

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

THIS DOCUMENT RELATES TO:

REGARDING DENIAL OF MONETARY AWARDS

MAF Physician, presided over each of their diagnoses, and Dr. [REDACTED] provided the supporting neuropsychological evaluations.

Two separate audits followed.

The first, starting in late 2017, focused on the practices of seven neuropsychologists, whom the Claims Administrator labeled the “Template Doctors.” This investigation resulted from the disqualification of neuropsychologist Dr. [REDACTED]. The Claims Administrator had previously found that Dr. [REDACTED] assessments did not meet the standard of care necessary under the Settlement Agreement.¹ These seven Template Doctors submitted virtually the same report template as Dr. [REDACTED] with their “report sections match[ing] almost perfectly with [hers].”² The reports were “remarkably similar, not only in their formats, but in their actual wording as well.”³ The Claims Administrator further concluded that these psychologists used assessments that violated the Settlement’s standardized procedures, ignored validity concerns, adopted Retired Players’ accounts of impairment while disregarding clear signs of exaggeration and malingering, deployed analyses that reached erroneous conclusions, and grossly inflated the time they spent on assessments.⁴

Notably, Dr. [REDACTED] told Dr. [REDACTED] who was one of the seven Template Doctors, “how evaluations were to be performed, allowed him to use her psychometrists, and even did initial report drafts for his evaluations under her letterhead.”⁵ The Claims Administrator’s Audit Report included an interview with Dr. [REDACTED] where he spoke about his process in evaluating Retired Players.⁶ The Claims Administrator highlighted that:

Dr. [REDACTED] said he was uncomfortable about how collateral information was collected and used, but he was told by Dr. [REDACTED] that this was the way this Program worked. In his regular practice, he would never solely rely on information received from the patient. He was under the impression that the neurologists were privy to all the collateral information and that neurologists had the duty to request and evaluate this data. The level of interaction with the neurologist was limited and that was not ideal.⁷

The Report also described potential issues with malingering by the Retired Players who were examined by the Template Doctors.⁸ The Claims Administrator finally noted that Dr. [REDACTED]

¹ Claims Administrator’s Rule 19 Summary Audit Report: Neuropsychological Doctors Using a Common Medical Record Template 1 (Mar. 27, 2018).

² *Id.* at 2.

³ *Id.*

⁴ *Id.* at 3–4.

⁵ *Id.* at 3.

⁶ *Id.* at 8–10.

⁷ *Id.* at 8–9.

⁸ *Id.* at 10.

prepared his reports on a different day than the testing regimen was administered, and alleged that he inflated his billed time.⁹

Ultimately, the Claims Administrator recommended disqualifying each of the Template Doctors, including Dr. [REDACTED] “and disallowing any Monetary Award Claim using their neuropsychological testing, while allowing those players to be retested by a BAP Provider or a Qualified MAF Physician.”¹⁰ Based on the Claims Administrator’s recommendation and pursuant to Audit Rule 18, the Audit Report was referred to the Special Masters on February 28, 2018.

The Settlement Class Members submitted a response report regarding Dr. [REDACTED] prospective disqualification.¹¹ In it, Dr. [REDACTED] contesting the Claims Administrator’s portrayal of and conclusions derived from his interview, argued that his timekeeping and validity assessment processes were proper.¹² He also emphasized that he provided a Qualifying Diagnosis to only half of the Retired Players he examined.¹³

Considering these arguments, Special Masters Pritchett and Verrier determined that rather than disallowing each of the Template Doctors’ diagnoses, those submissions were to be independently reviewed by the Settlement’s experts.¹⁴ In their September 17, 2018 Decision, the Special Masters ordered that a member of the Appeals Advisory Panel, in consultation with one AAP Consultant, provide an individualized assessment of each Template Doctor Claim.¹⁵ The Claims Administrator was to make a final determination based on those expert analyses, subject to Appeal.

The second audit, which also began in late 2017, focused on the Retired Players’ then-counsel, Acosta & Associates.¹⁶ The audit resulted from an anonymous tip alleging that Acosta & Associates provided coaching to Players, and even paid physicians, to guarantee that assessments would yield a Qualifying Diagnosis.¹⁷ A special investigation later revealed that the anonymous tip was fabricated.¹⁸ On January 23, 2020, Special Masters Pritchett and Verrier concluded that determinations for these Claims should follow the same evaluative process as outlined in the Template Doctors audit.¹⁹

The AAP determined that none of the Claims met the requirements for a Qualifying Diagnosis. The Claims Administrator consequently issued a series of Denials.

⁹ *Id.* at 4.

¹⁰ *Id.* at 2.

¹¹ Rule 20 Submission by Settlement Class Member(s) In Response to 3/27/2018 Audit Report: Neuropsychological Doctors Using a Medical Record Template (Apr. 28, 2018).

¹² *Id.*

¹³ *Id.*

¹⁴ Special Masters’ Ruling on Neuropsychological Doctors Using a Common Medical Record Template (Sept. 17, 2018), https://www.nflconcussionsettlement.com/Docs/template docs_SM.pdf.

¹⁵ *Id.*

¹⁶ Claims Administrator’s Rule 15 Audit Report: Acosta & Associates and Player 5 (Feb. 23, 2018).

¹⁷ *Id.* at 2–3.

¹⁸ Special Masters’ Ruling on [REDACTED], at 2 (Jan. 23, 2020) (not published for public access).

¹⁹ *Id.* at 2–3.

DISCUSSION

Each of these Players sought awards based on diagnoses made after the Settlement's Effective Date, using assessments conducted by a then-MAF physician. Thus, they were required to offer evidence generally consistent with the Settlement Injury Definitions. Where—as here—Retired Players appeal an adverse determination by the Claims Administrator on that basis, they must show that it was wrong by clear and convincing evidence.²⁰ That is, is it “highly probable or reasonably certain” that the Claims Administrator erroneously found that they had failed to offer evidence generally consistent with a Claim to relief?²¹

In considering that question, it's important to recognize that, descriptively, the Claims Administrator usually defers to the reasoned opinions of Retired Players' MAF and BAP diagnosing clinicians.²² The Special Masters have repeatedly justified that system in various opinions.²³ But deference is not always apt. When a completed audit is referred to the Special Masters for review and findings, Section 10.3(i) of the Settlement Agreement authorizes any appropriate relief. In the Template Doctor cases, the Special Masters required the AAP to perform an independent review of these Claims, as their records “may involve a misrepresentation, omission, or concealment of material fact.”²⁴ Thus, while the AAP typically would defer to the diagnosing physician's reasoned and completely articulated validity analysis (unless it was clearly

²⁰ See Settlement Agreement, Section 9.8; Order Appointing Special Masters, at 5.

²¹ “Clear and convincing evidence” is a recognized intermediate standard of proof—more demanding than preponderance of the evidence, but less demanding than proof beyond a reasonable doubt. *In re Fosamax Alendronate Sodium Prods. Liab. Litig.*, 852 F.3d 268, 285-86 (3d Cir. 2017) (“Black's Law Dictionary defines clear and convincing evidence as ‘evidence indicating that the thing to be proved is highly probable or reasonably certain.’”).

²² Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/-Docs/pre_diagnosis_evidence_sm.pdf.

²³ See Special Master Ruling on Use of TOPF Models to Determine Pre-Morbid IQ (May 1, 2020), https://www.nflconcussionsettlement.com/Docs/TOPF_SM.pdf (“Just as I have concluded that the Settlement Agreement requires the Claims Administrator to defer to choices explicitly left to front-line clinicians, so too is my review circumscribed.”); Special Master Ruling on Reliance by Claims Administrator on Judgment of the Treating Physician (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_judgment_SM.pdf (“Requiring a written explanation makes sense, as reasons tend to justify, enabling the Claims Administrator to defer to the judgment of the treating physician. That deference in turn promotes the Settlement's global concern for speedy and equitable administration.”); Special Master Ruling on Post-Diagnosis Evidence, at 5 (June 8, 2020), https://www.nflconcussionsettlement.com/Docs/post_diagnosis_evidence_SM.pdf (“[T]he Agreement's system of review turns on deference to contemporaneously created and articulated medical judgements...The Claims Administrator can, ...as is entirely appropriate, defer to the clinician's judgement.”); Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/-Docs/pre_diagnosis_evidence_sm.pdf (“The Settlement Agreement's appeals process is not intended to be an inquisitorial one, designed to nitpick the BAP and MAF physicians' clinical judgement. Rather, it is built around a layered deference to expertise.”); Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf (“The AAP 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.”).

²⁴ Special Masters' Ruling on Neuropsychological Doctors Using a Common Medical Record Template (Sept. 11, 2018), https://www.nflconcussionsettlement.com/Docs/templatedocs_SM.pdf.

wrong), here the AAP was asked to apply its judgment without any presumption of correctness.²⁵ The same is true regarding functional impairment, where the AAP's searching review was needed to remedy demonstrated infirmities in the diagnostic process.

Ultimately, based on a comprehensive evaluation of each Player's record and the Special Master-ordered AAP review, the Claims Administrator made a final determination in each Claim, which it recorded in a Notice of Denial.

Below, I divide my discussion into two groups: Level 1.5 and Level 2 Claims. These Claims—made by a neuropsychologist that the Claims Administrator recommended be disqualified—largely rely on sparse assessments that fail to include necessary detail for the Qualifying Diagnoses they assert. Furthermore, while a number of these Retired Players experience notable limitations—mental health and learning disorders—that would be expected to impact their testing performance, Dr. █████ failed to exercise his clinical judgment and make accommodations, as is permitted.²⁶ As a result of the deficiencies in Dr. █████ assessments, my review requires an atypical level of scrutiny, especially given the AAP and Claim Administrator's warnings. I have included the text of the relevant medical reviews to provide the Class guidance, though the result is an unusually long Opinion.

Generally, each Claim fails both because the underlying test results were not valid measures of players' cognitive function and because the relevant CDR analysis did not support the claimed level of functional loss.²⁷

I. Level 1.5 Neurocognitive Impairment Claims

For Retired Players diagnosed outside of the BAP after the Settlement Agreement's Effective Date, a Diagnosis of Level 1.5 Neurocognitive Impairment must be made in a manner generally consistent with the four diagnostic criteria set forth in the Settlement Agreement.²⁸ The Claims Administrator denied these Retired Players' Claims based on the AAP's concerns regarding both criterion (ii) (“[e]vidence of a moderate to severe cognitive decline . . . as

²⁵ Cf. Special Master Ruling on Neuropsychological Testing: Slick Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf.

²⁶ See Retired NFL Football Players' Baseline Assessment Program: Neuropsychologists Handbook (the Clinician's Interpretation Guide), at 11 (“Players may present with significant mental and physical limitations that impact their ability to execute tasks as required under typical circumstances. These may include severe dementia, orthopedic injury, paralysis, muteness, agitation, other psychiatric issues, and limited facility with English language. As in standard clinical practice, we will rely on the experience and skill of the highly qualified assessors administering this battery to characterize neurocognitive functioning to the best of their ability; however special note of these limitations will be required. Any emergent psychiatric or behavioral issues should likewise be handled according to your usual standards of care.”).

²⁷ The NFL Parties' and Player's counsel's briefing for Mr. █████ and the NFL Parties' briefing for Mr. █████, include discussion of how Dr. █████ applied demographic norm adjustments. The Claims Administrator's Notice of Denial did not assert this concern, nor did it earlier express the view that the Claims were insufficiently documented on this basis. See Special Master Ruling on Demographic Norm Adjustments, at 11 (Aug. 20, 2020), https://www.nflconcussionsettlement.com/Docs/demographic_norms_sm.pdf.

²⁸ Settlement Agreement, Exhibit A-1, (1)(b).

determined by and in accordance with the standardized neuropsychological testing protocol annexed in Exhibit 2 to the Settlement Agreement, in two or more cognitive domains”) and criterion (iii) (“functional impairment generally consistent with the criteria set forth in . . . Clinical Dementia Rating (CDR) scale Category 1.0 (Mild) in the areas of Community Affairs, Home & Hobbies, and Personal Care.”).²⁹

██████████ received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on August 6, 2017. Doc. 114413. The AAP Consultant recommended that his Claim be denied:

Dr. ████████ neuropsychological evaluation fails to meet the settlement’s requirements for objectively measured cognitive impairment/decline. The player failed multiple validity measures, and therefore low test scores should not be interpreted as documentation of cognitive impairment. Dr. ████████ acknowledged “suboptimal performance” on two validity measures. In addition, the player’s score was significantly elevated on one of the validity scales within the MMPI-2-RF. He obtained a T-Score of 79 (>99%) on the F-r Scale, indicating overreporting of psychological dysfunction due to a larger than average number of infrequent responses. Thus, the player’s subjective complaints should be viewed with caution since it is likely that a least some are exaggerated and/or fabricated. Furthermore, the neurological examination of Dr. ████████ also failed to provide evidence of cognitive impairment. Specifically, the player obtained a score of 28/30 on the MoCA, which is in the normal range and indicates intact cognitive functioning.

Slick validity criteria are included in the Settlement to assist with determining whether a retired player’s test data is a valid reflection of his optimal level of neurocognitive functioning. This player’s documentation shows inconsistencies raising concern about validity in terms of the Slick criteria. For example, there is a discrepancy for the Slick criteria involving *self-reported symptoms discrepant with known patterns of brain functioning*. The player provided an example of memory difficulties that involved forgetting how to tie a necktie. However, this is an example of procedural memory, which is typically not impaired with cognitive decline due to neurological disorder. It is well documented in the research and clinical literature that procedural memory remains intact, even in case of dementia.

In addition to these validity issues, the player’s score for Trail Making Test Part B should be disregarded because it cannot be used as documentation of impairment for the domain of executive functioning. Dr. ████████ did not administer the other

²⁹ For a Diagnosis of Level 1.5 Neurocognitive Impairment made outside of the BAP, the Settlement requires evaluation and evidence generally consistent with a CDR score of 1.0 in Community Affairs (“Unable to function independently at these activities although may still be engaged in some; appears normal to casual inspection”), Home & Hobbies (“Mild but definite impairment of function at home; more difficult chores abandoned; more complicated hobbies and interests abandoned”), and Personal Care (“Needs prompting”).

part of this test, Trails A. On page 2 of his report, Dr. [REDACTED] provided a list of the tests administered to the player, which shows that Trails A was not administered. The Settlement Guidelines state, "Trail Making Part A is not a required measure in the BAP for interpretive purposes, but must be administered because the norms for Part B are based on presumed administration of Part A just prior to Part B.

In terms of functional ratings, this player does not meet criteria on the CDR scale that is consistent with Level 1.5 Neurocognitive Impairment. This level of impairment is inconsistent with documentation showing that the player continues to drive, and continues to be employed full-time as a "broadcaster," and in "marketing/promotions." This type of employment is cognitively demanding and challenging, and not consistent with Level 1.5 impairment. Dr. [REDACTED] also reported that the player continues to give speeches, is frequently hired to provide autographs and photographs, continues to work out and play golf. He was also described as being able to "dress himself and care for his needs." These activities are inconsistent with the functional impairment required for Level 1.5 Neurocognitive Impairment.

Neither Dr. [REDACTED] nor Dr. [REDACTED] adequately addressed psychiatric problems or alcohol abuse, both of which are well documented problems for this player. The player meets DSM-5 criteria for Generalized Anxiety Disorder and Alcohol Use Disorder (Moderate), with possible Panic Disorder. It is well established that chronic alcohol abuse is associated with poor performance on neuropsychological testing. There is documentation of significant alcohol abuse, including a DUI a three years prior to testing. Furthermore, Dr. [REDACTED] actually documents that the player was drinking just three days prior to testing. Depression and anxiety, especially when insufficiently treated, can also adversely impact performance on neuropsychological testing.

In summary, Dr. [REDACTED] neuropsychological evaluation fails to meet the settlement's requirements for objectively measured cognitive impairment. Similarly, Dr. [REDACTED] neurological examination documents intact cognitive abilities. Furthermore, the available evidence regarding cognitively mediated losses in daily function is not generally consistent with the Settlement Agreement's criteria for Level 1.5 Neurocognitive Impairment.

Doc. 220604 (cleaned up). The AAP Reviewer adopted the Consultant's analysis and recommended a Denial and on April 21, 2020, the Claims Administrator denied the Claim, following the AAP's recommendation. Doc. 223656. On October 16, 2020, Mr. [REDACTED] appealed. Doc. 229434.

As the AAP recommended and the Claims Administrator found, while Mr. [REDACTED] has experienced some functional decline, his documented Community Affairs and Personal Care activities are not consistent with the level necessary for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. At the time of his submission, Mr. [REDACTED] worked as a broadcaster

and marketing ambassador, which the Settlement’s expert describes as “cognitively demanding and challenging.” Doc. 220604. Further, Mr. ██████ played golf, exercised, made paid public appearances to give speeches, signed autographs, and often took photos with fans. Dr. ██████ did explain that Mr. ██████ finds these activities increasingly troublesome—he became agitated during public appearances, was “less proficient” in “synthesizing the information about which he was going to speak” for the purpose of his broadcasting work, and has struggled with coordination during his physical activity. Doc. 114154. But this daily community-based activity is still inconsistent with a CDR score of 1.0 in Community Affairs.

Moreover, though Mr. ██████ reported that he has experienced difficulty with tying a necktie, his ability to generally dress himself and care for grooming needs does not indicate that he “needs prompting”—the necessary predicate for a CDR score of 1.0 in Personal Care.

Ultimately, the Claims Administrator, in adopting the AAP Reviewer’s analysis, concluded that Mr. ██████ daily activity, while inhibited, is not consistent with a level of decreased functioning required for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment.³⁰ That conclusion was not in error: Mr. ██████ has thus not offered evidence generally consistent with an entitlement to relief. The Appeal is denied.

████████████████████

██████████ received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on August 2, 2017. Doc. 128218. The AAP Consultant recommended that his Claim be denied:

It is highly unusual to extend a neuropsychological evaluation over a two-month time period. This raises concern about variability in symptoms over such a long time frame.

Dr. ██████ did not provide scores for one of the stand-alone validity measures, the MSVT. Actual raw test scores are required to be able to adequately assess effort and motivation during testing.

There are significant inconsistencies between mental status testing and the neuropsychological evaluation, which were performed on the same day. For example, the player failed simple visuospatial items on the MoCA (copying a cube, drawing a circle for the contour of a clock) and yet he was *not* impaired on visual spatial tasks during the neuropsychological evaluation. His performance was intact on a timed constructional task (Block Design 9%) and he was able to accurately draw complex figures from memory on the WMS-IV VRI (16%). In addition, the player failed screening items of abstract verbal reasoning on the MoCA (0/2), but during

³⁰ The Claims Administrator’s determination is not clearly in error for the additional reason that Mr. ██████ test results were invalid, marked by suboptimal performance of two performance validity tests, a score on a symptom validity measure of the MMPI-2-RF that indicates “overreporting of psychological dysfunction due to a larger than average number of infrequent responses,” and a lack of a Trail Making Test Part A score.

the neuropsychological evaluation he performed extremely well on a more difficult measure of abstract verbal reasoning (WAIS-IV Similarities Subtest 63%). These inconsistencies raise concern about poor effort during the neurological examination, especially since the MoCA does not have a validity measure to assess if effort is optimal.

In terms of the Slick validity criteria, the player shows a *discrepancy between test data and observed behavior* for the cognitive domain of language. According to the Slick criterion, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant with the observed level of cognitive function in a way that suggests an exaggeration or fabrication of dysfunction. This player presents with no significant language disturbance in conversational speech or during the neurological examination. On the same day as neuropsychological testing, Dr. [REDACTED] describes intact language for auditory comprehension (following commands) and normal speech. However, on formal neuropsychological testing, the player performs in the severely impaired range for two language tests of comprehension and confrontation naming (BNT T-Score = 14, <1%; CIM T-Score = 27, 1%). This severely impaired performance on formal measures of language is inconsistent with the player's ability to answer interview questions without the need for assistance during both the neurological examination and neuropsychological evaluation. In fact, Dr. [REDACTED] reported that the player was even able to "make jokes" during the clinical interview. The player did not report any problems with language to either Dr. [REDACTED] or Dr. [REDACTED]. Furthermore, language problems are not described in the Affidavit of [REDACTED]. In fact, Ms. [REDACTED] reports that the player continues to participate in interviews with the media. She did not describe any language problems when the player "meets and talks during media sessions" or during charity events. In addition, the player independently provided written answers to Audit questions (02/18/2020) that show intact comprehension and well formulated responses with intact language abilities.

Dr. [REDACTED] rendered the diagnosis of "Mild Neurocognitive Impairment[.]" This indicates a condition that is milder than dementia, essentially mild cognitive impairment (MCI). This is not the same as Major Neurocognitive Disorder.

Dr. [REDACTED] did not adequately address the contribution psychopathology and other important comorbid factors to the player's clinical presentation. This includes psychiatric disorders (depression, social anxiety disorder) and factors such as chronic pain and insomnia.

The player functions at a level inconsistent with Level 1.5 Neurocognitive Impairment. He is independent in personal care including basic and instrumental activities of daily living (e.g. cooking and driving), and he continues to have sessions with the "media" and to play golf. Furthermore, he was also able to attend both the

neurological and neuropsychological examinations independently without the need for anyone to accompany him.

For these reasons, the neuropsychological evaluation does not support a diagnosis of moderate dementia and the player does not meet the Settlement neuropsychological criteria for Level 1.5 Neurocognitive Impairment. In addition, there is no objective documentation of functional limitations caused by cognitive impairment/decline.

Doc. 224736 (cleaned up). The AAP Reviewer adopted the Consultant's analysis and recommended a Denial and on July 23, 2020, the Claims Administrator denied the Claim, following the AAP's recommendation. Doc. 226815. On October 23, 2020, Mr. [REDACTED] appealed. Doc. 229816.

The AAP Reviewer recommended that the Claims Administrator deny the Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. As the AAP Consultant explained, there are a number of factors that complicated the strength of Mr. [REDACTED] Claim. For example, while two of Mr. [REDACTED] three Language test scores were "in the severely impaired range," he did not report language-related issues during his medical examination, and, according to Dr. [REDACTED] "[h]is speech was with normal prosody and content was adequate."³¹ Doc. 122789. According to his third-party affiant, he continues to "talk to media." Doc. 122790. The Reviewer further pointed to Mr. [REDACTED] failure of visuospatial and abstract verbal reasoning items on the MoCA—a cognitive screening tool not required by the Settlement Program—and his satisfactory performance on analogous tests included in the Settlement's test battery.³²

Mr. [REDACTED] history appears consistent with some level of neurocognitive impairment that may very well qualify him for a Monetary Award. He has experienced mood swings, social isolation, irritability with loved ones, and difficulties engaging in recreational activities like golfing. In the event that Mr. [REDACTED] does submit a future Claim Package, his physicians, based on their sound clinical medical judgement and a review of the clearly documented impairment included in this

³¹ This implicates *Slick* Criterion 3: "Discrepancy Between Test Data and Observed Behavior." Settlement Agreement, Exhibit 2, Section 2. While Mr. [REDACTED] "speech and language abilities were notable for deficits in word-finding" during Dr. [REDACTED] mental status examination, the AAP Consultant nevertheless concluded that the absence of any mention of speech difficulty during his neurological assessment was inconsistent with glaring failures in his testing, thus compromising the overall validity of the Claim. Doc. 224736.

³² The MoCA is a screening test for detecting Mild Cognitive Impairment, which often precedes and leads to dementia. See Ziad S. Nasreddine, Natalie A. Phillips, Valérie Bédirian, Simon Charbonneau, Victor Whitehead, Isabelle Collin, Jeffrey L. Cummings, & Howard Chertkow, *The Montreal Cognitive Assessment, MOCA: A Brief Screening Tool for Mild Cognitive Impairment*, 53 J. OF THE AM. GERIATRICS SOC'Y 695, 699 (2005). As I have previously explained, while cognitive screening tests not included in the Settlement's prescribed test battery may be used as a part of neuropsychological examinations, it would be erroneous to rest a Denial entirely or substantially on a Retired Player's performance on such exams. See Special Master Decision Regarding Clinical Judgment on Generally Consistent Standard 2 (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_judgment_sm.pdf. Here, the AAP did not solely use Mr. [REDACTED] performance on the MoCA as grounds for determining that he lacks a Qualifying Diagnosis—nor should the Reviewer have.

current Claim, may consider whether to date a new Qualifying Diagnosis back to his 2017 evaluation.³³

But on appeal, he must show that the Claims Administrator's Denial was clearly erroneous. That ruling relied on AAP's expert determination that certain elements of this Claim—discrepancies in data regarding Mr. [REDACTED] speech, visuospatial skills, and abstract verbal reasoning; a lack of a raw score for the MSVT performance validity test (a deficiency each of these Claims share); and possible fluctuations in symptoms across the atypical two-month testing time period—rendered it incompatible with the Settlement's requirements for a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. The Claims Administrator's reliance on the AAP Reviewer's individualized, articulated analysis—which the Special Masters deemed was essential for making a determination on this Claim, and others—was not clearly in error.

Therefore, the Appeal is denied.

[REDACTED]

[REDACTED] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on July 14, 2017. Doc. 97148. The AAP Consultant recommended that his Claim be denied:

Validity is a problem for this neuropsychological evaluation and therefore the test scores should not be used as documentation of cognitive impairment. The player failed 3 validity measures, which includes 2 embedded validity measures (WMS-IV LM Recognition, WMS-IV VPA Recognition) and 1 subtest of a stand-alone validity measure (MSVT). In addition, validity information is incomplete. Dr. [REDACTED] did not provide scores for the MSVT. Actual numeric scores are required to adequately evaluate the player's motivation to perform well. This failure of multiple validity measures raises concerns about suboptimal effort. Dr. [REDACTED] actually describes "suboptimal performance" and "some instances whereby his performance was less than ideal." He attributes the player's poor effort to "pain, emotional distress, environmental distractors, and/or testing fatigue[.]"

³³ See Settlement Portal, Frequently Asked Questions, FAQ #101(c)(5) (explaining that "the physician making a diagnosis may conclude, in the exercise of his or her sound medical judgment, that he or she has enough information from personal examination, medical records from other healthcare providers, medical history, corroborating evidence from non-family members and other information that medical specialists rely on in their clinical practices, to form a sound medical judgment that the Player's Qualifying Diagnosis conditions existed at a date earlier than the date of a personal examination . . ."). The Qualified MAF Physician cannot rely solely on the 2017 diagnosis (because the diagnosis may not be supported under the Settlement Agreement criteria) but may rely on objective facts or evidence provided by the terminated providers in the reports from their exams. See FAQ #93.2 (addressing reliance on records from providers who were terminated because of questionable medical practices, as was the case with Dr. [REDACTED]).

The player had a neurological examination with Dr. [REDACTED] on the same day as the neuropsychological evaluation (05/31/2017). Given his suboptimal performance with Dr. [REDACTED] it is highly likely that suboptimal performance also impacted his performance on the MoCA, which was administered the same day by Dr. [REDACTED]. His MoCA score should be interpreted with caution given documentation of poor performance on other cognitive testing the same day.

Symptom validity is also a concern for this evaluation. The player's T-score is significantly elevated for the FBS-r validity scale within the MMPI-2-RF. His T-score of 80 (>99%) indicates significant over-reporting of symptoms associated with *noncredible cognitive and somatic complaints*. Therefore, subjective complaints and self[-]reported functional limitations should be interpreted with caution since it is likely that his self-report of symptoms is exaggerated and/or fabricated.

There are multiple discrepancies in terms of the Slick validity criteria. This player shows numerous *discrepancies between test data and observed behavior*. For example, his low scores on formal neuropsychological testing is inconsistent with his everyday functioning, which includes the ability to continue to drive, independently grocery and clothes shop, and golf. In addition, he continues to be employed full-time as an elementary school teacher, assists with building sets for school plays, and attends tailgate sports events with friends.

Another *discrepancy between test data and observed behavior* involves the cognitive domain of language. According to the Slick criterion, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant with observed level of cognitive function in a way that suggests an exaggeration or fabrication of dysfunction. This player is well educated (i.e. college degree) and presents with no significant language disturbance in conversation speech during the clinical interview portion of the neuropsychological evaluation, but performs in the impaired range on two language tests: verbal fluency and comprehension (Category Fluency T-Score 36, CIM TScore 13). Impaired performance on formal measures of language is inconsistent with the player's ability to continue to work successfully as an elementary school teacher.

Another Slick criterion involves *a pattern of neuropsychological test performance that is markedly discrepant from currently accepted models of normal and abnormal CNS function*. It is extremely unusual for an individual with moderate to severe cognitive decline to have no deficits for learning and memory. His performance was consistently intact for multiple measures of learning and memory, yet memory is the player's primary complaint. Similarly, Mr. [REDACTED] Affidavit primarily describes memory problems.

Self-reported symptoms are discrepant with known patterns of brain functioning is another relevant Slick criterion. The player reports unusual symptoms inconsistent

with his clinical presentation. For example, he describes difficulty remembering “facts,” which is a form of declarative memory, and typically spared with most neurological disorders. He also describes difficulty recognizing objects, which is a rather rare neurological symptom and not consistent with this player’s clinical presentation.

Psychiatric disorders, chronic pain/headaches, and poor sleep are significant factors that impact functional limitations for this player. Dr. [REDACTED] describes “rather significant psychopathology” and “significant psychological distress and evidence of multiple mood disorders.” In addition, the player endorsed “unusual and aberrant experiences, and a high degree of anger and aggressiveness,” and he was “anxious/panicked[.]” At the time of testing, the player is described as “anxious” and requiring numerous breaks during testing. Dr. [REDACTED] concludes, “Psychological treatment is imperative for mood stabilization.” The player meets DSM-5 criteria for Major Depressive Disorder (Recurrent), Social Anxiety Disorder, and Generalized Anxiety Disorder. In addition, he is a moderate risk for suicide. Mr. [REDACTED] Affidavit also describes significant depression and anxiety, which is adversely impacting the player’s socialization and participation in community affairs. For example, he describes the player as “not motivated to socialize” and “withdrawn” and refusing to engage with family/friends for long periods of time, which is attributed as “Most likely, this is a results of depression and his decision to be left alone for reasons none of us understand.” His untreated psychiatric disorders are likely playing a major role in this player’s alleged functional difficulties with everyday activities.

The player functions at a level inconsistent with Level 1.5 Neurocognitive Impairment. He is able to continue living alone, thus he is independent in personal care including basic and instrumental activities of daily living. In addition, he is responsible for caring for his teenage son who sometimes stays with him. He continues to work full-time as an elementary school teacher, and occasionally socializes with friends. This level of independent functioning is inconsistent with the Level 1.5 Neurocognitive Impairment.

For these reasons, Dr. [REDACTED] neuropsychological evaluation does not provide evidence of a moderate to severe decline from a previous level of performance (Level 1.5 Neurocognitive Impairment). Furthermore, the retired player does not exhibit functional impairment consistent with CDR Category 1.0.

Doc. 221041 (cleaned up). The AAP Reviewer adopted the Consultant’s analysis and recommended a Denial and on April 23, 2020, following the AAP’s recommendation, the Claims Administrator denied the Claim. Doc. 223771. Mr. [REDACTED] appealed on October 23, 2020. Doc. 229808.

Mr. [REDACTED] has worked as an elementary school teacher, and while he has experienced what Dr. [REDACTED] referred to as “cognitive fatigue” at the end of workdays, he nonetheless has generally been able to perform his work responsibilities independently. Doc. 97143. As a result, Mr. [REDACTED] level of activity is not generally consistent with a CDR score of 1.0 in Community Affairs. Similarly, at the time of submission, Mr. [REDACTED] could dress himself independently, a level of functioning also not generally consistent with a CDR score of 1.0 in the area of Personal Care. Mr. [REDACTED] cognitive function may be consistent with a CDR score of 1.0 in the area of Home & Hobbies—he has abandoned pastimes such as fishing and travel, and has required his son’s assistance with some household chores (it is unclear whether he is able to otherwise complete these chores in his son’s absence). But Mr. [REDACTED] daily functioning, taken as a whole, does not meet the requirements for a Level 1.5 Neurocognitive Impairment Diagnosis.

The Claim also is undermined a lack of performance validity, including suboptimal performance in three validity measures and an overreporting of symptoms was similarly detected on the MMPI-2-RF. And while Dr. [REDACTED] concluded that “a complete analysis of...Mr. [REDACTED] performances across measures, along with self-report of cognitive problems would not flag any of the considerations of the Slick...indications of malingering,” the AAP Reviewer disagreed. Doc. 97144; Doc. 221041. For example, Dr. [REDACTED] did not document any issues with Mr. [REDACTED] language skills in his report, and explained that Mr. [REDACTED] “demonstrated meaningful interaction” and “[h]is thoughts were linear and appropriate.” Doc. 221041. As the AAP Reviewer underlined, there was a discrepancy between these observations and Mr. [REDACTED] purported impairment in two Language tests.³⁴ Similarly, the assessment’s discussion of Mr. [REDACTED] issues with memory did not match his strong performance on the battery’s individual Learning and Memory test.³⁵

I therefore conclude that, in making its determination, the Claims Administrator’s adoption of the AAP Reviewer’s analysis of Mr. [REDACTED] Claim was not clearly erroneous. The Appeal is denied.

[REDACTED]

[REDACTED] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on July 28, 2017. Doc. 107763. The AAP Consultant recommended that his Claim be denied:

Scores provided show that the player failed one embedded validity measure, the WMSIV VR II Recognition Subtest. However, Dr. [REDACTED] did not provide sufficient information to determine if the player’s effort was optimal. He did not provide any of the raw scores for one of the stand-alone validity measures, the MSVT. Actual numeric scores are required to adequately evaluate the player’s motivation to perform well.

³⁴ This implicates *Slick* Criterion 3: “Discrepancy Between Test Data and Observed Behavior.” Settlement Agreement, Exhibit 2, Section 2.

³⁵ *Id.*

Symptom validity is a serious problem for this evaluation. Failure of symptom validity undermines the credibility of the player's self-report of symptoms/complaints. His MMPI-2-RF protocol is invalid because of excessive fixed, content-inconsistent 'True' responding (TRIN-r T-score = 88, >99%). Furthermore, his RBS Scale T-score of 92 (>99%) indicates significant over-reporting of an unusual combination of symptoms associated with *non-credible memory complaints*. This failure of symptom validity is especially important because much of Drs. [REDACTED] and [REDACTED] functional ratings are based on the player's self-report of symptoms. Based on this documentation of failed symptom validity, the player's subjective complaints, and his description of functional limitations, should be viewed with caution since it is likely that his subjective complaints are not a valid/accurate representation of his functional abilities.

There are numerous inconsistencies and discrepancies involving Slick validity criteria. In particular, the player shows multiple *discrepancies between test data and observed behavior*. For example, his poor performance on formal neuropsychological testing is inconsistent with his independence for a wide range of everyday activities. This includes his ability to continue to work as an assistant coach, drive a vehicle, travel independently, routinely cook meals for his family, and attend medical appointments without requiring anyone to accompany him.

Another *discrepancy between test data and observed behavior* includes the cognitive domain of language. According to the Slick criterion, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant with the observed level of cognitive function in a way that suggests an exaggeration and/or fabrication of dysfunction. This player is well educated (e.g. college degree) and presents with no significant language disturbance in conversational speech or during the clinical interview portion of the neuropsychological evaluation. Dr. [REDACTED] specifically states, "His speech/language was intact[.]" Similarly, Dr. [REDACTED] describes, "His speech is clear, without aphasia or dysarthria, normal prosody[.]" In contrast, the player performs in the severely impaired range on two language tests of comprehension and confrontation naming (BNT T-Score 36, CIM T-Score 27). Severely impaired performance on formal measures of language is inconsistent with the player's clinical presentation as described by both Dr. [REDACTED] and Dr. [REDACTED] and inconsistent with his ability to continue to work as an assistant coach, and his ability to travel independently (e.g. from Arizona to California for the two evaluations).

Neuropsychological testing shows that the player's memory is intact for multiple formal measures of visual and verbal learning /memory. It is highly unusual for an individual with alleged moderate dementia to not show any impairment of learning/memory on neuropsychological testing. This highlights yet another Slick inconsistency, which involves *a pattern of neuropsychological performance that is*

markedly discrepant from currently accepted models of normal and abnormal CNS function.

To the extent that the player is experiencing any change in functional abilities, this is less likely caused by cognitive impairment, but rather due to major psychiatric disorders, ongoing chronic pain, and chronic sleep problems. Dr. [REDACTED] describes the player as meeting DSM-5 criteria for Major Depressive Disorder (Recurrent) and Generalized Anxiety Disorder. Dr. [REDACTED] also describes chronic pain and a range of affective changes, including “agitation at work,” and that the player is “less interested in hobbies or activities outside the home[.]” Dr. [REDACTED] highlights “depressive symptoms,” and states, “a component of his issues may be due to untreated psychiatric or psychological issues[.]” Mr. [REDACTED] also describes prominent psychiatric problems as the major cause for limited socialization and for an “attitude change.” Mr. [REDACTED] describes depressive behaviors that include not being as “excited to socialize with others,” and “short-tempered,” and he “continues to withdrawal from activities he enjoyed in the past including golf and traveling.” Mr. [REDACTED] also states, “There are times he will refuse to engage with friends and family for long periods of time. He will not return phone calls. He will not answer phone calls. He will not appear where he is supposed to appear. On these occasions, I have checked on him to make sure he is ok. Most likely, this is a result of depression and his decision to be left alone for reasons none of us understand.” Similarly, Dr. [REDACTED] describes significant psychiatric symptoms as limiting factors including anger, irritability, frustration, moderate to severe stress, worries, sleep problems, excessive tiredness, on-going chronic pain, feeling fearful, a tendency to isolate himself, and feeling “as if he does not care anymore.” Dr. [REDACTED] specifically describes the player at the time of testing as “anxious.” In fact, he apparently became so “overwhelmed” with the Trails B test, that he “needed help[.]” Dr. [REDACTED] characterizes him as “experiencing significant psychological distress,” and “significant mood dysfunction,” with “significant anxiety and mood issues” and “a sense of unremitting stress, diminished interest in social functioning, and a pervasive sense of frustration,” and he “endorsed suicidal thoughts[.]”

The player functions at a level inconsistent with Level 1.5 Neurocognitive Impairment. Dr. [REDACTED] documents a MoCA score in the normal range. The player is described with “good hygiene,” and is independent in personal care including basic and instrumental activities of daily living. And Dr. [REDACTED] reports that he continues to drive and is employed as an assistant football coach. He was able to travel independently from Arizona to California for the evaluations with Drs. [REDACTED]. In addition, he did not require anyone to accompany him to either of these medical appointments, and was able to provide a detailed history. Mr. [REDACTED] Affidavit states that the player “often cooks,” he continues to drive, and has been able to successfully learn how to use reminders on his smart phone. This level of independent functioning is inconsistent with Level 1.5 Neurocognitive Impairment.

For these reasons, the neuropsychological evaluation does not support a diagnosis of moderate dementia and the player does not meet the neuropsychological criteria for Level 1.5 Neurocognitive Impairment. Furthermore, there is no objective documentation of functional limitations caused by cognitive impairment/decline.

Doc. 221246 (cleaned up). The AAP Reviewer adopted the Consultant's analysis and recommended a Denial and on May 11, 2020, the Claims Administrator, following this analysis, denied the Claim. Doc. 224294. Mr. ██████ appealed on October 9, 2020. Doc. 229063.

In discussing Mr. ██████ psychiatric condition, the AAP Consultant emphasized that Dr. ██████ diagnosed the Retired Player with Major Depressive Disorder (Recurrent) and Generalized Anxiety Disorder. That Disorder complicates the relationship between his documented functional deficiencies and his asserted cognitive impairment.³⁶ The AAP Consultant determined that it was more likely that Mr. ██████ issues with daily cognitive functioning—his withdrawal from recreational activities such as golf and travel, refusal to engage with family and friends, and apparent anxiety during the neuropsychological assessment itself—resulted from his depression and anxiety, rather than cognitive impairment. That reasoned determination justifies the Claims Administrator's Denial. Doc. 221246.

The AAP also correctly identified issues with validity. For example, Mr. ██████ record contains numerous mentions of issues with memory—to the point where Mr. ██████ reported that he has consistently forgotten tasks and chores immediately asked of him—yet his scores in Learning and Memory tests largely did not indicate signs of cognitive impairment in this domain.³⁷ Mr. ██████ similarly showed no documented difficulty with language and speech during his examination, yet demonstrated varying levels of impairment in different Language tests.³⁸ Finally, Mr. ██████ demonstrated suboptimal performance in one validity test, and his MMPI-2-RF scoring undermined the credibility of his self-reported symptoms.

I therefore conclude that, in making its determination, the Claims Administrator's adoption of the AAP Consultant's and Reviewer's analysis of Mr. ██████ Claim was not clearly erroneous. The Appeal is denied.

³⁶ Dr. ██████ report thoroughly discussed Mr. ██████ apparent mental health issues—during his examination, he projected a “lowered mood state,” showcasing “irritability, a sense of unremitting stress, diminished interest in social functioning and a pervasive sense of frustration.” Doc. 107818. Mr. ██████ neuropsychological assessment further notes that there was evidence that Mr. ██████ had suicidal thoughts. Similarly, Dr. ██████ neurological evaluation explains that Mr. ██████ had “[d]epressive symptoms, with prior history of prolonged grief and depression.” Doc. 107819.

³⁷ This implicates *Slick* Criterion 2: “A pattern of neuropsychological test performance that is markedly discrepant from currently accepted models of normal and abnormal central nervous system (CNS) function.” Settlement Agreement, Exhibit 2, Section 2. Mr. ██████ listed “memory loss” as his primary symptom on a questionnaire he completed, yet scored “low average” in two Learning and Memory tests, and average in four. The AAP Reviewer classified this discrepancy as “highly unusual.” Doc. 221246.

³⁸ This implicates *Slick* Criterion 3: “Discrepancy Between Test Data and Observed Behavior.” Settlement Agreement, Exhibit 2, Section 2.

[REDACTED]

[REDACTED] received a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment on October 15, 2017. Doc. 146333. The AAP Consultant recommended that his Claim be denied:

Validity is a concern for this neuropsychological evaluation, thus the test scores should be interpreted with caution. The player failed one subtest of the MSVT (Consistency). Furthermore, Dr. [REDACTED] did not provide raw scores [on] this validity measure[.]. Actual numeric scores are required to allow adequate evaluation of the player's motivation to perform well.

The player failed multiple symptom validity measures. His MMPI-2-RF profile was deemed *invalid* due to failure of 4 validity scales. His RBS Scale T-score of 92 (>99%) indicates significant over-reporting of an unusual combination of symptoms associated with *non-credible memory complaints*. His T-score of 82 (>99%) on the VRIN-r scale and T-score of 92 (>99%) on the F-r Scale both render his protocol *invalid*. His Tscore of 89 (>99%) on the FBS-r Scale documents over-reporting of symptoms associated with *non-credible cognitive and somatic symptoms*. Failure of symptom validity is important because much of Dr. [REDACTED] functional rating is based on the player's self-report of symptoms. Dr. [REDACTED] actually states that the MMPI-2-RF "is not likely an accurate reflection of his current psychological functioning, thus the findings were not considered valid for interpretation[.]" Failure of symptom validity undermines the credibility of the player's self-report of symptoms/complaints, and it is likely that his description of functional limitations for everyday activities is fabricated and/or exaggerated.

There are numerous inconsistencies that highlight problems with the Slick validity criteria, especially *discrepancies between test data and observed behavior*. For example, his poor performance on formal neuropsychological testing is inconsistent with his ability to continue to drive and work. In fact, the player is able to continue to drive on a regular basis, and he was able to successfully begin new employment after the 2017 neuropsychological evaluation. His new employment as a radio commentator requires high-level cognitive abilities, which is inconsistent with his neuropsychological test performance. Records also indicate that he continues to coach on a part-time basis and provide "appearances" for a professional football team. Similarly, his ability to independently travel from [REDACTED] to California for the neuropsychology/neurology examinations, is inconsistent with his poor performance during formal testing. Furthermore, he was able to attend both evaluations without requiring anyone to accompany him.

Another *discrepancy between test data and observed behavior* includes the cognitive domain of memory. According to the Slick criterion, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant

with observed level of cognitive function in a way that suggests an exaggeration or fabrication of dysfunction. This player is well educated and presents with no significant memory impairment during the neuropsychology clinical interview. In fact, Dr. [REDACTED] describes his memory during the interview as “intact[.]” The player provides an extremely detailed background describing his medical, birth/developmental, educational/vocational, and social history. In contrast, the player performs in the severely impaired range on verbal memory tests (WMS-IV LM I T-Score 27, LM II T-Score 23).

There are multiple important factors that likely impacted test performance, but were not adequately addressed by Dr. [REDACTED]. Fatigue is a major problem for this player. He suffers from severe insomnia and reported to Dr. [REDACTED] that he sleeps an average of only 2 to 3 hours per night. Plus, jet lag likely added to his fatigue since he traveled from [REDACTED] to California for the evaluations, and both examinations occurred on the same day. In fact, Dr. [REDACTED] describes the player as showing “testing fatigue” requiring him to provide a break from testing. Psychiatric symptoms, especially depression, also likely impacted test performance. Dr. [REDACTED] diagnosed an Unspecified Depressive Disorder (using DSM-5 criteria). At the time of testing, the player was described as “depressed,” with “low frustration tolerance,” and showed “testing fatigue[.]”. Dr. [REDACTED] describes “severe sadness and depression,” and suicidal ideation, which occurs on a “daily basis.” Similarly, in his 2015 report, Dr. [REDACTED] describes a prior suicide attempt. The player admitted to thinking about suicide “all the time” and he provided a detailed plan of putting a shotgun to his chest, adding that he has a permit to carry a gun and “keeps a gun on him at all times[.]” Dr. [REDACTED] also describes significant problems with mood swings, irritability, and almost constant suicidal ideation. Substance abuse is not adequately addressed by Dr. [REDACTED]. The player reported regular use of both alcohol and cannabis, and Dr. [REDACTED] recommended “substance abuse treatment, for both his alcohol and cannabis use[.]” Even if the player was sober at the time of testing, individuals with chronic substance abuse often perform poorly on neuropsychological tests. The player was previously diagnosed with ADHD and is prescribed medication for this disorder (Adderall). ADHD is associated with impaired performance on neuropsychological measures, especially measures of attention and memory. Similarly, most of his subjective complaints (trouble with attention/concentration, multi-tasking, focus, and memory) are consistent with his prior diagnosis of ADHD.

Dr. [REDACTED] reports that he bases part of his diagnosis on a prior neuropsychological evaluation of the retired player that was carried out by Dr. [REDACTED] in 2015. This evaluation is not consistent with the NFL Settlement test battery and should be used to support a diagnosis of neurocognitive impairment. Dr. [REDACTED] does not provide any test scores, and provides names of only a few tests. He administered just one measure of validity, but did not provide any scores. He also described significant psychiatric symptoms including affective problems, anxiety, depression,

stress, hostility, insomnia, irritability, suicidal ideation, and a high level of social isolation, and chronic pain. Dr. [REDACTED] describes impairment in cognitive domains that were intact when the player was tested two years later by Dr. [REDACTED]. He reports impairment in executive functioning, language processing, visual sensory/motor, visuomotor speed, visual perception and visuomotor coordination, impaired cognitive flexibility, and impaired short-term visual memory. Dr. [REDACTED] did not document impairment in these cognitive domains, indicating that his 2017 scores actually document an *improvement* in cognitive functioning.

The player functions at a level inconsistent with Level 1.5 Neurocognitive Impairment. He is independent in personal care including basic and instrumental activities of daily living. He is able to independently travel long-distances (i.e. [REDACTED] to CA) and is able to attend medical appointments without requiring anyone to accompany him. He continues to drive and work in various positions, including full-time as an “on-air talk radio host,” and assisting coaching professional-level football, and he is paid to make “appearances” for a professional football team. In addition, he reports that he serves as an assistant to his wife in her business. The player was able to learn to use new technical devices, such as the calendar on this cell phone. He continues to play golf and ride his bike, and is able to shop online. This level of independent functioning is inconsistent with Level 1.5 Neurocognitive Impairment.

For the numerous reasons detailed above, Dr. [REDACTED] neuropsychological evaluation does not support a diagnosis of moderate dementia and the player does not meet the Settlement’s neuropsychological criteria for Level 1.5 Neurocognitive Impairment. Furthermore, there is no objective documentation of functional limitations caused by cognitive impairment or decline from a prior level of functioning.

Doc. 222950 (cleaned up). The AAP Reviewer adopted the Consultant’s analysis and recommended a Denial and on June 4, 2020, the Claims Administrator, following this analysis, denied the Claim. Doc. 225317. Mr. [REDACTED] appealed on October 26, 2020. Doc. 229882.

On review, I conclude that Mr. [REDACTED] documented Community Affairs activity is not consistent with the Settlement’s requirement for a CDR score of 1.0. Mr. [REDACTED] admitted that he has often guest-hosted sports radio talk shows, and began officially co-hosting his own show in October 2018. Mr. [REDACTED] also contended that he must “write a lot more things down than [his] my co-workers” and has only able to fully perform the duties of the job with the assistance of his colleagues. Doc. 218471. Yet, as the AAP Reviewer noted, such a job requires a high level of cognitive ability. His ability to serve in this cognitively demanding role—albeit with some assistance—is not consistent with the demonstrated impairment necessary for the Qualifying Diagnosis he sought. Additionally, the self-reported information that Mr. [REDACTED] provided about his functional impairment—isolating from friends, avoiding in-person shopping, playing golf only

with the assistance of an instructor, and ensuring that grooming needs are organized by his wife—was not corroborated by any third-party affidavit, as the Settlement requires.³⁹

Mr. [REDACTED] Claim also includes notable issues with the validity of his testing. As the AAP Consultant explained, he failed four validity scales on the MMPI-2-RF, meaning that it is “likely that his description of functional limitations for everyday activities is fabricated and/or exaggerated.” Doc. 222950. The AAP Consultant further underscored that many of Mr. [REDACTED] reported medical issues—deficiencies in concentration, memory, and focus—are consistent with his prior diagnosis of ADHD.

The Claims Administrator’s adoption of the AAP analysis of Mr. [REDACTED] Claim was not clearly erroneous. Therefore, the Appeal is denied.

II. Level 2 Neurocognitive Impairment Claims

For Retired Players diagnosed outside of the BAP after the Settlement Agreement’s Effective Date, a Diagnosis of Level 2 Neurocognitive Impairment must be made in a manner generally consistent with the four diagnostic criteria set forth in the Settlement Agreement.⁴⁰ The Claims Administrator denied these Retired Players’ Claims based on the AAP’s concerns regarding both criterion (ii) (“[e]vidence of a severe cognitive decline from a previous level of performance, as determined by and in accordance with the standardized neuropsychological testing protocol annexed in Exhibit 2 to the Settlement Agreement, in two or more cognitive domains”) and criterion (iii) (“functional impairment generally consistent with the criteria set forth in . . . Clinical Dementia Rating (CDR) scale Category 2.0 (Moderate) in the areas of Community Affairs, Home & Hobbies, and Personal Care.”).⁴¹

[REDACTED]

[REDACTED] received a Qualifying Diagnosis of Level 2 Neurocognitive Impairment on July 24, 2017. Doc. 107228. The AAP Consultant recommended that his Claim be denied:

Validity is a concern for this neuropsychological evaluation and therefore the test scores should be interpreted with caution. The player failed 2 validity measures, which includes 2 embedded validity measures (WAIS-IV Reliable Digit Span, WMS-IV VPA Recognition). Furthermore, Dr. [REDACTED] did not provide scores for

³⁹ Settlement Agreement, Exhibit A-1, (1)(a)(iii) (explaining that, in the absence of documentary evidence showcasing functional impairment, the Retired Player’s functional impairment “must be corroborated by a third-party sworn affidavit..., the sufficiency of which will be determined by the physician making the Qualifying Diagnosis.”).

⁴⁰ Settlement Agreement, Exhibit A-1, (2)(b).

⁴¹ For a Diagnosis of Level 2 Neurocognitive Impairment made outside of the BAP, the Settlement requires evaluation and evidence generally consistent with a CDR score of 2.0 (Moderate) in Community Affairs (“No pretense of independent function outside home; appears well enough to be taken to functions outside a family home”), Home & Hobbies (“Only simple chores preserved; very restricted interests; poorly maintained”), and Personal Care (“Requires assistance in dressing, hygiene, keeping of personal effects”).

one of the stand-alone validity measures, the MSVT. Actual numeric scores are required to adequately evaluate the player's motivation to perform well. Dr. [REDACTED] acknowledges the player's suboptimal effort ("the inability to obtain reliable neuropsychological testing"), but incorrectly attributes failed validity testing "to his baseline history of dyslexia[.]"

Furthermore, symptom validity is a major problem for this evaluation and the player's MMPI profile is invalid. Failure of multiple measures of symptom validity undermines the credibility of the player's self-report of symptoms and complaints about functional limitations. Therefore, his subjective complaints should be interpreted with caution. T-scores are significantly elevated for numerous validity scales within the MMPI-2-RF. The player's TRIN-r T-score of 95 indicates an invalid protocol because of excessive fixed, content-inconsistent 'True' responding. His T-score of 106 on the F-r Scale documents over-reporting of psychological dysfunction due to endorsing an extremely large number of infrequent responses. Additional evidence of an invalid protocol is his Fp-r Scale T-score of 120, showing over-reporting of an excessive number of symptoms rarely described by individuals with genuine severe psychopathology. His Fs scale (Tscore = 99) illustrates over-reporting of somatic symptoms rarely described by individuals with genuine medical problems. And his elevated score on the FBS-r Scale (T-score = 86) shows over-reporting of an unusual combination of responses associated with non-credible cognitive/somatic symptoms. This overwhelming evidence of failed symptom validity is especially important given that Dr. [REDACTED] states that he bases his diagnosis of Level 2.0 Neurocognitive Impairment on the player's "personal descriptions of his functional impairment[.]"

In addition to these validity problems, the player's score for Trail Making Test Part B cannot be used to establish impairment for the domain of executive functioning. Dr. [REDACTED] did not administer the other part of this test, Trails A. Dr. [REDACTED] provided a list of the tests administered to the player, which shows that Trails A was not administered. The Settlement Guidelines state, "Trail Making Part A is not a required measure in the BAP for interpretive purposes, but must be administered because the norms for Part B are based on presumed administration of Part A just prior to Part B."

There are multiple inconsistencies involving Slick validity criteria. The player shows numerous discrepancies between test data and observed behavior. For example, his impaired scores on formal neuropsychological testing is inconsistent with his everyday functioning, which includes the ability to continue to drive, and the ability live independently, including caring for his son who is unable to work due to a chronic psychiatric disorder. Dr. [REDACTED] reports that the player was continuing to work as a case maker/carpenter. The player was able to travel independently from Texas to California for the neuropsychological and neurological evaluations. Furthermore, he did not require anyone to accompany him to either appointment,

indicating that Drs. [REDACTED] and [REDACTED] considered him a reliable historian. All of these activities are inconsistent with his neuropsychological performance and with Level 2.0 Neurocognitive Impairment.

In addition, it does not make sense that the player allegedly has “severe dyslexia,” but was able to read the MMPI-2-RF without any difficulty. The MMPI-2-RF has a minimum 5th grade reading level, so it is difficult to understand how the player was able to read this lengthy inventory (over 300 items) without any reported difficulty.

Multiple psychiatric disorders, chronic pain, and insomnia are major factors impacting functional limitations/decline. The Affidavit of Ms. [REDACTED] clearly describes problems working due to the player’s “attitude” and “difficulty controlling his anger,” and has become “very reclusive.” Dr. [REDACTED] describes “demoralization, a sense of hopelessness, social isolation, significant emotional distress, anxiety, unusual beliefs, hostility, paranoia, anger, and hypomanic activation[.]” The player reports, “excessive fatigue,” and states that “pain impacts his emotional state, insofar as he is less motivated to participate in daily activities. Using DSM-5 criteria, Dr. [REDACTED] diagnosed Major Depressive Disorder (Recurrent, Severe) and Generalized Anxiety Disorder. To the extent that the player has any functional impairment for everyday activities, these psychiatric disorders and chronic pain are likely playing a prominent role.

The player does not meet criteria for Level 2.0 Neurocognitive Impairment, and Dr. [REDACTED] actually points this out, “He did not demonstrate Level 2 impairment in 2 or more categories[.]”

The player functions at a level inconsistent with Level 2.0 Neurocognitive Impairment. Dr. [REDACTED] states, “He remains living independently.” In fact, the player is independent in personal care including basic and instrumental activities of daily living, and he provides a home for one of his children with a chronic psychiatric disorder. The player continues to drive, and travels independently (including across the country), and does not require anyone to accompany him to medical appointments. This level of independent functioning is incompatible with the Level 2.0 Neurocognitive Impairment.

Considering all of these issues, Dr. [REDACTED] neuropsychological evaluation does not support a diagnosis of moderate dementia and the player does not meet the neuropsychological criteria for Level 2.0 Neurocognitive Impairment. Furthermore, there is no documentation of a decline in functional abilities because of cognitive impairment.

Doc. 221143 (cleaned up). Adopting this analysis, the Claims Administrator denied the Claim on May 13, 2020. Doc. 224422. Mr. [REDACTED] appealing on October 13, 2020, asked that the Denial be

reversed or that I find that he was entitled to, in the alternative, a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 229325.

Mr. [REDACTED] physicians, and the AAP Reviewer, considered how Mr. [REDACTED] dyslexia shape his Claim. First, there was discussion in his reports about appropriate calculation of his premorbid intelligence.⁴² Dr. [REDACTED] exercising his expert clinical judgment, used combined demographics and TOPF prediction equations to determine Mr. [REDACTED] premorbid intellectual ability, which he considered to be “below average.” Dr. [REDACTED] also explained:

It should be noted that the patient self-reports a history of dyslexia and this test measures premorbid intellectual ability through reading. Therefore, it is highly likely that this test underestimates his true intelligence and the patient’s premorbid functioning was likely much higher than a 66. However, in order to comply with the requirements from the NFL Class Action Concussion Lawsuit, no additional tests were given and the Below Average Impairment Criteria were used.

Doc. 107259. While Dr. [REDACTED] could have used a demographics-only model for predicting premorbid functioning, he did not. This choice was entitled to deference.⁴³

In further addressing the prevalence of Mr. [REDACTED] dyslexia, his neuropsychologist argued that “[w]hile his prior history of dyslexia may be playing a role in some of his cognitive difficulties, the memory and executive functioning deficits do not appear to be related to this learning disorder and instead are more congruent with actual injury to the brain.” Doc. 107259. Yet, the AAP Reviewer, in thoroughly considering the role of his dyslexia in assessment outcomes, emphasized that Mr. [REDACTED] performance on the MMPI-2-RF without reported difficulty is inexplicable given his learning disorder. That’s so because the MMPI-2-RF is a test that requires relatively high-level reading comprehension skills. Given this discrepancy, it was not wrong for the Claims Administrator to adopt the AAP Reviewer’s analysis and question whether his test results indicated an underlying cognitive impairment.

Based on his record, Mr. [REDACTED] exhibited Level 2 Neurocognitive Impairment in Executive Function and Level 1 in Learning and Memory, and no documented impairment in the Settlement’s other domains. Therefore, as even Dr. [REDACTED] explained, he did not demonstrate Level 2 impairment in two or more cognitive domains. As a result, Mr. [REDACTED] test performance is not generally consistent with a Qualifying Diagnosis of Level 2 Neurocognitive Impairment.

⁴² On the Diagnosing Physician Certification Form, Dr. [REDACTED] notably also explained that Mr. [REDACTED] “neuropsychological testing [was] limited in value due to the patient[’]s dyslexia causing a presumed falsely low premorbid intelligence calculation.” Doc. 107237. And yet the testing was administered. The Settlement requires the test battery to be administered unless “the Retired NFL Football Player’s dementia is so severe,” not because of dyslexia, for which other adjustments can be made. Settlement Agreement, Exhibit A-1(2)(b); *see* Special Master Ruling on Qualified MAF Physician’s Certification that Testing is Medically Unnecessary (May 27, 2020), https://www.nflconcussionsettlement.com/Docs/physician_certification_testing_sm.pdf.

⁴³ *See generally* Special Master Ruling on Test of Premorbid Functioning (TOPF) Models to Determine Pre-Morbid IQ (May 1, 2020), https://www.nflconcussionsettlement.com/Docs/topf_sm.pdf.

There are additional validity concerns with Mr. [REDACTED] Claim that prevent the alternatively requested Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment from being approved. Mr. [REDACTED] performance in two embedded validity measures was suboptimal, and his Claim includes “overwhelming evidence of failed symptom validity” in the MMPI-2-RF. Doc. 221143. He also has experienced a sense of hopelessness, social isolation, significant emotional distress, anxiety, hostility, paranoia, anger, hypomanic activation, and chronic pain, which all have impacted his ability to function on a daily basis. As the Settlement’s expert concluded, these factors are likely to play a significant and likely leading role in Mr. [REDACTED] decline in daily functioning.

As a result, his Claim is not generally consistent with a Qualifying Diagnosis of Level 1.5 or Level 2 Impairment. The Claims Administrator’s determination was not clearly erroneous, and thus the Appeal is denied.

[REDACTED]

[REDACTED] received a Qualifying Diagnosis of Level 2 Neurocognitive Impairment on October 1, 2017. Doc. 142965. The AAP Consultant recommended that his Claim be denied:

Validity is a problem for this neuropsychological evaluation, thus the test scores should be interpreted with caution. The player failed one embedded validity measure (ACS Word Choice). And although he does not technically fail the TOMM, it is important to be aware that his scores show variable effort. Using TBI normative data, his score of 33 for Trial 1 is 2.7 deviations below the mean (T-Score = 23, <1%). And his score of 45 for Trial 2 is at the cut-off for indicating malingering. Also using TBI norms, this score of 45 is 3.4 standard deviations below the mean (T-score = 20, <1%). In addition, Dr. [REDACTED] did not provide scores for the other stand-alone validity measure, the MSVT. Actual raw/numeric scores are required to adequately evaluate the player’s motivation to perform well.

Furthermore, symptom validity is a serious problem for this evaluation. Failure of symptom validity undermines the credibility of the player’s self-report of symptoms/complaints. This is especially important because Dr. [REDACTED] bases much of his clinical ratings on the player’s subjective symptoms and self-reported functional limitations. The player’s subjective complaints and his description of functional limitations should be viewed with caution since it is likely that they are exaggerated and/or fabricated. In fact, Dr. [REDACTED] actually acknowledges, “issues with validity on the MMPI-2-RF,” and “symptom exaggeration” and “over-reporting[.]” T-scores are significantly elevated for 2 validity scales within the MMPI-2-RF. His RBS Scale Tscore of 84 (>99%) indicates significant over-reporting of an unusual combination of symptoms associated with *non-credible memory complaints*. Furthermore, his T-score of 86 (>99%) on the FBS-r Scale documents over-reporting of symptoms associated with *non-credible cognitive and somatic symptoms*.

Slick criteria---there are multiple *discrepancies between test data and observed behavior*:

- The player is able to continue to drive, independently grocery shop, and volunteer as a coach.
- The player was able to travel independently from Georgia to California for medical appointments. And he did not require anyone to accompany him to those appointments.
- His ability to independently travel across country is also inconsistent with his report that he has “difficulty remembering where he is, where he is going, and what he should be doing[.]”

The player does not meet criteria for impairment at any level for the cognitive domain of executive functioning. His score for Trail Making Test Part B cannot be used to establish impairment for this domain. Dr. [REDACTED] did not administer the other part of this test, Trails A. Dr. [REDACTED] provided a list of the tests administered to the player, which shows that Trails A was not administered. The Settlement Guidelines state, “Trail Making Part A is not a required measure in the BAP for interpretive purposes, but must be administered because the norms for Part B are based on presumed administration of Part A just prior to Part B.” Furthermore, Dr. [REDACTED] describes the player as confused during the administration of this test (“could not grasp the task”), and “the test was discontinued[.]”

Dr. [REDACTED] does not adequately consider the effect on test performance for: psychiatric disorders, alcohol use, insomnia, and chronic pain. He diagnosed the player as meeting DSM-5 criteria for Major Depressive Disorder (Recurrent, Moderate) with intermittent suicidal ideation. Dr. [REDACTED] describes the player as withdrawn, with severe mood swings, sadness, depression, helplessness, anxiety, nervousness, anger (including outbursts), irritable, and a volatile personality. Dr. [REDACTED] reports that the player often feels “emotional distress” and overwhelmed, with a loss of interest in activities, and he “prefers to be alone,” and “does not want to get out of bed in the mornings[.]” Dr. [REDACTED] states that depressive symptoms are “the most problematic” for the player. He also described “constant pain.” The player is characterized as “having significant problems interpersonally,” and he is “socially withdrawn” and he is purposely “isolating from friends and family and prefers solitary activities[.]” Dr. [REDACTED] also describes significant depressive symptoms, social isolation, and chronic pain, along with “insomnia and daytime sleepiness.” In addition, Dr. [REDACTED] reports possible problems with alcohol use that are not adequately explored (“drinks 3-4 drinks most nights[.]”) Similarly, Mr. [REDACTED] Affidavit also describes behavior changes and limited social interactions associated with depression, which include “refusing” to answer or return phone calls, and being “distant and estranged from his friends.” Mr. [REDACTED] attributes these changes to “a result of depression and his decision to be left alone for reasons none of us understand.” All of these factors (psychiatric disorders, regular heavy alcohol use, chronic pain, and insomnia) appear to be far greater contributors to the

player's interpersonal difficulties and functional limitations than any cognitive impairment.

The player functions at a level *inconsistent* with Level 2.0 Neurocognitive Impairment. Documentation shows that he is independent in terms of traveling, and he actually traveled from Georgia to California for neuropsychological testing and the neurological examination. This trip involved an overnight stay, thus illustrating that the player is independent for personal care including basic and instrumental activities of daily living. Furthermore, he did not require anyone to accompany him to either of these appointments. The player reports that he is actively involved in coaching a school track team, which requires him to attend 5-practice session per week, and 1-2 track meets per week. In addition to coaching, he reports that, "On occasion I monitor classrooms when teachers are unavailable[.]" He reports that he "drives as needed[.]" This includes driving to the track practices and meets, and he rides a bus to away track meets. The player reports that he has been successfully volunteering as a track team coach since 2011 and he "intends to continue to coach track in 2020[.]" He also continues to regularly drive to the grocery store. In fact, he reports that he "shops at the grocery store for food weekly[.]" There are inconsistencies concerning his participation in his business. Dr. [REDACTED] reports that the player "has been able to maintain employment[.]" and is employed in real estate. But the player's accountant states that a management company handles the day-to-day activities of this business. The player refers to himself as a "partner" in the real estate company. In addition, the player reports that he plays golf less and attends church less frequently. However, his wording suggests that he still participates in these activities, but less frequently. The player reports that he did not require any assistance in preparing answers and completing the lengthy and detailed audit questions. All of these activities demonstrate a level of independent functioning that is *not* consistent with Level 2.0 Neurocognitive Impairment.

Doc. 222419 (cleaned up). On May 25, 2020, the Claims Administrator, adopting this analysis, denied the Claim. Doc. 224737. Mr. [REDACTED] appealing on September 18, 2020, asked that the Denial be reversed or that I find that he was entitled to, in the alternative, a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 228235.

Mr. [REDACTED] has volunteered for as many as ten hours per week as a track coach at a local high school, where he has also "monitor[ed] classrooms when teachers are unavailable." Doc. 216833. He reported shopping weekly for groceries without difficulty. He also travelled independently across the country for his examinations. His counsel fails to address this activity, arguing that, because he has been unable to secure employment and has needed his wife's assistance while driving, he has no pretense of independent functioning outside of the home, and therefore a CDR score of 2.0 in Community Affairs is appropriate. However, as the AAP Reviewer reasoned, these community-based activities are not consistent with such a score. That conclusion is not clearly erroneous. The extent of this independent functioning also indicates that a CDR score of 1.0 in

Community Affairs is also not compatible with his record, therefore precluding his alternatively requested relief of Level 1.5 Neurocognitive Impairment.

The AAP Reviewer also underlined that Dr. [REDACTED] diagnosed Mr. [REDACTED] with Major Depressive Disorder with intermittent suicidal ideation which causes “sadness, depression, anxiety, and nervousness,” as well as social isolation. In addition to this psychiatric condition, Mr. [REDACTED] record includes signs of regular heavy alcohol use, chronic pain, and insomnia—all of which complicate the relationship between reported decreased functioning and his asserted cognitive impairment. Last, a number of validity-related issues exist: Mr. [REDACTED] failed one embedded validity measure, showed variable effort on the TOMM, and the MMPI-2-RF suggests an overreporting of symptoms.

I therefore conclude that, as a whole, the Claims Administrator’s adoption of the AAP Reviewer’s analysis of Mr. [REDACTED] Claim was not clearly erroneous. Given Mr. [REDACTED] community activity and the concerns the AAP Reviewer had with the Claim’s validity, a Monetary Award is not appropriate. The Appeal is denied.

[REDACTED]

[REDACTED] received a Qualifying Diagnosis of Level 2 Neurocognitive Impairment on September 20, 2017. Doc. 142990. The AAP Consultant recommended that his Claim be denied:

VALIDITY. The scores provided show that the player failed 2 embedded measures of validity (WMS-IV LM Recognition, WMS-IV VPA Recognition). Dr. [REDACTED] actually acknowledges “suboptimal performance” and “some instances whereby his performance was inconsistent,” which he attributes to possible “pain, emotional distress, environmental distractors and/or testing fatigue[.]” Dr. [REDACTED] describes multiple behaviors that likely impacted testing. This includes “low energy,” and the player was “uncomfortable in his seat, and appeared to be in some distress.” He was “depressed and anxious,” and “affect was sad.” And he demonstrated “low frustration tolerance,” and “required a lot of encouragement” to continue testing. Given these behaviors during testing, it is not surprising that the player’s performance was poor on the two embedded measures noted above, or that his TOMM subtest scores are extremely variable. For example, although he obtains passing scores for Trial 2 and the Retention Trial, his TOMM Trial 1 score of 40 is 3.8 standard deviations below the mean (T-Score = 20, <1%, NCI norms).

Information provided for validity measures is insufficient to determine if effort was optimal. Dr. [REDACTED] did not provide the raw scores for a standalone measure of validity, the MSVT. He listed the percentile scores for this test, but did not provide any of the raw scores. Actual numeric scores are required to adequately evaluate the player’s motivation to perform well.

SYMPTOM VALIDITY. The player's MMPI-2-RF protocol is invalid due to failure of multiple validity scales. His protocol is invalidated by his T-Score of 82 on the VRIN-r scale. And, he over-reports an excessive number of infrequent responses (F-r, T-Score = 101, >99%). In addition, his protocol is also deemed invalid because he over-reports a very unusual combination of responses associated with non-credible memory complaints (RBS, T-Score = 97, >99%). Further evidence of over-reporting includes a very unusual combination of responses associated with non-credible somatic and/or cognitive symptoms (FBS-r, T-Score = 86, >99%). The player also over-reported symptoms on the Fs Scale (T-Score = 83, >99%), which indicates an unusual combination of non-credible somatic and/or cognitive symptoms. Dr. [REDACTED] does not adequately address this evidence of over-reporting. Given this invalid protocol, the player's subjective report of symptoms should be interpreted with caution since it is very likely that his subjective symptoms/complaints are also exaggerated and/or fabricated. This issue is particularly important since Dr. [REDACTED] describes using the player's subjective complaints as the basis for his functional ratings. Dr. [REDACTED] states his CDR rating are based on the player's "reported symptoms[.]"

SLICK CRITERIA VALIDITY. The neuropsychological report contains multiple discrepancies raising concern about validity in terms of the Slick Criteria. There are significant discrepancies between test data and observed behavior. For example, the player's performance was in the impaired range for multiple cognitive domains, which is inconsistent with his ability to travel independently from Arkansas to California for the two evaluations. And, he did not require anyone to accompany him to either evaluation. Furthermore, he reportedly continues to drive and independently shops.

Another inconsistency involves significant discrepancies in mental status testing within only a 6-month time period. The player's treating physician (Dr. [REDACTED]) documents intact functioning with the MMSE (25/30, Normal Range) on 12/22/2016. This is only a 6 months prior to Dr. [REDACTED] administering the MoCA and obtaining a score of 18/30 (06/07/2017). This certainly raises concern about suboptimal effort on the MoCA.

Also on 12/22/2016, Dr. [REDACTED] documents intact language/speech, which is inconsistent with the player's impaired performance on language tests during neuropsychological testing. This discrepancy between test data and observed behavior involves the cognitive domain of language. According to the Slick criterion, validity is an issue if performance on two or more neuropsychological tests within a domain is discrepant with the observed level of cognitive function in a way that suggests an exaggeration or fabrication of dysfunction. This player is well educated (Master's degree in education) and presents with no significant language disturbance in conversational speech, or with Dr. [REDACTED] who is the player's treating

physician. In addition, Dr. [REDACTED] describes intact language/speech. And yet he performs in the severely impaired range on two language tests (BNT T-Score <10, CIM T-Score <10).

TEST ADMINISTRATION ERROR. The player's score for Trail Making Test Part B cannot be used to establish impairment for the domain of Executive Functioning. Dr. [REDACTED] did not administer the first part of this test, Trails A. Dr. [REDACTED] provided a list of the tests administered, which shows that Trails A was not administered. The Settlement Guidelines state, "Trail Making Part A is not a required measure in the BAP for interpretive purposes, but must be administered because the norms for Part B are based on presumed administration of Part A just prior to Part B."

NO OBJECTIVE DOCUMENTATION OF FUNCTIONAL IMPAIRMENT DUE TO COGNITIVE IMPAIRMENT/DECLINE. Dr. [REDACTED] reports that 7 years ago the player "went on disability for physical issues[.]" There are numerous references in the medical evaluations and Affidavits, of the player's ability to continue to drive, shop, and play golf. In fact, the player himself describes independently driving himself to purchase gas, shop at the corner store and Walmart, and go to McDonalds ("to drink coffee"), and play. Per Dr. [REDACTED] report, he "does some laundry, limited vacuuming, makes the bed, and takes out the garbage, and can do "some yard work." And "he can dress himself[.]"

PSYCHIATRIC DISORDERS AND CHRONIC PAIN. At the time of testing, Dr. [REDACTED] describes the retired player as meeting DSM-5 criteria for Major Depressive Disorder (Recurrent, Severe) and Social Anxiety Disorder.

These mental health disorders appear to be the primary factor limiting the retired player for social and community activities. Dr. [REDACTED] describes him as experiencing severe chronic pain that "affects his emotional state, decreases his energy, and saps his interest in plans or activities[.]" In addition to pain, the player experiences numbness, sensory loss, and hearing loss. Dr. [REDACTED] reports significant problems with mood, anxiety ("a high degree"), nervousness, stress, sadness, depression, and chronic sleep problems. The player reports feeling as if he "no longer cares about things," and he frequently worries. At the time of testing, Dr. [REDACTED] noted that his energy was low and he was "uncomfortable in his seat, and appeared to be in some distress," and was "slightly resistant" during the administration of tests[.] During testing he was also described as "depressed and anxious" and "sad." His frustration tolerance was "low" and he "required a lot of encouragement on tasks he found difficult[.]" Dr. [REDACTED] concluded that the player was experiencing "clinical mood disorders," and he was reporting 'suicidality[.]' Other symptoms include "helplessness, negative emotional experiences, stress, worry, social avoidance and disaffiliativeness," and "clinically significant distress[.]" Dr. [REDACTED] also describes chronic pain, irritability, depression, and

anxiety. Per Dr. [REDACTED] the player “doesn’t like being around people,” so he limits his “engagement in social activities and has stopped visiting with friend and family.” And he is quick to anger, argues all the time, and has lost interest in hobbies. Similarly, Mr. [REDACTED] (Affidavit 08/07/2017) describes the player as “depressed, and withdrawn over the years.” Mr. [REDACTED] reports that he is less social and “prefers to be by himself.” Mr. [REDACTED] describes the player as short-tempered and “paranoid,” and states that his change in community and social activities is “a result of depression, and his decision to be left alone for reasons none of us understand,” and adds, “He has really lost all interest in things he used to enjoy.”

Taken together, the results of Drs. [REDACTED] and [REDACTED] evaluations do not support the diagnosis of a major Neurocognitive Disorder, and do not satisfy the NFL Concussion Settlement Program’s Criteria for Level 2.0 Neurocognitive Impairment. Furthermore, there is no objective documentation of functional limitations due to cognitive impairment.

Doc. 221387 (cleaned up). On May 13, 2020, the Claims Administrator, adopting this analysis, denied the Claim. Doc. 224421. Mr. [REDACTED] appealing on October 13, 2020, asked that the Denial be reversed or that I find that he was entitled to, in the alternative, a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 229149.

Mr. [REDACTED] neurological assessment includes a documented history of cognitive decline, including refusing to attend social events such as fraternity and church meetings he once enjoyed, being unable to complete basic home repairs, and lapses in grooming and personal hygiene. But Mr. [REDACTED] reports driving to the corner store, to the gas station, to Walmart, and to McDonald’s. While his activity outside the home may be limited to these specific destinations, he nonetheless has retained some independent functioning outside of the home in performing these tasks, thus conflicting with the necessary CDR score of 2.0 in Community Affairs. He also has been able to dress himself, although struggling to choose what to wear, which is inconsistent with the requirement of a need for assistance in such grooming activities for a CDR score of 2.0 in Personal Care.

Moreover, validity-related issues also weaken Mr. [REDACTED] Claim. Mr. [REDACTED] demonstrated suboptimal performance on two embedded validity measures, and, as the AAP Consultant explains, also “over-report[ed] an excessive number of infrequent responses” on the MMPI-2-RF, which Dr. [REDACTED] did not address. Doc. 221387. He also needed consistent encouragement during the testing, leading the AAP Consultant to conclude that the variability of his results may in large part be due to a lack of effort.

Ultimately, while Mr. [REDACTED] Claim supports a finding of some level of cognitive impairment, concerns with the validity of his testing indicate that neither a Qualifying Diagnosis of Level 2 nor Level 1.5 Neurocognitive Impairment is appropriate. If Mr. [REDACTED] decides to submit a Claim in the future that rests on a proper assessment devoid of validity-related issues, dating a

Qualifying Diagnosis back to October 2017 may be appropriate.⁴⁴ However, regarding his present Claim, the Claim Administrator's determination was not clearly erroneous, and the Appeal is denied.

CONCLUSION

To establish a right to relief under Settlement Agreement, these eight Retired Players—
[REDACTED] were required to show “that there is a high degree of probability that the determination of the Claims Administrator being appealed was wrong.”⁴⁵

In denying each of these Claims, the Claims Administrator adopted the informed analyses of the Settlement's experts, whose perspectives were especially instructive given the histories of audit and the Special Masters' concerns. The Claimants have not met their burden of showing that Claims Administrator's decisions were wrong. As such, the Appeals are denied.

Date: February 16, 2021



David A. Hoffman, Special Master

⁴⁴ See Settlement Agreement, Section 9.1(c)(i), *supra* note 33; FAQs #101(c)(5) and 93.2, *supra* note 33.

⁴⁵ Rule 26 of the Rules Governing Appeals of Claim Determinations.