

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

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

seizures as well as monitoring of his overall cognitive status. Doc. 178742. In 2015, Dr. [REDACTED] referred Mr. [REDACTED] for neuropsychological testing after Mr. [REDACTED] reported concerns about a sudden and significant decline in executive functioning and memory. Doc. 178746.

On January 5, 2016, Mr. [REDACTED] underwent neuropsychological testing conducted by Dr. [REDACTED], a board-certified neuropsychologist. Doc. 197136. The exam was conducted in an inpatient setting, and Dr. [REDACTED] report indicates that Mr. [REDACTED] “was discharged before we were able to administer the last few tests of [the] intended battery.” *Id.* Dr. [REDACTED] wrote that the testing results, though incomplete, could still “serve as a baseline for comparison to assess the trajectory of [Mr. [REDACTED] cognitive functioning.” *Id.*

On June 3, 2016, Mr. [REDACTED] returned to Dr. [REDACTED] for further neuropsychological testing, and this time completed the full test battery. Doc. 178746. In the evaluation report, Dr. [REDACTED] wrote:

In summary, Mr. [REDACTED] has completed two neuropsychological evaluations that each indicated a number of cognitive deficits, with some test scores worsening from January to June, 2016. His difficulties on measures of executive dysfunction and on some measures of learning and memory . . . in combination with his report of having problems in activities of daily living (including his reported inability to adequately manage finances and medications; not being able to perform his job as a sportscaster), indicate that he may have a dementing illness.

Id. at 4.

Mr. [REDACTED] had an appointment with Dr. [REDACTED] on June 13, 2016. Doc. 178743. Dr. [REDACTED] noted that Mr. [REDACTED] was experiencing specific functional limitations including needing help with medication administration and requiring assistance for “all ADLs if fatigued from [seizure] activity.” *Id.* He was also evaluated by [REDACTED], a nurse practitioner, who wrote: “his short term memory is affecting his ability to function around others up to the point at times where he forgets mid sentence what he is talking about. This is causing him to want to stay inside and not engage with others.” *Id.* Ms. [REDACTED] acknowledged that Mr. [REDACTED] had recently completed neuropsychological testing with Dr. [REDACTED] (“Will be discussing results with Dr. [REDACTED] today. . . . Formal report pending”) but there is no discussion or adoption of the test results. *Id.*

On August 23, 2016, Dr. [REDACTED] certified a diagnosis of dementia for Mr. [REDACTED] application for 88 Plan benefits. Doc. 178740. The application was approved in November 2016. Doc. 198082.

On October 17, 2017, Mr. [REDACTED] underwent another neuropsychological evaluation, this time conducted by Dr. [REDACTED], a licensed—though not board-certified—neuropsychologist. Doc. 178741. In the evaluation report, Dr. [REDACTED] concluded that the Mr. [REDACTED] test results showed “evidence of impaired performance compared to his superior estimated premorbid functioning across multiple cognitive domains” as well as “cognitive decline compared to [Mr.

██████████ 2016 evaluation, especially in areas of executive functioning and visual memory.” *Id.* at 9.

On August 21, 2018, Mr. ██████████ was evaluated by Dr. ██████████, a board-certified neurologist and Qualified MAF Physician. Doc. 183514. Dr. ██████████ performed a comprehensive neurological evaluation, in which he determined that Mr. ██████████ displayed functional impairment most consistent with an overall Clinical Dementia Rating Scale score of 2.0—based upon CDR scores of 2.0 in the categories of *Home and Hobbies* and *Personal Care*, and a score of 1.0 in *Community Affairs*. *Id.* at 5, 14. Additionally, Dr. ██████████ reviewed “74 pages of medical records,” including the neuropsychological test reports from Dr. ██████████ January 2016 evaluation and Dr. ██████████ October 2017 evaluation, which he found to be consistent with and provide support for his diagnosis of moderate dementia.¹ *Id.* at 8.

Mr. ██████████ filing a claim for benefits on February 4, 2019, asserted two Qualifying Diagnoses. Doc. 198080. The first was a June 3, 2016, Pre-Effective Date Diagnosis of Level 1.5 Neurocognitive Impairment, certified by Dr. ██████████.² Doc. 198084. The second was an August 21, 2018 Diagnosis of Level 2 Neurocognitive Impairment, certified by Dr. ██████████ Doc. 183515.

The Claims Administrator, reviewing only the 2016 claim for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, issued a Notice of Preliminary Review on April 1, 2019 identifying several deficiencies. Doc. 204331. Mr. ██████████ timely responded. The claim was subsequently reviewed by both an AAP Reviewer and Consultant. Doc. 219034; Doc. 219043.

The AAP Consultant, evaluating the neuropsychological testing records, specifically focused on the evaluation performed by Dr. ██████████ on June 3, 2016. Doc. 219034. The Consultant concluded, “I do not believe that there is documentation to support a finding of Level 1.5 impairment as of 6/3/2016. The player may qualify at a later date but this would require more up to date evaluation by a qualified neuropsychologist.” *Id.* The AAP Reviewer agreed with this conclusion, writing:

The Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on 6/3/16 was not made in a manner generally consistent with the Settlement criteria, due to neuropsychological test results that were most compatible with mild cognitive impairment or Level 1 Neurocognitive Impairment. . . . A later neurological evaluation in 2018 [performed by Dr. ██████████] could support Neurocognitive Impairment up to level 2.0; however, a qualified neuropsychological evaluation was not provided then.

¹ Dr. ██████████ acknowledged the possibility that the available neuropsychological test results might be insufficient, writing: “According to the patient’s wife this testing was not done in accordance with NFL settlement guidelines because they predated the beginning of the NFL settlement program. Nevertheless, I found the repots and the testing that had been completed both comprehensive and high quality.”

² On the Diagnosing Physician Certification Form, Dr. ██████████ wrote “per neuropsych testing” underneath the box containing the provided diagnosis date. Doc. 198084.

Doc. 219043.

On February 10, 2020, the Claims Administrator, adopting the findings of the AAP Reviewer and Consultant, denied Mr. ██████ claim for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 220645. Mr. ██████ appealed. Doc. 223435. Though the NFL Parties did not file briefing, I sought additional, independent, AAP Review. That subsequent Review came to a different conclusion about the 2016 testing:

The claim of 6/30/16 appears to hinge on whether Dr. ██████ neuropsychological assessments are generally consistent with Level 1.5 Impairment. This is indeed a difficult determination. Players at the extremes of estimated baseline intelligence and verbal skills are not well accounted for in the Injury Definitions. The premorbid intelligence bands are based on TOPF scores of 110 above average. However, Dr. ██████ provided a TOPF score of 131 at the 6/3/16 assessment. The TOPF scoring guideline indicate that scores >129 are considered “Very Superior,” a premorbid state different from above average and not addressed in the Injury Definitions. In the absence of specific guidance in the Injury Definitions, deferral to the treating clinician’s impressions appears appropriate.

Dr. ██████ attested to a clinical state of dementia in the 88 Plan application of 8/23/2016. Dr. ██████ affirmed a clinical diagnosis of dementia in a letter of 9/9/2016. Dr. ██████ [sic] diagnosed Major Neurocognitive Disorder (i.e., the DSM-5 equivalent of dementia) on the basis of neuropsychological assessment conducted 10/2/17. Dr. ██████ diagnosed dementia of moderate severity and documented a progressive course based on an encounter of 8/21/18.

Given the consistency of the clinicians’ diagnoses, including a neurologist with an ongoing doctor-patient relationship for another condition, and the player’s estimated premorbid function outside the boundaries established by the Injury Definitions, general consistency with a diagnosis of Level 1.5 Neurocognitive Impairment is supported.

Doc. 226427.

DISCUSSION

There are several difficulties in evaluating this Appeal. The first is to determine which Qualifying Diagnosis is properly before me. The Claim Form that Mr. ██████ filed in February 2019 alleges two Qualifying Diagnoses: Level 1.5 Neurocognitive Impairment, as of June 2016, and Level 2 Neurocognitive Impairment, as of August 2018. Evidence has been provided in support of each. However, Mr. ██████ cannot receive a Monetary Award for more than one Qualifying Diagnosis on the same claim. FAQ 137 states that when a Claimant has offered two separate diagnoses, the Claims Administrator will consider only one:

If your Diagnosing Physician Certification Form states more than one Qualifying Diagnosis, the Claims Administrator or AAP doctor will determine if you are eligible for a Monetary Award based on the Qualifying Diagnosis that will pay the higher Award, according to the Monetary Award Grid found here, unless you direct the Claims Administrator to review a different Qualifying Diagnosis.

Mr. [REDACTED] 2018 Level 2 Diagnosis would have paid the higher Award had it been approved. Nonetheless, the Claims Administrator, without explanation, evaluated and rejected the 2016 Diagnosis. On my inquiry, the Claims Administrator disclosed that it did so because it believed that the 2018 Diagnosis (which lacked supporting neuropsychological testing) was plainly insufficient, so that proceeding on the 2016 Diagnosis provided the highest *expected* award (i.e., the final award multiplied by its likelihood) even though, as it turns out, that Claim too was denied. This choice contravened FAQ 137, which explicitly separates out the question of eligibility from that of which proposed claim is “higher . . . according to the Monetary Award Grid.” At the very least, the Claims Administrator’s choice to focus on the expected, rather than asserted, “higher award” should have been memorialized in writing and explained.

Mr. [REDACTED] arguably acceded to this irregular choice by filing an Appeal that focused entirely on the 2016 Diagnosis. Still, the Claims Administrator’s failure to explain why it deviated from FAQ 137 would indicate a remand if it were plausible that the medical records as submitted could justify a Diagnosis based on the 2018 Claim.

Beginning, then, with the 2018 Level 2 Diagnosis, the problem is that very thorough evaluation by Dr. [REDACTED] is missing up-to-date, qualifying, neuropsychological testing. FAQ 110 provides that neuropsychological testing must occur within one year of the diagnosing physician’s evaluation. The 2016 testing did not fall within one year of Dr. [REDACTED] evaluation. Thus, as Claims Administrator pointed out, the 2018 Diagnosis would seem to be incomplete on its face.

And yet, under that same FAQ, the Claims Administrator retains the discretion—rarely used, and never for a two-year look back—to permit the MAF Physician to consider test results that are more than a year old. Before remanding to ask the Claims Administrator to consider that novel procedure, it seemed therefore wise to directly consider the Level 1.5 2016 Diagnosis itself to see if the available neuropsychological testing is generally consistent with the requirements of the Settlement.

Mr. [REDACTED] has submitted records from three separate neuropsychological evaluations; however, only one of the three—that performed by Dr. [REDACTED] on June 3, 2016—is pertinent.³ Although not identical, an AAP Consultant found “substantial overlap” between the BAP test battery and the examination performed by Dr. [REDACTED] on June 3, 2016. Doc. 219034. Additionally,

³ The other two examinations do not meet the requirements for neuropsychological testing requirements set forth in the Settlement. The examination conducted by Dr. [REDACTED] on January 1, 2016 was incomplete, and thus not even plausibly generally consistent. The test results from Mr. [REDACTED] October 2017 Post-Effective Date examination cannot support his claim because Dr. [REDACTED] who performed the testing, was not board-certified. *See* Settlement Agreement, Section 6.3 (a)(i).

the Consultant's report acknowledges that Mr. [REDACTED] passed all utilized validity measures, and that appropriate demographic adjustments were applied. *Id.* Assuming, without deciding, that the battery and test validity would be generally consistent, the key issue is the scores Mr. [REDACTED] obtained.

Based upon an above-average estimated level of pre-morbid functioning, and in accordance with the scoring tables provided in the Settlement, Mr. [REDACTED] performance on the June 3, 2016 examination reflects evidence of moderate cognitive decline in only *one* cognitive domain.⁴ Doc. 197136; Doc. 212028; Doc. 219034. A Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment requires evidence of cognitive decline in *two or more* domains. Thus, as the original two AAP analyses concluded, the 2016 test scores do not support a Qualifying Diagnosis.

But, the most recent AAP Review states, Mr. [REDACTED] pre-morbid IQ was "very superior." Doc. 226427. Does that not mean that more deference is due to Dr. [REDACTED] views? Having very carefully considered that question, I must conclude that the Settlement does not permit that interpretation, based on the following key text:

It is necessary to estimate premorbid intellectual functioning in order to use the criteria for impairment set out in this document. Estimated premorbid intellectual ability will be assessed and classified as:

- Below Average (estimated IQ below 90);
- Average (estimated IQ between 90 and 109);
- Above Average (estimated IQ above 110).

Settlement Agreement, Exhibit 2, Section 4.

Two aspects of this definition undermine the most recent AAP Reviewer's conclusion. First, it categorically states that premorbid ability "will be assessed and classified" in one of only three ways. Second, the Above Average category is defined as all IQ scores "above 110," with no upper limit indicated. The definition notably does not distinguish between the various lower-than-average TOPF categories—"low average" and "borderline." Rather, it collapses the available TOPF categories into three buckets, each having a particular consequence for the Settlement's administration. Mr. [REDACTED] premorbid IQ was estimated to be above 110, placing it squarely into the Exhibit's "Above Average" category.

It is therefore not the case that the injury definitions "do not address" IQ scores exceeding 129. The AAP Reviewer's conclusion cannot follow from mistaken premises. As Dr. [REDACTED] did not identify evidence of cognitive decline over two or more domains, Mr. [REDACTED] 2016 testing is not generally consistent with a Level 1.5 Diagnosis.

⁴ Mr. [REDACTED] meets the criteria for Level 2 Impairment in the category of *Learning and Memory*, in which he obtained four scores below a T score of 35. In *Executive Function*, he meets the criteria for Level 1 Impairment, having obtained two T scores below 37. In the remaining categories, he does not meet the threshold for any degree of cognitive impairment. Thus, the results are consistent with Level 1.5 impairment in only one cognitive domain: *Learning and Memory*.

Given this inevitable conclusion about the 2016 testing, it would be futile to remand to ask the Claims Administrator to consider the 2018 Diagnosis based upon the evidence currently available.

CONCLUSION

Mr. [REDACTED] has provided a detailed history of his progressive cognitive impairment. Both the AAP Reviewer and the Consultant who evaluated Mr. [REDACTED] claim in December 2019 specifically highlighted the strength of Dr. [REDACTED] 2018 evaluation. Doc. 219034; Doc. 219043. As the Consultant wrote, “Dr. [REDACTED] evaluation could support a finding in 2018 of neurocognitive impairment up to a level 2.0.” Doc. 219034. “However,” they continued, “we do not have a qualified neuropsychological provider’s evaluation at this point.” *Id.*

The record indicates that Mr. [REDACTED] is experiencing decline which likely will entitle him to a Monetary Award. What’s needed to sustain such an Award is a Qualifying Diagnosis that comports with the Settlement’s requirements. Notably, in making such a new Diagnosis, a qualifying clinician must either conduct valid neuropsychological testing or appropriately certify that its administration would be medically unnecessary.⁵ He or she also may consider whether to date the Diagnosis back to the 2018 evaluation, whose thoroughness was only reinforced by the expert reviewers’ analysis which I relied upon in arriving at this Appeal’s disposition.⁶

The procedural history of this case has introduced unfortunate complications in its resolution. However, it was not clearly erroneous for the Claims Administrator to conclude that Mr. [REDACTED] June 3, 2016 Diagnosis of Level 1.5 Neurocognitive Impairment was not generally consistent with the Settlement’s requirements. Given that conclusion, remand to additionally consider the 2018 Diagnosis would be at this point futile. Mr. [REDACTED] may, however, use information from this 2018 Diagnosis in supporting and dating a new Claim.

For now, I agree with the Claims Administrator that Mr. [REDACTED] has not provided evidence generally consistent with the injury definitions put forth in the Settlement, and his Appeal is therefore denied.

Date: August 11, 2020



David A. Hoffman, Special Master

⁵ As the Parties will be well-aware, for Qualifying Diagnosis of Level 2 Neurocognitive Impairment, the diagnosing physician has the option to certify that neuropsychological testing is medically unnecessary. *See* Settlement Agreement, Exhibit A-1 (2)(b). Dr. [REDACTED] did not do so here, but that choice may be appropriately available on a fresh examination.

⁶ FAQ 101 describes the Claims Administrator’s general approach to Diagnosis dating, which focuses on the importance of deference to “sound clinical judgment.”