

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

Impairment,² but “he did not show significant functional impairment according to the Clinical Dementia Rating (CDR),” making him ineligible for benefits. Doc. 276453 at 7; Doc. 276473 at 9.

In 2022, Dr. ██████ again found Mr. ██████’s testing to evidence cognitive loss, equating to Level 2 impairment in Complex Attention and Processing Speed, Learning & Memory, Language, and Executive Functioning. Doc. 276473 at 10. Mr. ██████ also displayed Level 1.5 Impairment in Visual-Perceptual Processing. *Id.* Overall, Dr. ██████ concluded that Mr. ██████’s scores supported a finding of Level 2 Neurocognitive Impairment. *Id.* at 9.³

During his examination, Dr. ██████ completed a *Slick* criteria checklist. *Id.* at 4-5. Because Mr. ██████’s performance on the Medical Symptom Validity Test was suboptimal, *Slick* criteria #1 was triggered. *Id.* at 4, 5. Dr. ██████ also concluded that criteria #3 and #8 were triggered, noting that “[i]n the office setting, [Mr. ██████] does not present as the typical individual with advanced dementia, as is suggested by the test results.” *Id.* at 4-5, 8.

Despite these findings, however, Dr. ██████ ultimately contended that Mr. ██████ should be “given the benefit of the doubt, and test results overall . . . considered to be valid.” *Id.* at 8. He cited “two specific moderating factors” that supported his conclusion. *Id.* “First, [Mr. ██████]’s abnormal scores on the performance validity measure are just outside the norm. Second . . . there is a fair degree of consistency between the current test results and those from 2017.” *Id.* at 9.

In the course of his examination, Dr. ██████ administered the MMPI-2-RF to assess Mr. ██████’s psychological functioning. He found that the MMPI-2-RF results:

suggest a tendency for Mr. ██████ to present himself in an overly negative light. There is possible exaggeration of cognitive, somatic, and psychological symptoms. Other validity scales suggest the opposite, i.e., that Mr. ██████ in some respects may have tried to portray himself in an overly positive light, denying minor faults and shortcomings.

Id. at 7.

He went on to note that “[b]ecause of the validity scales profile, the MMPI-2-RF should be interpreted cautiously. With this caveat in mind, Mr. ██████ expresses complaints of head and neck pain, neurological symptoms, and he may have a preoccupation with physical functioning.” *Id.*

Dr. ██████ also administered the MINI. *Id.* at 7. He found that, given those results, Mr. ██████ “endorsed symptoms associated with the full range of psychiatric disorders” and reported

² In 2017, Mr. ██████ displayed Level 1.5 Impairment in Learning & Memory, Level 2 Impairment in Language, Level 1 Impairment in Executive Functioning, and no impairment in Complex Attention and Processing Speed, and Visual-Perceptual Processing. Doc. 276453 at 7.

³ In calculating Mr. ██████’s scores, Dr. ██████ mistakenly did not use the New Method. As routine practice to ensure accuracy, the Claims Administrator applied the New Method to Mr. ██████’s raw scores during claims review. Doc. 296604. Under the New Method, he displayed no impairment in the domain of Visual-Perceptual Processing. *Id.* This result did not change his overall impairment level. *Id.*

diagnoses of major depression, hypomania (possibly Bipolar II), panic disorder, social phobia, OCD, PTSD, and generalized anxiety disorder. *Id.*

Overall, Dr. █████ concluded that:

Mr. █████ meets . . . criteria for overall Level 2 Neurocognitive Impairment. As mentioned above, in relation to the evaluation from 2017, there is a fair degree of consistency in Mr. █████'s performance across measures, with a few showing substantial decline . . . [n]ow the question remains whether, according to the CDR, Mr. █████ is judged by a MAF diagnosing physician as having functional impairment consistent with neurocognitive deficits on testing.

Id. at 9.

On October 25, 2022, Dr. █████ examined Mr. █████. Doc. 276475. During the examination, Dr. █████ reviewed Mr. █████'s medical records (including Dr. █████'s 2022 report), conducted a physical examination, and interviewed Mr. █████ and his wife. *Id.* Mr. █████'s wife disclosed that his “memory is terrible,” and that, in moments of forgetfulness, he gets “very frustrated and angry and create[s] a rampage.” *Id.* at 1. Mr. █████ himself reported that “his memory has been diminishing gradually over the last five years, which is very frustrating.” *Id.* at 3.

Based on his impressions of Mr. █████, Dr. █████ assigned CDR scores of 2 in Community Affairs and Home & Hobbies and 1 in Personal Care. *Id.* at 7. He then ultimately concluded:

[h]is present CDR subscores are community affairs 2, home and hobbies 2, personal care 1, and global score 2.0. His personal interview and examination with me are consistent with these findings, and there is I find no presenting evidence of a mixed etiology, ie findings of cerebrovascular, medical-systemic, toxic-metabolic, other neurodegenerative, mental processes that are significantly contributory to his presentation. His onset was insidious and progression was gradual in nature. I am diagnosing him with Alzheimer's Disease, with a date of diagnosis of Oct 25 2022.

Id. at 8.

On January 27, 2023, Mr. █████ filed a claim for benefits based on Dr. █████'s diagnosis of Alzheimer's. Doc. 276495. His Claim then went into audit until June 2023. Doc. 285137.

On September 21, 2023, the Claims Administrator contacted Dr. █████, requesting additional information about several diagnoses Dr. █████ had rendered without providing adequate support. Doc. 289562. Mr. █████'s diagnosis was among these. *Id.* at 2. The Claims Administrator asked Dr. █████ to clarify why he diagnosed Mr. █████ with Alzheimer's “despite the Player having other potential alternative causes (Bipolar, OCD, Major Depression, Hypomania, and Panic Disorder) that affect his functioning” and to explain how he “determined

that a steadily progressive, gradual decline in cognition without extended plateaus was present despite lack of supporting documentation.” *Id.*

With this request, Claims Administrator also included a message from an Appeals Advisory Panel (AAP) Member elaborating on its basis. *Id.* The Member noted the discrepancy between Dr. [REDACTED]’s report and that of Dr. [REDACTED], noting that Dr. [REDACTED] “identified that the player ‘endorses symptoms associated with a broad range of psychiatric disorders raising the possibility of Bipolar and OCD, among other diagnoses’ and provides MINI diagnoses of Major Depression, Hypomania, Panic Disorder, etc.,” findings that “directly contradict[] Dr. [REDACTED]’s assertion that he found ‘no presenting evidence of a mixed etiology, i.e. findings of mental processes that are significantly contributory to his presentation.’” *Id.*

The Member further contended that Dr. [REDACTED]:

also does not address that (1) onset of Alzheimer’s Disease in a person’s 30s, even with autosomal dominant genetic origins, is so rare as to be functionally nonexistent, (2) the player’s course is inconsistent with early onset AD, per the ICD-10 clinical descriptions that indicate it should have ‘relatively rapid deterioration, with marked multiple disorders of the higher cortical functions. Aphasia, agraphia, alexia, and apraxia occur relatively early in the course of the dementia.’ and (3) the player had two different types of PET scans that failed to identify Alzheimer patterns.

Id. at 2-3.

On November 28, 2023, Dr. [REDACTED] responded to this request. Doc. 295933. Rather than defend or explain his Alzheimer’s diagnosis, Dr. [REDACTED] instead switched course entirely. *Id.* He wrote that upon re-reviewing Mr. [REDACTED]’s records, “my neurologic opinion is of him having a qualifying diagnosis of neurocognitive impairment level 2.0.” *Id.*

Understandably, the Claims Administrator then requested review of Mr. [REDACTED]’s Claim by an AAP Consultant. Doc. 297491. On December 20, 2023, the Consultant reported that features of Mr. [REDACTED]’s neuropsychological exams were “difficult to reconcile” with a diagnosis of Level 2 Neurocognitive Impairment. *Id.* at 1. There were four of particular relevance.

First, the Consultant pointed to an invalidity finding from a 2021 neurocognitive examination, along with “the presence of three Slick criteria in his most recent (2022) exam” as “suggestive of malingered neurocognitive dysfunction (MND).” *Id.* at 2.

Second, the Consultant complained that “[a]lthough Dr. [REDACTED] labeled the test results valid, he also acknowledges that the patient’s “self-reported symptoms and test data ... are at odds with behavioral observations. In the office setting, he does not present as the typical individual with advanced dementia, as is suggested by the test results.” *Id.*

Third, the Consultant found Mr. [REDACTED]’s rate of symptom progression suspect, noting that while Mr. [REDACTED] “complained of a severe decline in cognitive functioning and a marked increase in

psychopathological symptoms between 2017 to 2022, there is “a fair degree of consistency” in his performance over time. *Id.* Per the Consultant, “[t]his would be atypical for a progressive dementia.” *Id.*

Fourth, the Consultant expressed concern that “[o]n the MMPI-2-RF, the patient’s highest scores were on the (in)validity scales. His score on RBS (T=101) indicates extreme, noncredible memory complaints. His scores on Fs and FBS-r (T=83) also indicate infrequently seen, highly unlikely symptoms.” *Id.*

The Claims Administrator asked Dr. [REDACTED] to respond to these concerns. Doc. 319985. On April 8, 2024, Dr. [REDACTED] sent an addendum to his report to the Claims Administrator. Doc. 320402. In response to the Consultant’s first concern about the risk of malingering, Dr. [REDACTED] noted that while “test results in another neuropsychologist’s office in 2021 were interpreted as showing suboptimal effort,” when Dr. [REDACTED] evaluated Mr. [REDACTED] in 2017, “his scores across performance validity measures were unquestionably in a range suggesting optimal effort.” *Id.* at 1.

He then added that while he found three *Slick* criteria present during his examination, he did not find this result suggestive of invalidity. *Id.* In explaining how he interpreted the presence of the first criterion, Dr. [REDACTED] noted that “looking at the specific results, [Mr. [REDACTED]] was within the norm on 2 measures but scored in the fail range on a third measure. However, his failing scores were just outside the norm, increasing the likelihood that they represent a false positive (i.e., incorrectly suggesting suboptimal effort).” *Id.*

He went on to describe his analysis of the other two triggered *Slick* criteria:

The second Slick criterion indicates a discrepancy between test data and observed behavior, and I continue to hold to the position that such a discrepancy exists. The third criterion indicates a discrepancy between self-reported symptoms and behavioral observations. One factor may be that Mr. [REDACTED] is overreporting his cognitive symptoms (as suggested by the MMPI-2-RF), but it does not mean that he does not have legitimate cognitive impairment.

Id.

Next, Dr. [REDACTED] addressed the Consultant’s concerns regarding the discrepancy between Mr. [REDACTED]’s test scores and behavior in office. *Id.* at 2. Dr. [REDACTED] reconciled this concern by noting that in his twenty-six years of clinical experience, “it is not entirely uncommon to evaluate a patient who presents as cognitively normal on casual observation and during the clinical interview, only to find that testing reveals significant cognitive deficits consistent with dementia.” *Id.* Nonetheless, he reported “continu[ing] to believe that Mr. [REDACTED] did not present as an individual with advanced dementia. As far as his self-reported symptoms, it is possible that he was overreporting, but this does not mean that he does not have legitimate cognitive deficits.” *Id.*

Dr. [REDACTED] next responded to the Consultant’s issues with Mr. [REDACTED]’s symptom progression between 2017 and 2022. *Id.* In response, Dr. [REDACTED] asserted “at least one part of the premise of this question is incorrect,” going on to insist:

When I wrote in my 2022 report that there was ‘a fair degree of consistency,’ I was speaking to the validity of the data, not in relation to any cognitive changes. In fact, analysis of the data shows that of the 10 WAIS-IV subtests, there was a 6 point (or less) raw score difference in 7 of the 10 scores. On the 6 WMS-IV subtests, there was a 4 point (or less) raw score difference in 5 of the 6 scores. As for a progressive dementia, despite Mr. [REDACTED]’s claim of declining memory, it may simply be that he has dementia that is non-progressive.

Id.

Finally, Dr. [REDACTED] indicated that, when it came to the Consultant’s examination of Mr. [REDACTED]’s MMPI-2-RF scores, he agreed. *Id.*

Ultimately, however, he insisted that “it is my strong opinion that Mr. [REDACTED]’s test results merit careful review and should not simply be dismissed as invalid . . . I continue to have concerns about the validity of the test data, but there are arguments to be made in both directions (i.e., valid v. invalid).” *Id.*

With this addendum, the ball was back in the Consultant’s court. Doc. 322667. The Consultant elaborated on the issues with the *Slick* criteria, claiming that in addition to criteria #1, #3, and #8, “an extremely good case can be made for criterion #2 and #7 to be present as well.” *Id.* at 2. Per the Consultant:

The patient’s profoundly low scores on the BMT, BDAE-CIM, and TMT (all below the 0.1 percentile), as well as his ability to read and respond consistently on the MMPI-2-RF while having profoundly abnormal language test scores all suggest that criterion #2 . . . is present.

Id.

Moreover:

The fact that three MMPI validity scales are highly abnormal (Ts > 80) and he met MINI criteria for seven different psychiatric disorders indicate that the patient’s self-reported symptoms are discrepant with known patterns of brain functioning in psychiatric or neurologic patients (*Slick* criterion #7). Thus, five *Slick* criteria for possible malingering appear to be present.

Id.

The Consultant then responded to the points of disagreement between the Consultant’s report and Dr. [REDACTED]’s report. The Consultant first claimed that while it may be true that “although the patient is overreporting his cognitive symptoms, he might actually have legitimate impairments,” that is “irrelevant.” *Id.*

Next, the Consultant disagreed with Dr. [REDACTED]'s conclusions that "it is not unusual for a patient to have severe cognitive impairments consistent with dementia on neuropsychological testing, but to appear cognitively normal." *Id.* Instead, per the Consultant, "it would be extremely unusual for a sophisticated interviewer to not detect Level 2 impairment in 4/5 cognitive domains." *Id.* at 3. Lastly, the Consultant insisted that while Dr. [REDACTED] "wrote that the 'fair degree of consistency' he noted was in relation to validity test scores, not neurocognitive test scores," this assertion "is different from what he states in the first full paragraph on page 9 of his report." *Id.*

The Consultant concluded by declaring that while Dr. [REDACTED] continues to think "there are arguments to be made in both directions," in the Consultant's opinion, "the evidence for invalidity is overwhelming." *Id.*

With Dr. [REDACTED]'s addendum received and reviewed, the Claims Administrator turned back to Dr. [REDACTED]. Doc. 323185. On April 23, 2024, the Claims Administrator asked Dr. [REDACTED] to address whether Dr. [REDACTED]'s addendum affected his diagnosis, and "to provide an articulated medical reasoning for the assigned CDR ratings in light of multiple psychological and medical factors that appear to have worsened the Player's functional impairment." *Id.* at 1-2. In making this request, the Claims Administrator also reminded Dr. [REDACTED] that "CDR scoring requires that the rater determine scores 'due to cognitive loss alone, not impairment due to other factors.'" *Id.* at 2.

Instead of providing a response to these questions and concerns, Dr. [REDACTED] simply resubmitted his report from October 25, 2022. Doc. 326598.

On July 28, 2024, the AAP conducted a Diagnosis Review of Mr. [REDACTED]'s Claim of Level 2 Neurocognitive Impairment. Doc. 350375. While the AAP found that Mr. [REDACTED] satisfied criteria (i) and (iv), it ultimately found that Mr. [REDACTED] failed to satisfy criteria (ii) and (iii). *Id.*

The issues with criterion (ii) turned on validity. *Id.* at 1. Noting Dr. [REDACTED]'s finding of *Slick* criteria #1, #3, and #8, along with the Consultant's concerns about *Slick* criteria #2 and #7, the AAP also found that Dr. [REDACTED] made "no note of aphasic disturbances" which posed an issue because "intact conversational language would not be expected with the Player's scores on the language tests." *Id.* "Furthermore, the language scores themselves are highly suggestive of malingered deficits." *Id.* All of these indicators supported the Consultant's finding that "the evidence for invalidity is overwhelming." *Id.*

As for criterion (iii), the AAP found that:

Dr. [REDACTED]'s documentation and medical decision making does not address the requirement for CDR scoring that the assigned CDR domain scores were 'due to cognitive loss alone, not impairment due to other factors.' In contrast, he specifically notes that the player was '[e]xperiencing head and neck pain, possibly

depression, some degree of anxiety, associated with a broad range of psychiatric disorders.’

Id.

The AAP continued:

His impression notes that the player ‘has a ‘complex insomnia’ and may have REM sleep behavioral disorder.’ Without further addressing the functional impact of these conditions, the medical basis for Dr. [REDACTED]’s conclusory and dismissive statement ‘I find no presenting evidence of a mixed etiology, ie findings of cerebrovascular, medical-systemic, toxic-metabolic, other neurodegenerative, mental processes that are significantly contributory to his presentation’ is overtly contradicted by the information in the same note.

Id.

On October 1, 2024, the Claims Administrator adopted the AAP’s conclusion and issued a Notice of Denial. Doc. 360692. Mr. [REDACTED] timely appealed. Doc. 376063.

With his Appeal, Mr. [REDACTED] submitted an addendum from Dr. [REDACTED], dated January 22, 2025. Doc. 376066 at 12. In this addendum, Dr. [REDACTED] responded to the AAP and Claims Administrator’s issues with his CDR scoring, writing:

[i]n my detailed interviews with the claimant’s spouse and the claimant and my observations of his physical exam and of him engaging in physical tasks, I do not see signs of headache or neck/musculoskeletal pain preventing activity. I also am not observing and do not have positive information on questioning about his affect, initiation, energy or interest level being the primary cause of his dysfunction in these realms.

Id.

Noting that he considers himself as “an acute observer of human physiologic and psychologic activity,” Dr. [REDACTED] concluded:

[r]egarding the ‘complex insomnia’ (my term for very impaired central regulation of sleep wake cycles . . .) the vast majority of these men with TES (Traumatic Encephalopathy Syndrome) manifest this and in my opinion it is not an independent determiner of loss of function . . . Therefore, I am reaffirming my neurologic opinion of [REDACTED] meeting criterial of a Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

Id.

I subsequently requested another AAP review of Mr. [REDACTED]’s Claim, including Dr. [REDACTED]’s addendum. In response to Dr. [REDACTED]’s addendum, an AAP Member found that it “does not provide new information or interpretations to support the claimed diagnosis.” Doc. 393831. Namely, the Member found Dr. [REDACTED]’s reliance on in-clinic observations misplaced, as “[t]he CDR is based on convergent historical factors, not direct observation alone.” *Id.* Accordingly, Dr.

■■■■'s failure to address Mr. ■■■■'s joint pain, headache, sleepiness, dizziness, depression, anxiety, and stress made his report insufficiently supportive of his CDR ratings. *Id.*

Moreover, the Member found that while “Dr. ■■■■’s statements about the frequency of sleep disturbance” amongst those with neurocognitive impairment “are generally true,” “[h]is dismissal of them as determinants of loss of function is not supported [by] the medical literature.” *Id.*

RESOLVING THIS APPEAL

In making his case, Mr. ■■■■ argues that the Claims Administrator should have deferred to his examining clinicians. I partially agree with him—under the circumstances, deference was due Dr. ■■■■’s judgment that Mr. ■■■■’s neuropsychological test scores were valid.

But, to prevail on Appeal, Mr. ■■■■ needs to show, by clear and convincing evidence, that the Claims Administrator erred in reaching its conclusions about both criterion (ii) *and* criterion (iii). He has not met this burden, because the Claims Administrator appropriately concluded that Mr. ■■■■ did not satisfy criterion (iii). At the most basic level, Dr. ■■■■ failed to address the question of mixed etiologies despite being instructed to do so by the relevant CDR worksheet and again in the review process.

Accordingly, I deny Mr. ■■■■’s Appeal.

1. Validity

As a rule, the AAP and Claims Administrator “should defer to a clinician’s *Slick*-criteria-based validity analysis when it results from reasoning completely articulated in contemporaneous reports, unless the analysis is clearly erroneous.”⁴

In this case, Dr. ■■■■ repeatedly explained why, despite indicators of invalidity, he nonetheless found Mr. ■■■■’s neuropsychological test results valid. He noted that while Mr. ■■■■ scored sub-optimally on performance validity tests, his “abnormal scores . . . are just outside the norm.” Doc. 276473 at 9. He also reasoned that there was “a fair degree of consistency between [Mr. ■■■■’s 2022] test results and those from 2017,” which supports validity. *Id.*

Moreover, while he acknowledged that Mr. ■■■■ did not present as a typical dementia patient, Dr. ■■■■ drew on twenty-six years of experience to find that “it is not entirely uncommon to evaluate a patient who presents as cognitively normal on casual observation and during the clinical interview, only to find that testing reveals significant cognitive deficits consistent with dementia.” Doc. 320402 at 2.

As I have held:

⁴ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=slick_validity_testing_sm.pdf.

[t]he ‘clearly erroneous’ bar for overriding a clinician’s articulated reasoning is—appropriately—very high. It is not enough to conclude that [a clinician] was mistaken or even ‘wrong’ in his judgment. Rather, any flaws in [his] reasoning would need to be ‘so basic and foundational as to render his determinations unreasonable.’⁵

On appeal, at my request, a different Consultant reviewed Dr. ██████’s validity analysis. I asked the Consultant to attend to the Settlement’s settled approach to validity and deference. Doc. 396946. While, in the Consultant’s opinion, “the preponderance of the evidence favors invalidity,” the reviewer ultimately found that Dr. ██████ “fully articulated a consideration of validity including all Slick criteria” and could “identify no errors ‘so basic and foundational as to render his determinations unreasonable.’” *Id.*

Thus, while the AAP Consultants who reviewed Dr. ██████’s report all assert that they would have come to different validity conclusions, none have identified “flaws in [his] reasoning ‘so basic and foundational as to render his determinations unreasonable.’” The most recent AAP Consultant says as much. Accordingly, applying the usual deference the Settlement applies to the articulated validity findings of examining clinicians, the Claims Administrator erred in not deferring to Dr. ██████’s validity analysis.

Mr. ██████ thus satisfies criterion (ii).

2. Isolating Cognitive Loss

The Settlement requires diagnosing physicians to isolate cognitive loss as the cause of a Player’s functional decline. As FAQ #111 explains:

The CDR scale also requires the diagnosing physician to determine whether the functional decline in a Player from a previous usual level was due to cognitive loss, and not due to other factors. For example, if the Player’s functional impairment resulted from a physical handicap or injury, chronic pain, sleep apnea, or other causes other than cognitive loss, the Player cannot be found to have a Level 1.5 or Level 2 Qualifying Diagnosis.⁶

And yet, Dr. ██████ repeatedly failed to explain how he determined that Mr. ██████’s functional decline results from cognitive loss. In his initial report, Dr. ██████ offered a conclusory assertion that he found “no presenting evidence of a mixed etiology.” Doc. 276475 at 8. When asked to clarify his reasoning on this matter, he merely re-submitted a copy of that decision document. Doc. 326598. In his post-Denial addendum, meanwhile, Dr. ██████ repeated that he

⁵ Special Master Ruling on Validity Testing and Deference, at 7 (Feb. 14, 2024) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_testing_deference_sm_2.pdf.

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

did not “see signs of headache or neck/musculoskeletal pain preventing activity” or “observ[e] . . . [Mr. █████]’s] affect, initiation, energy or interest level being the primary cause of his dysfunction.” Doc. 376066 at 12. He also insisted that, in his opinion, sleep disturbances are “not an independent determiner of loss of function.” *Id.*

When assigning CDR scores, Dr. █████ “was not required to show that cognitive loss was the sole cause of functional impairment.”⁷ But he “had to offer some kind of isolating framework to the ‘extent feasible.’”⁸ Instead, Dr. █████ advanced “conclusory and dismissive” statements insisting only that he found “no presenting evidence of a mixed etiology” and did not “observe” any other “primary cause of [Mr. █████]’s] dysfunction.” Doc. 350375, Doc. 376066. These unsubstantiated assertions amount to the type of “bare statement” that is “insufficient to clear even [FAQ #111’s] low bar.”⁹

Significantly, an AAP Member identified multiple issues with Dr. █████’s late-arriving attempt to explain his conclusions. Per the Member, Dr. █████’s focus on clinical observation in his addendum was misplaced, because “[t]he CDR is based on convergent historical factors, not direct observation alone.” Doc. 393831. The Member also insists that Dr. █████’s contention that sleep disturbances are not independent causes of functional loss “is not supported [by] the medical literature.” *Id.*

The Claims Administrator appropriately adopted the Member’s informed and articulated views over the cursory explanations offered by Dr. █████. As I initially held in July 2024 and reaffirmed in November of that year:

[the Settlement’s] prudential standards urging deference have limited application here. The relevant diagnosing neurologist was Dr. █████ . . . I [have] determined that because of Dr. █████’s diagnostic practices, as well as the unusual arrangements he made with [third-parties] it would be inappropriate to give his views deference in the review process . . . consequently the Claims Administrator need not reflexively defer to his views.¹⁰

Dr. █████, who mysteriously and abruptly changed his Diagnosis from Alzheimer’s to Level 2 Impairment, and either refused or was unable to justify materially confounding symptoms, was thus entitled to no deference. Worse, he failed to explain himself with care, and the AAP was not convinced by what he wrote. The Claims Administrator was justified in adopting the Member’s conclusions, and in denying the Claim.

Consequently, Mr. █████ has not offered clear and convincing evidence of error in the Denial.

⁷ Special Master Ruling on Validity Testing, External Evidence, and Functional Impairment, at 10 (Mar. 27, 2023) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_evidence_impairment_sm.pdf.

⁸ *Id.* at 10-11.

⁹ *Id.* at 11.

¹⁰ Special Master Ruling on Neuropsychological Testing, at 7 (Nov. 22, 2024) https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=np_testing_sm_4.pdf.

CONCLUSION

Mr. [REDACTED]'s Claim was denied on two bases, either of which was sufficient to justify that rejection. One of those grounds was that his diagnosing neurologist had not sufficiently explained how his functional loss resulted from his cognitive decline, rather than other factors. On review, I conclude that the Claims Administrator correctly made that determination. I therefore deny Mr. [REDACTED]'s Appeal.

Date: July 10, 2025



David A. Hoffman, Special Master