying Diagnosis through the Baseline Assessment Program (“BAP”) . . . the neuropsychologist . . . reported two or more failed performance validity measures.” *Id.* The Claims Administrator therefore explained that it would “coordinate with the [Appeals Advisory Panel Consultants] and let you know if we need any additional information.” *Id.*

After reviewing Mr. [REDACTED] medical records, an AAP Consultant denied the Claim’s validity, writing that Mr. [REDACTED]

[S]cores below expectations across all but 2 ACS scores as well as TOMM and MSVT. Symptom validity subtests are also elevated. In my opinion he triggers at least 2 if not 3 Slick criteria and his is not a valid test. The neuropsychologist acknowledges it as such but then attributes the performance to fatigue and pain but this does not change the fact that it is not likely valid.

Doc. 231544.

On September 3, 2020, following up on the issue flagged by the Claims Administrator when reviewing the claim, the BAP Administrator contacted Dr. [REDACTED] and Dr. [REDACTED] to request clarification:

It appears that the diagnosis of a Level 1.5 was made without the necessary supporting documentary evidence. We now have that evidence and . . . have attached it to this secure email. Please review and then provide a revision/addendum advising whether these records do or do not corroborate your initial findings.

Also, there is some question about the appropriate Qualifying Diagnosis Date and we would ask your opinions about this as well. Per the settlement, when documentary evidence is required such as in the case of a Level 1.5 or 2, we are required to use the latest date applicable, either the date of the 2nd BAP appointment or the date the affidavit was signed/medrecs were dated, etc., whichever comes last, as the Qualifying Diagnosis Date. Due to the original documentary evidence issue, it is possible that the [REDACTED] Testing I have attached here can now act as the date of diagnosis and would allow the player a date in 2016. However, the original Date of Diagnosis was listed as [1]/22/2019 as this was the

latter of the 2 required BAP appointment dates per protocol. Which date do you feel is the appropriate date to use on the Diagnosing Physician Certification Form and why?

Doc. 235646.

Dr. [REDACTED] replied on September 4, 2020, emphasizing that “there is no question in my mind that [Mr. [REDACTED]] was suffering from the same disorder in 2016 as in 2019. I am however not sure of the complexities of the legal issues around the assigned date . . . I would prefer to see the earlier date used.” *Id.* Dr. [REDACTED] however, responded that:

I’d like to explore the discrepancies between Dr. [REDACTED] and Dr. [REDACTED] testing. In the 2016 eval, the patient scored a level 2 in Learning and in Executive Function. Whereas, in the 2018 eval, there was no impairment in these domains. My understanding is that Dr. [REDACTED] diagnosis of 1.5 was based on a level 2 in Complex Attention in combination with a CDR of 1. However, the additional data provided by the 2016 evaluation, in my opinion, question[s] the 1.5 qualifying diagnosis (as opposed to substantiating it). Dr. [REDACTED] – I’d love to discuss with you by phone so you can help me understand why the 2016 evaluation substantiates the 1.5 diagnosis. Once I clearly understand, then we can broach the subject of date of diagnosis.

Id. On September 5, 2020, Dr. [REDACTED] replied to Dr. [REDACTED]

Thank you for your comments. I have enclosed a copy [of] my spread sheet with the [REDACTED] raw scores and T scores added for the two areas in which a deficit is found: Attention Processing and Language. [The] [REDACTED] raw and T scores are in red while mine remain in black.

For the attention area, the scores differ slightly but not more than would be expected by a test-retest (all scaled scores within 2 points of each other) over two years. Using just the [REDACTED] data, the client qualifies for Level 2 consistent with our later findings.

Analysis of the language area is more difficult, as only 2 of the three tests were administered. Both of those are in the low normal range (T scores of 40–45) do not meet the criteria. [REDACTED] presents other tests to argue for the presence of the cognitive deficit, but they are not in this test battery and cannot meet the current criteria.

Thus while the testings are similar, he does not meet the technical criteria of the settlement in 2016 as only one area is impaired. As a result, the date of impairment should be considered without the [REDACTED] data.

Id. (errors in original).

Subsequently, on September 4, 2020 and September 8, 2020, Dr. [REDACTED] and Dr. [REDACTED] submitted revised evaluations, each reiterating a Diagnosis of Level 1.5 Neurocognitive Impairment. Docs. 228944; 228945.

In an addendum report dated November 17, 2020, Dr. [REDACTED] explained that after reviewing Mr. [REDACTED] 2016 testing—which he had just described as not meeting the “technical criteria of the settlement”—it was now his belief that “Mr. [REDACTED] suffered from the disorder identified in 2018 as early as 2016 . . . such a finding makes Mr. [REDACTED] eligible for settlement funds dating back to the time of those medical records.” Doc. 230431. Dr. [REDACTED] also submitted an addendum report on November 19, 2020. Doc. 230436. There, she stated that “it is clear that the patient was suffering from cognitive and functional impairment at the time of his neuropsychological testing back in 2016. Therefore, these records corroborate the initial findings of a Level 1.5 and also support backdating the Qualifying Diagnosis to 2016.” *Id.*

Dr. [REDACTED] and Dr. [REDACTED] then submitted a third Diagnosing Physician Certification Form for a Level 1.5 Qualifying Diagnosis on November 19, 2020, listing the date of Diagnosis as December 9, 2016. Doc. 230430.

On January 6, 2021, the Claims Administrator issued a Claim Status Update informing Mr. [REDACTED] that an “AAPC member reviewed your claim and testing results for the failed performance validity measures evident in the records. After that input, review by the AAP is required to verify this claim.” Doc. 231644.

On April 1, 2021, the Claims Administrator wrote to Dr. [REDACTED] that it needed “just a little more explanation to help us understand” her Diagnosis. Doc. 237700. The Claims Administrator outlined Dr. [REDACTED] and the AAP’s concerns regarding validity, as well as the AAP’s concerns regarding Dr. [REDACTED] CDR ratings. *Id.* According to the AAP, the CDR ratings:

[A]ppear to be based on incorrect methods of collecting the information and formulating the ratings according to officially published directions [from Washington University in St. Louis]. . . . In this case the factors of pain and fatigue acknowledged do not appear to have been considered. The effects of [Mr. [REDACTED] psychiatric symptoms, headaches and sleep disturbances also need to be considered for effects on his daily functioning. Furthermore, an interview of a reliable informant or collateral source was not conducted.

Id. On April 2, 2021, Dr. [REDACTED] responded:

Thanks for your email. This case has been particularly troubling. From the start, I questioned the neuropsychological results, but I lean heavily on the opinion of the neuropsychologist—particularly regarding a 1.5 diagnosis. *And Dr. [REDACTED] was very assertive with his impression that the patient met 1.5 criteria.* Maybe we could discuss by phone?

Id. (emphasis added).

On April 6, 2021, Dr. [REDACTED] emailed the Claims Administrator: “[i]n anticipation of our call, can you LMK if you have a copy of the message trail in the BAP portal between Dr. [REDACTED], and me?” Doc. 237706. Mr. [REDACTED] file contains no further information regarding this phone call.

On April 24, 2021, presumably as a result of this phone call, Drs. [REDACTED] and [REDACTED] submitted a fourth Diagnosing Physician Certification Form. They maintained December 9, 2016 as the date of Diagnosis. But, with no further written explanation, they changed the Qualifying Diagnosis itself to Level 1 Neurocognitive Impairment. Doc. 234999.

After reviewing this new Diagnosis, the Claims Administrator denied Mr. [REDACTED] Claim on August 3, 2021. Doc. 237416. The Notice stated (in part):

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: There are four diagnostic criteria for a Qualifying Diagnosis of Level 1.5 Neurocognitive [I]mpairment diagnosed through the Baseline Assessment Program (BAP). Criterion (i) requires documentation of concern for a severe cognitive decline; (ii) requires evidence of a moderate to severe cognitive decline in accordance with the standardized neuropsychological protocol; (iii) requires documentation of functional impairment generally consistent with scores of 1.0 for the CDR categories of Community Affairs, Home/Hobbies, and Personal Care; and (iv) requires that the cognitive deficits do not occur exclusively in the context of a delirium, acute substance abuse, or as a result of medication side effects. **In this case, criterion (ii) was not met because of multiple validity concerns, and criterion (iii) was not met because it was unclear to what extent the Player’s functional decline is related to untreated major depression, headaches and insomnia rather than cognitive impairment. . . .**

Criterion (ii): Regarding validity, Dr. [REDACTED] noted that the Player’s “effort was not passing. He failed the TOMM, MSVT, and ACS Word Choice. Overall, [he] appeared to have difficulties as a result of his constant pain and fatigue.” Slick Criteria were reported as positive for only one item #1 (suboptimal validity scores). . . .

[The reviewing AAP Member] agree[s] with the AAPC that the evidence indicates that this is a non-credible cognitive profile. As a result, the neuropsychological test data obtained from this evaluation is not valid and cannot be interpreted.

With regard to the Slick criteria, more than just the first item is implicated. The pattern of neuropsychological test performance is markedly discrepant from currently accepted models of normal and abnormal central nervous system function (Slick criterion 2). Despite the apparently severe impairments in Complex Attention and Language, the Player performed normally on the other three cognitive domains. Furthermore, the MMSE score was within normal limits and the MoCA was compatible with only mild cognitive impairment. These scores are not at all consistent with a diffuse neurodegenerative brain disorder causing dementia, and this marked discrepancy was not reconciled by the diagnosing physician. Lastly, reported or endorsed symptoms are improbable in number, pattern, or severity; or markedly inconsistent with expectations for the type of severity of documented medical problems (Slick criterion 7). As documented by the MMPI results, “His MMPI profile should be interpreted with caution . . . as elevations in validity scores indicate that [he] may have responded to questions in a manner that is not typical of most people.”

Criterion (iii): The CDR ratings in this case failed to consider the factors of pain and fatigue acknowledged by Dr. [REDACTED]. They also do not consider the effects of his psychiatric symptoms, headaches and sleep disturbance on his daily functioning, even though there was concern that the Player needed neuropsychiatric evaluation and treatment.

Based on the failures of Settlement criteria (ii) and (iii) as described above, the diagnosis does not meet the Settlement criteria for the Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.

After further review, the BAP Providers determined that a Level 1 Neurocognitive Impairment diagnosis is more appropriate and provided an updated Diagnosing Physician Certification Form (Doc ID 234999). Level 1 Neurocognitive Impairment is not a Qualifying Diagnosis under Section 2.1(yyy) of the Settlement Agreement and therefore is not eligible for a Monetary Award under Section 6.2(a).

Id. (emphasis added).

Mr. [REDACTED] passed away on March 14, 2021 due to malignant hypertension with chronic kidney disease, end stage renal disease, and nephrotic syndrome. Doc. 238413. [REDACTED] was appointed Representative Claimant on September 28, 2021 and timely appealed. Doc. 238716; 242425.

Ms. [REDACTED] submitted new evidence on appeal, including (what is styled as a) Diagnosing Physician Certification Form, which would have been Mr. [REDACTED] fifth, and an accompanying report from [REDACTED], DO. Ms. [REDACTED] also submitted: an email from Dr. [REDACTED] affirming that his CDR evaluation of Mr. [REDACTED] was based solely on brain injury and cognitive decline; an email from Dr. [REDACTED] emphasizing that he only “‘downgraded’” to a Level 1 Diagnosis because he thought he had to align with Dr. [REDACTED] and an affidavit from [REDACTED], Mr. [REDACTED] ex-wife, corroborating functional impairment. Docs. 242420–242424.

DISCUSSION

Mr. [REDACTED] first filed a Claim for benefits five years ago, and the neuropsychological evaluations generating this latest submission started in 2018. What resulted was an inconsistent, inadequately considered and incompletely documented set of results (by the Program’s own doctors), leading to a convoluted and obscure process. This could not have been what the Settlement’s drafters, nor the Class, contemplated. But on appeal the question is whether the Claims Administrator was wrong to deny Mr. [REDACTED] Claim for benefits. It did so on two bases: he satisfied neither criterion (ii)—due to multiple validity concerns—nor criterion (iii) because it was “unclear to what extent [his] functional decline [was] related to untreated major depression, headaches and insomnia rather than cognitive impairment.” Doc. 237416. I will examine these grounds, either of which would be sufficient to deny the Appeal, serially.

1. Validity Testing

Regarding criterion (ii), it is not disputed that Mr. [REDACTED] failed multiple ACS measures as well as the TOMM and MSVT.² Docs. 223882; 231544. There is a discrepancy between Dr. [REDACTED] report, which stated that Mr. [REDACTED] failed two of the five ACS measures, and the AAP Consultant’s message, which stated that Mr. [REDACTED] failed three of the five. *Id.* In either event, the Settlement’s quantitative metrics for validity are not met. As for the *Slick* criteria, the Claims Administrator, with input from the AAP, determined that:

[M]ore than just the first [*Slick*] item is implicated. The pattern of neuropsychological test performance is markedly discrepant from currently accepted models of normal and abnormal central nervous system function (*Slick* criterion 2). Despite the apparently severe impairments in Complex Attention and Language, the Player performed normally on the other three cognitive domains. Furthermore, the MMSE score was within normal limits and the MoCA was compatible with only mild cognitive impairment. These scores are not at all consistent with a diffuse neurodegenerative brain disorder causing dementia, and this marked discrepancy was not reconciled by the diagnosing physician. Lastly, reported or endorsed symptoms are improbable in number, pattern, or severity; or markedly inconsistent with expectations for the type of severity of documented medical problems (*Slick* criterion 7). As documented by the MMPI results, “His MMPI profile should be interpreted with caution . . . as elevations in validity scores

² Settlement Agreement, Exhibit A-2, Section 1.

indicate that [he] may have responded to questions in a manner that is not typical of most people.”

Doc. 237416.

On appeal, Ms. [REDACTED] reiterates Dr. [REDACTED] critique of how validity operates within the Settlement by submitting a report from [REDACTED], DO. Dr. [REDACTED] a MAF physician, did not examine Mr. [REDACTED] in person. After a chart review, he opined that:

Irrespective of the different levels offered [in prior evaluations], consideration [should be given] of the patient’s situation and the fact that he is deceased and not available for additional independent evaluations. . . . [T]his issue of performance on validity testing remains a challenge in many patients since many physical and attentional factors impact on a person’s ability to appropriately show consistency on those validity testing. . . . I am not aware of any consideration provided in the program for such issues. Under the current criteria patients can have a significant disability neurocognitively and have their entire scoring and evaluation deemed invalid from a qualification standpoint when utilizing the CDR basis for establishing levels if they fail on validity testing. Generally, neurologists have no leeway at this time in providing a contrary opinion even if on neurological testing and data provided by the family shows a patient to be significantly demented or impaired

Doc. 242420.

I appreciate Dr. [REDACTED] frustration and understandable desire to flexibly apply the rules to a Claim where the Claimant has died and thus cannot be retested. He and Dr. [REDACTED] would permit neurologists and neuropsychologists the discretion to diagnose Players such as Mr. [REDACTED] with Level 1, Level 1.5, and Level 2 Neurocognitive Impairments, even in the face of failing performance validity scores. But this is not what the Parties agreed upon when they drafted the Settlement. While Dr. [REDACTED] and Dr. [REDACTED] may prefer a different approach, applying the Settlement’s text and procedures consistently promotes fairness across the Class. As they both acknowledge, Mr. [REDACTED] validity results simply do not meet the Settlement’s criteria.

To further support a Level 1.5 Diagnosis, Ms. [REDACTED] asserts the following regarding validity:

The same validity criteria apply to Neurocognitive Impairment Level 1, Level 1.5, and Level 2. In other words, if your validity scores were inadequate for Level 1.5, they would likewise be inadequate for Level 1 as well. After Dr. [REDACTED] consultation with the Claim[s] Administrator, she still diagnosed him with a Level 1. . . . Therefore Dr. [REDACTED] must have felt, even given the issues already raised in Dr. [REDACTED] report, and those raised by the Claims Administrator, that Mr. [REDACTED] put forth sufficient effort to support a diagnosis—regardless if it was a Level 1 or Level 1.5—since the criteria [are] the same.

Doc. 242419.

True, validity criteria are fundamentally insensitive to the level of Neurocognitive Impairment. Thus, if Mr. [REDACTED] scores were (in fact) valid so as to justify Level 1 Supplemental benefits, they would also be presumptively valid for Level 1.5 and Level 2.

However, according to the Program's experts and even his own doctors, Mr. [REDACTED] testing did not offer valid estimates for any impairment level under the Settlement. Dr. [REDACTED] despite his emphatic endorsement of a Level 1.5 Diagnosis, freely admitted that Mr. [REDACTED] "performance on the effort tests would be described as suboptimal." Doc. 228944. All the same, it was his "strong opinion that [Mr. [REDACTED]] did make his maximum effort although his ability to focus and concentrate over an exam was compromised by his attentional and physical issues." *Id.* Dr. [REDACTED] in her report, similarly recognized that "[t]he patient failed validity measures. This *was felt* [by Dr. [REDACTED]] perhaps] to be secondary to the patient's pain and fatigue." Doc. 228945. (emphasis added).

In other words, although Dr. [REDACTED] and Dr. [REDACTED] submitted their initial Diagnosing Physician Certification Forms for a Level 1.5 Qualifying Diagnosis, they did so acknowledging that Mr. [REDACTED] failed the performance validity tests, and that the remaining *Slick* criteria also were discordant. That Dr. [REDACTED] subsequently changed her Diagnosis to Level 1 Neurocognitive Impairment does not alter these underlying findings.

And, although Mr. [REDACTED] BAP Providers stated that a Level 1 award was correct, the Claims Administrator never actually accepted or verified the validity of the underlying testing. Doc. 237416. It merely stated that:

After further review, the BAP Providers determined that a Level 1 Neurocognitive Impairment diagnosis is more appropriate and provided an updated Diagnosing Physician Certification Form (Doc ID 234999). Level 1 Neurocognitive Impairment is not a Qualifying Diagnosis under Section 2.1(yyy) of the Settlement Agreement and therefore is not eligible for a Monetary Award under Section 6.2(a).

Id. As Mr. [REDACTED] died *before* the BAP Providers issued the Level 1 Diagnosis, it does not appear that anything ever happened administratively to further confirm the Diagnosis, or to provide Mr. [REDACTED] supplemental benefits.

On appeal, Ms. [REDACTED] must show by clear and convincing evidence that the decision by the Claims Administrator was wrong. Here, the Claims Administrator found that Mr. [REDACTED] test results were invalid estimates of his performance: it did not err in denying Mr. [REDACTED] Claim on this ground.³

³ Ms. [REDACTED] challenges Dr. [REDACTED] and (at the time) Dr. [REDACTED] decision to change Mr. [REDACTED] Diagnosis from Level 1.5 Neurocognitive Impairment to Level 1 Neurocognitive Impairment. Docs. 242419; 234999. To support this argument, Ms. [REDACTED] submits a January 27, 2022 email exchange between her attorney and Dr.

2. Functional Impairment

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 Community Affairs, Home & Hobbies, and Personal Care.⁴

In its Notice of Denial, the Claims Administrator explained that:

The CDR ratings in this case failed to consider the factors of pain and fatigue acknowledged by Dr. [REDACTED]. They also do not consider the effects of [Mr. [REDACTED]] psychiatric symptoms, headaches and sleep disturbance on his daily functioning, even though there was concern that [Mr. [REDACTED]] needed neuropsychiatric evaluation and treatment.

Doc. 237416.

Mr. [REDACTED] claims file does corroborate some level of functional impairment. The sworn statement from Mr. [REDACTED] childhood friend, [REDACTED], details how Mr. [REDACTED] needed occasional reminders to brush his teeth and bathe, would go to the refrigerator four times within an hour, “forgetting what he got up for each time,” and that Mr. [REDACTED] had stopped working at youth football camps because the “[f]ear of speaking to the kids and forgetting what he [was] talking about would be unbearable.” Doc. 223882. But the Claims Administrator, with assistance from the AAP, still determined that Mr. [REDACTED] level of impairment did not satisfy the CDR thresholds. Doc. 237416. And on appeal, there is not clear and convincing evidence that this determination was in error. Dr. [REDACTED] the diagnosing neurologist, neither provided a careful analysis of functional impairment in her original report (notably, she failed to acknowledge the CDR category of Personal Care entirely), nor did she provide any supplemental analysis to support an appropriate finding for criterion (iii) despite ongoing communication with the Claims Administrator about the sufficiency of Mr. [REDACTED] Claim.⁵ Doc. 223883.

[REDACTED] in which Dr. [REDACTED] confirms that his recommended Diagnosis “is, and has always been Level 1.5 Neurocognitive Impairment.” Doc. 242423. Dr. [REDACTED] then underscores that he only “downgraded” to a Level 1 Diagnosis because he thought he could not disagree with Dr. [REDACTED]. *Id.* Whether or not this is true, under the BAP, the providers must agree as to a Level 1.5 Diagnosis, and here, they did not. It is quite clear from the correspondence that Dr. [REDACTED] felt pressured by Dr. [REDACTED] to issue any Diagnosis at all.

⁴ 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).

⁵ Even if Dr. [REDACTED] had provided a more robust CDR analysis, she would have also needed, “to the extent feasible,” to “attempt to isolate . . . functional impairment due to cognitive loss alone.” *See generally* Special Master Ruling on Functional Impairment/Cognitive Decline, at 9-10 (Sept. 7, 2021), https://www.nflconcussionsettlement.com/Docs/functional_impairment_sm_5.pdf. She did not attempt to do so.

Ms. [REDACTED] now relies on a supplemental email from Dr. [REDACTED] in which Dr. [REDACTED] emphasized that Mr. [REDACTED] “was a CDR Level 1 due to his brain injury/cognitive decline alone,” and that to the extent there were “external factors unrelated to brain injury . . . they are not included in [his] assessment of . . . CDR for the settlement.” Doc. 242422. But this late-arriving explanation does not come close to constituting clear and convincing evidence of error on part of the Claims Administrator. “[A] letter offered in support of an Appeal is no substitute for a medical judgment created contemporaneously with an exam, in a setting where expressing such a judgment, and not post hoc advocacy, is the order of the day.”⁶ In this case, not only was the letter produced for this Appeal, but it is simply restates Dr. [REDACTED] own conclusion without engaging seriously with the evidence (or its absence). Put simply, in the contemporaneous files, there is not sufficient support to justify a CDR of Level 1.⁷

For these reasons, the Claims Administrator was not wrong in deciding that criterion (iii) had not been fulfilled.

CONCLUSION

Ms. [REDACTED] has not presented clear and convincing evidence that the Claims Administrator erred. I concur with the Claims Administrator that Mr. [REDACTED] validity scores do not support a monetary award. And Mr. [REDACTED] medical records do not satisfy the Settlement’s required CDR thresholds. I therefore deny Ms. [REDACTED] Appeal.

Date: April 25, 2022



David A. Hoffman, Special Master

⁶ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 11 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

⁷ Ms. [REDACTED] is correct that Dr. [REDACTED] did not need to interview anybody other than Mr. [REDACTED]. But, as she acknowledges, the Claims Administrator’s observation that “‘Dr. [REDACTED] did not report interviewing anybody other than the Player’” was not a basis for denial. Doc. 242419.