

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 A
MONETARY AWARD

Mr. [REDACTED] did not appeal this second Denial, but rather saw a BAP neuropsychologist (Dr. [REDACTED]) on November 20, 2019. Mr. [REDACTED]'s wife reported that he was experiencing profound functional deficits:

[H]e currently has no ability to meaningfully function or complete routine household activities. She indicated that he frequently needs assistance with dressing, needs prompting to groom and wash, and eats messily with a spoon. She further indicated that he exhibits severe memory loss, increased frustration and emotional lability, no longer drives, and discontinued working primarily due to memory difficulty.

Doc. 233367, at 2. Dr. [REDACTED], having performed neurocognitive testing, commented:

Mr. [REDACTED] did not perform in the optimal range on all embedded and stand-alone measures of cognitive performance validity. One out of three stand-alone measures was passed (Word Choice Test). On the Word Memory Test, the "easy versus hard" difference was 26.67. This difference is not typical for people with dementia or genuine memory impairment. Performance on all but one embedded measure was adequate. He was given the benefit of the doubt, given the mixed validity results. Overall, Mr. [REDACTED]'s performance was determined to be acceptable according to the Slick criteria checklist.

...

Mr. [REDACTED] completed the Minnesota Multiphasic Personality Inventory-2-RF in a normal amount of time, indicating he is neither overly impulsive, nor overly indecisive in his test taking approach. His responses on the validity scales yielded a much larger than average number of infrequent responses, which may indicate over-reporting of symptoms (F-r T=74; RBS T=80), specifically in regard to somatic symptoms and cognitive complaints (COG T=91). This combination of responses may occur in individuals with substantial emotional dysfunction who report credible symptoms, but it could also reflect exaggeration. In light of these findings, the profile should be interpreted with caution and the interpretive summary presented herein will focus primarily on the emotional symptoms reported.

...

Based on his responses, he met criteria for Major Depressive Episode (Current, With Melancholic Features) and Generalized Anxiety Disorder (Current). Mr. [REDACTED] endorsed a history of outpatient mental health treatment but is not currently under the care of a mental health provider.

Doc. 233367, at 3, 8.

Given her assessment of both the neurological testing and his functional loss, she concluded that Mr. [REDACTED] met the criteria for an overall impairment of Level 1.5 Neurocognitive Impairment. Doc. 233367, at 10.

Neurologist [REDACTED] concurred on July 29, 2020. Doc. 233368. As he commented:

[Mr. [REDACTED]'s] cognitive decline has been progressive since [2013], such that he no longer is able to be employed, is hardly able to do even house chores, is unable to drive, and frequently needs reminders from his wife even in matters relating to self hygiene. He also has depression, sleep disturbance and chronic daily headaches for which he has not received treatment for this.

Given his significant cognitive deficits as assessed by neuropsychologist Dr. [REDACTED] done in November 2019 and given his Clinical Dementia Rating score of 2 for memory, orientation, as well as judgement/problem solving, I believe Mr. [REDACTED] qualifies for Level 2 neurocognitive impairment given his overall CDR score of 2.

It is highly possible that Mr. [REDACTED] is suffering from Chronic Traumatic Encephalopathy (CTE) given the combination of cognitive decline, depression, and headaches.

Doc. 233368, at 3 (paragraph breaks added)

While those BAP reports were being collected and evaluated, the Court ordered changes to the Program to eliminate use of race-based norming of neuropsychological test scores. Mr. [REDACTED]'s scoring was automatically evaluated, and the BAP Administrator reported that it now nominally qualified him for Level 2, instead of Level 1.5, Impairment. Doc. 274100. Mr. [REDACTED] filed a Claim form reflecting that Diagnosis on December 7, 2022. Doc. 274242.

By December 20, the AAPC, filing a review, questioned the validity of Mr. [REDACTED]'s test results:

Dr. [REDACTED] coded only Slick criteria #1 and #7 as present. However, criteria #2 and #5 are also present:

#2 Patterns of performance markedly discrepant from accepted models of CNS dysfunction -- Full-Scale IQ increased 21 points between two psychological exams; patient scored in severely impaired range of processing speed & complex attention and language, yet completed the 331-item MMPI-2-RF in a normal amount of time and without any mentioned indicators of carelessness or inattention

#5 Discrepancy between test data and documented background or history -- This patient,

reportedly with severe dementia (Level 2 Neurocognitive Impairment), had just earned his MBA.

Despite the reports of the patient's wife and his friends that he has severe dementia, the objective evidence indicates that he does not. His failure of major performance validity tests (Slick criterion #1) and his triggering on at least three other Slick criteria strongly suggests willful underperformance and symptom exaggeration and/or fabrication.

Doc. 274913.

At the same time, an AAPLC neurologist, reviewing the CDR scoring, noted that Dr. [REDACTED]'s July 2020 exam had recognized a "score of 2 for memory, orientation, as well as judgement/problem solving," but had not addressed Community Affairs, Home & Hobbies, or Personal Care. Doc. 275760, at 1. Dr. [REDACTED]'s November 2019 CDR analysis had found only Level 1 in those areas. When she addended her report in the fall of 2022, she stated that as the "neurologist assigns the CDR," she would defer to Dr. [REDACTED]. Doc. 274100, at 18.

The Claims Administrator reached out to Drs. [REDACTED] and [REDACTED] to better understand bases for their determinations.

Dr. [REDACTED] responded. Doc. 276207. She acknowledged that *Slick 2* was triggered by the difference between the FSIQ scores, suggesting that factors other than cognitive loss could have contributed to Mr. [REDACTED]'s performance, including migraines and pain. She further agreed that Mr. [REDACTED]'s timely completion of the MMPI-2-RF was discrepant and triggered the that same criterion. She next revised her view to conclude that *Slick 5* was triggered, stating that she had not known at the time of her 2019 exam that Mr. [REDACTED] had just completed an MBA. She conceded that "one would not be expected to be capable of MBA-level coursework (even with tutoring and accommodations) if the scores produced during ... [the] evaluation were valid." But, she said, since the embedded measures were passed, "my opinion does not change that there were mixed validity results." Doc. 276207, at 2.

Dr. [REDACTED] did not respond to the Claims Administrator's multiple requests for clarification. While the Claims Administrator waited in vain, Mr. [REDACTED]'s counsel uploaded explanations regarding his MBA and arguments about the validity of his results. After reviewing all those materials, the Claims Administrator denied Mr. [REDACTED]'s second Claim on August 1, 2023. In relevant part, the Administrator concluded:

The AAPC determined there was failure of two major performance validity tests (the TOMM and the MSVT), identified likely over-reporting of symptoms on the MMPI-2-RF, identified multiple Slick criteria indicators of invalidity (Slick criteria #1, #2, #5, and #7), and concluded that objective evidence indicated the Player did not have severe dementia and that the testing results were invalid due to willful underperformance and symptom exaggeration and/or fabrication.

In response to a request for additional explanation based on this feedback, Dr. [REDACTED] provided a letter dated 1/23/2023 in which she reiterated mixed validity results were present and conceded that there were issues with Slick criteria number 2 and number 5. The AAPC reviewed Dr. [REDACTED]'s response and concluded the new/additional information did not change the conclusion that the information did not meet the Settlement Program criteria for any Qualifying Diagnosis. Therefore criterion (ii) is still not fulfilled.

Criterion (iii): Dr. [REDACTED] reported the Player did not drive, cook, or do laundry, needed prompting to shower and change into clean clothes, his wife managed the finances, and he was able to use a cell phone to call and text but denied any use of computers, and listed ratings of 1.5 for the CDR category of Community Affairs, 1.0 for Home/Hobbies, and 1.0 for Personal Care, with an overall CDR rating of 1.0. An addendum by Dr. [REDACTED] dated 1/10/2021 indicated again that the CDR score would be 1.0. However, an additional addendum by Dr. [REDACTED] dated 9/13/2022 indicated deference to the CDR rating of 2.0 that was assigned by the neurologist, Dr. [REDACTED].

Dr. [REDACTED] reported CDR scores of 2.0 for Memory, Orientation, and Judgement/Problem Solving, and that the Player was not able to be employed, was hardly able to do chores, was unable to drive, frequently needed reminders for self-hygiene, and an overall CDR score of 2. There is a CDR Worksheet (Doc ID 233369) that appears to have been complete in February 2021, which reported the Player was not working, that memory/thinking problems contributed to the decision to retire, was not driving, rarely/never shopped or carried out activities outside the home independently, was not able to help with chores, had no meaningful function for household chores, and scores of 0 were circled for dressing, washing/grooming, eating and sphincter control.

There is another, undated CDR Worksheet (Doc ID 274100, pp. 39-44) that, in addition to the above, indicates the Player was not able to work out, and scores of 1 were circled for dressing and washing/grooming, and scores of 0 were circled for eating and sphincter control. A third-party affidavit by [REDACTED] dated 11/20/2019 indicated the Player no longer shows the same enthusiasm for volunteer activities and community works, no longer shops for himself, no longer cares about his appearance, is less social, no longer works, had memory issues when he did work last, doesn't do any chores, does no activities besides therapy rehabilitation, and had a decline in personal hygiene and dressing.

Dr. [REDACTED] does not provide determinations of general consistency with CDR scores of 2 in the required domains of Community Affairs, Home & Hobbies, and Personal Care. His documentation and interpretation also do not adequately address the requirement that the functional deficits be scored due to cognitive loss, not impairment due to other factors. There are multiple statements that the Player

has lost interest, and/or "does not do" many activities rather than that he is "unable to do" them because of cognitive losses.

Dr. [REDACTED]'s documentation does not provide evidence of his decision-making that the cognitive losses were the source of the Player's functional limitations rather than other factors like sleep disturbance with excessive daytime sleepiness, mood disturbance, frequent severe headaches, photosensitivity, orthopedic limitations, and pain behaviors. These were sufficient for Dr. [REDACTED] to recommend further evaluation and treatment for sleep, headache, and mood. The role of mood and affect are especially important since Dr. [REDACTED]'s evaluation identified that the Player met criteria for Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD). Apathy is a core characteristic of MDD and avoidant behaviors are typical in GAD.

The Claims Administrator asked Dr. [REDACTED] for additional explanation regarding his CDR assessment, but he did not provide any additional clarification. Because the available information does not address the non-cognitive sources of the Player's functional impairments, the CDR is not supported, and this criterion is not fulfilled.

Doc. 286787.

Mr. [REDACTED], appealing on October 1, 2023, submitted new evidence and I remanded to the Claims Administrator to permit it to consider its views again. During that remand, the Claims Administrator asked Mr. [REDACTED] about inconsistencies in the file, including his driving (which both clinicians and third-party affiants had denied, but which he continued to do), participation in golf and other community events, and his completion of the [REDACTED]'s MBA program. With his counsel's assistance, Mr. [REDACTED] responded by providing more detail about those activities on October 26, 2023. Doc. 291577.

The Claims Administrator, reissuing its denial on January 19, 2024, concluded:

The AAP member reviewed the new/additional clarification provided in response to the 8.6(b) questions. The Player's response, dated 10/26/2023, indicated the Player had a decline in driving ability, his driving was not safe, he had accidents when driving, he participated in a Patriot's HOF panel, played golf occasionally, misplaced items such as golf clubs, he participated in usAmericafest 2021, that an event in Dubai did not actually happen, and he required assistance from tutors and others to complete the MBA Degree program.

While the new/additional information does clarify some of the inconsistencies with the reporting of the functional impairments, it does not change the prior determination that the diagnosis does not meet the Settlement criteria for Level 1.5 or Level 2 Neurocognitive Impairment because: (1) it does not affect criterion (ii) being not fulfilled due to invalidity of the neuropsychological evaluation results, as

more fully explained in the 8/1/2023 Notice of Denial; and (2) it does not address the issue of non-cognitive sources of the Player's functional impairments, also more fully discussed in the 8/1/2023 Denial Notice, and so criterion (iii) would also still not be fulfilled.

Doc. 299664.

That January Denial Notice led to this Appeal.

RESOLVING THIS APPEAL

The Claims Administrator concluded that the medical records satisfied neither the second nor the third criteria for Level 2 Neurocognitive Impairment. Doc.299664. On appeal, Mr. [REDACTED] must show by clear and convincing evidence that this conclusion was in error. Through counsel, he has attempted to do so through a thorough—20 pages of text not including an additional 9 of introductory materials—Appeal, densely argued and deeply engaged with the Settlement Program's guidance documents.

His argument, stripped of some of its detail, is that the Claims Administrator ought to have deferred to Dr. [REDACTED]'s 2019 validity analysis, as supplemented in January of 2023. Mr. [REDACTED] rests his case on prior decisions stating that when a clinician has completely articulated her *Slick* analysis in contemporaneous reports, that judgment is entitled to deference unless it is clearly erroneous.² Asserting that Dr. [REDACTED]'s views were completely articulated, Mr. [REDACTED] criticizes the AAP for substituting their own views for hers.

The problem is that the operative validity report is not Dr. [REDACTED]'s 2019 decision to give Mr. [REDACTED] the “benefit of the doubt” given a mixed finding. Rather, it's her 2023 addendum, which conceded that Mr. [REDACTED] had triggered not two (as she had originally found) but four *Slick* factors (including two performance validity tests). She agreed that the reviewers had identified problems in Mr. [REDACTED]'s presentation which suggested a lack of adequate effort, and expressed concerns about not fully appreciating Mr. [REDACTED]'s retained function at the time of her examination. Notwithstanding those concessions, she wrote that “my opinion does not change that there were mixed validity results.” Doc. 276207, at 2.

The Claims Administrator was correct to conclude that this was not sufficient. First, *mixed* validity results are not what the Settlement Agreement requires. Rather, what's necessary is the neuropsychological results are a “valid reflection of [Claimant's] optimal level of neurocognitive functioning.”³ Thus, it is concerning that Dr. [REDACTED] appeared to put a general thumb on the scale of validity in a way that the Settlement Agreement does not contemplate. Second, her reasoning was not completely articulated. Dr. [REDACTED] did not adequately square what she had learned—both regarding errors in her analysis and the facts that she had not

² Special Master Ruling on Slick Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

³ Settlement Agreement, Exhibit A-2 (2).

previously known—with her prior judgment. In fact, she agreed that she now saw red flags regarding the test results.

Given these facts, the Claims Administrator did not apply the wrong standard when evaluating Dr. [REDACTED]'s conclusion that Mr. [REDACTED]'s test scores were valid. As she herself agreed, multiple converging lines of evidence indicated that the observed test scores did not fairly represent his optimal performance. And, although it's the case that the case for deference is at its apex when evaluating the conclusions of Claimants who come through the BAP, it's difficult to know how to defer to Dr. [REDACTED]'s original report when her addendum fundamentally undermined the facts on which it rests. Mr. [REDACTED] has not offered clear and convincing evidence that the Claims Administrator's process of evaluating test validity was in error. And its conclusion finds support in the concessions of Mr. [REDACTED]'s own examining clinician.

As for functional impairment, the most recent Denial notices articulated two sorts of problems.

First, the documented record is inconsistent with the required level of functional loss. What's needed in community affairs is an individual with "[n]o pretense of independent function outside home"; in Home & Hobbies, "poorly maintained" and "very restricted interests, while the patient can perform only "simple chores"; while in Personal Care the patient "[r]equires assistance in dressing, hygiene, [and] keeping of personal effects." Dr. [REDACTED] provided no formal reporting at all on those categories. Moreover, his cursory general reporting of Mr. [REDACTED]'s profound lack of function—based on testimonials from Mr. [REDACTED]'s friends and family—appears to be contraindicated by the contemporaneous record of Mr. [REDACTED]'s retained abilities, including obtaining an MBA, golfing and occasionally driving.⁴

Dr. [REDACTED]'s reporting does not change the calculus. Her initial analysis concluded after a review of the CDR that Mr. [REDACTED]'s functional impairment was at a Category 1, which would justify only a Level 1.5 Qualifying Diagnosis. Her later shift in an addendum explicitly relied on Dr. [REDACTED]'s report, which as I've described does not identify the appropriate categories and appears contraindicated by the record. Thus, the Claims Administrator was correct to find that the contemporaneous records do not contain an articulated report explaining why Mr. [REDACTED]'s functional impairment was consistent with a Level 2 Neurocognitive Impairment.⁵

⁴ That is not to say that any of these activities are dispositive of a Claimant's functional impairment. Mr. [REDACTED]'s briefing offers point-by-point rebuttals as to each, and of course isolated good days do not establish a pattern that undermines a finding of persistent functional loss. But even a good lawyer's briefing is no substitute for a clinician's contemporaneous reporting. The point is rather that Dr. [REDACTED] did not mention facts about Mr. [REDACTED]'s actual hobbies or activities in his reports, likely because he was not told about them. Nor did he respond to repeated requests to supplement his views. He thus never explained how these activities were consistent with the lack of function Mr. [REDACTED]'s serious Diagnosis entails.

⁵ Because the Claim file does not sufficiently demonstrate his testing was valid, Mr. [REDACTED] is not eligible for a Level 1.5 Award, as his briefing suggests as an alternative. Had the race-adjusted testing justifying the original Level 1.5 conclusion been submitted, it would have been equally rejected as invalid. Simply put, there are no records demonstrating valid testing for an Award at any level in Mr. [REDACTED]'s file.

Second, the Denial Notice pointed out that Dr. [REDACTED]'s report did not adequately attempt to show that "the cognitive losses were the source of the Player's functional limitations rather than other factors like sleep disturbance with excessive daytime sleepiness, mood disturbance, frequent severe headaches, photosensitivity, orthopedic limitations, and pain behaviors." Doc. 286787. As FAQ #111 states:

In situations where the diagnosing physician determines that a Player suffers from functional impairment that is due to both cognitive loss and emotional/psychiatric factors such as depression, anxiety, or sleep disorders (other than sleep apnea), the diagnosing physician should, to the extent feasible, then attempt to isolate the functional impairment due to cognitive loss alone and assign a CDR rating based solely on that cognitive loss.⁶

The Claims Administration process does not require "magic words [from diagnosing physicians] to achieve relief."⁷ "[A] diagnosing physician's 'articulated consideration' of confounding factors is typically sufficient to establish that a Player's impairment is generally consistent with the Settlement's requirements."⁸ As Mr. [REDACTED]'s counsel ably points out, it's meaningful that Dr. [REDACTED]'s report flagged concerns for Mr. [REDACTED]'s mental health, and proximately thereafter reiterated his conclusion that Mr. [REDACTED] suffered from the Qualifying Diagnosis. It might be fair to infer that he'd done his best to isolate the degree to which Mr. [REDACTED]'s functional withdrawal resulted from cognitive loss alone.

However, when confronted with a potential gap in the record, Dr. [REDACTED] said nothing in response to repeated requests for clarification, leaving it unclear (at best) what he meant. Though the question is close—because the bar for addressing these difficult confounds is low—I cannot conclude that the Claims Administrator's decision here was in error.

CONCLUSION

Mr. [REDACTED] has not offered clear and convincing evidence of error in the Denial. I deny his Appeal.

Date: July 15, 2024



David A. Hoffman, Special Master

⁶ *Frequently Asked Questions: FAQ #111* (How are diagnosing physicians to apply the Clinical Dementia Rating (CDR) scale to Level 1.5 and Level 2 Neurocognitive Impairment Qualifying Diagnoses?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

⁷ Special Master Ruling on Functional Impairment, at 11 (Sept. 7, 2021), https://www.nflconcussionsettlement.com/Docs/functional_impairment_SM_5.pdf

⁸ Special Master Ruling on Validity Testing and Mental Illness, at 5 (Oct. 16, 2023), [nflconcussionsettlement.com/Docs/validity_testing_mental_illness_SM.pdf](https://www.nflconcussionsettlement.com/Docs/validity_testing_mental_illness_SM.pdf)