

IN RE: NATIONAL FOOTBALL LEAGUE  
PLAYERS' CONCUSSION INJURY  
LITIGATION

MDL No. 2323

THIS DOCUMENT RELATES TO:  
NFL PARTIES' APPEAL OF CLAIM  
DETERMINATION FOR SETTLEMENT  
CLASS MEMBER [REDACTED]

██████████, a Retired NFL Football Player and Class Member under the Amended Class Action Settlement Agreement, filed a claim for benefits based on a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. The Claims Administrator, denying Mr. ██████████ Claim, determined that his neuropsychological testing was invalid. Because Mr. ██████████ has not shown by clear and convincing evidence that the Claims Administrator's determination was in error, I deny his Appeal.

This Claim, Mr. [REDACTED] first, is based on evaluations by MAF neurologist [REDACTED] and neuropsychologist [REDACTED]. Doc. 238278. Dr. [REDACTED] completed Mr. [REDACTED] neurological evaluation on December 18, 2020, assigning him a CDR score of 1.0 across the board and concluding that he was “clearly very impaired from a cognitive point of view, scoring a 13/30 on the Montreal cognitive [sic] assessment (MoCA).” Docs. 238279; 267294 at 20. Mr. [REDACTED] was evaluated by Dr. [REDACTED] on November 9, 2020. Doc. 238711. She had previously evaluated Mr. [REDACTED] through the BAP on August 1, 2017. Doc. 262664.<sup>1</sup>

In her 2020 MAF evaluation, Dr. [REDACTED] initially concluded that his performance did not meet the criteria for neurocognitive impairment. Doc. 238711. Mr. [REDACTED] MAF testing was rescored under the New Method (on June 2, 2022), yielding test results that reflected Level 2 Neurocognitive Impairment in Executive Functioning and Complex Attention and Level 1.5

<sup>1</sup> After rescoring under the New Method on April 27, 2022, Mr. [REDACTED] 2017 BAP testing was determined qualify for Level 1 Neurocognitive Impairment.

Impairment for Learning & Memory. Doc. 265340. He then filed his Claim on September 20, 2021, based on a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment. Doc. 238496.

Mr. [REDACTED] Diagnosis was referred to the AAP to determine whether it was “generally consistent” with the BAP requirements for Level 1.5 Diagnoses. Doc. 265907. The AAP Member reviewing the Claim requested input from an AAPC, who evaluated his Claim on June 4, 2022, and concluded that his neuropsychological exam did not support his Diagnosis based on concerns about performance validity:

This patient scored below the acceptable (valid) range on every PVT administered, both embedded and free-standing. On all 8 measures, his scores are so low as to be inconsistent with adequate effort. Some are even below chance guessing (e.g., ACS Word Choice = 21/50; TOMM Trial 2 = 13/50), strongly suggesting deliberate underperformance. Furthermore, these scores and the patient’s Overall Cognitive Impairment rating of Level 2 (severe dementia) are inconsistent with his working full-time in medical device sales (alterations in activities due largely to COVID), driving, shopping independently, working out at the gym 3x per week, and obtaining CDR scores of 0.5 in CA, and 0 in both HH and PC. Dr. [REDACTED] statement that no Slick criteria are present is clearly inaccurate. Criteria 1, 4, 5, and 7 are unambiguously positive. In summary, the results of this neuropsychological exam does not and cannot support the Qualifying Diagnosis.

Doc. 265398.

Dr. [REDACTED] was given the opportunity to respond and did so via an addendum submitted on July 24, 2022. Doc. 267295. She acknowledged, as she had in her initial report, that Mr. [REDACTED] scores on several stand-alone and embedded performance validity measures were “below specified cut-off[s].” *Id.* at 2. She explained that she attributed these suboptimal scores to multiple contributing factors, including a history of learning difficulties and his diagnosis of dementia by Dr. [REDACTED], which could put him “at risk of performing below expectations on performance validity measures.” *Id.* at 4. In her view, his suboptimal validity scores were counterbalanced by “broad consistency between test results (2017 and 2020 results), self-reported symptoms, behavioral observations, and clinical history as documented in recent medical records.” *Id.* at 2.

After receiving Dr. [REDACTED] addendum, the same AAPC re-reviewed Mr. [REDACTED] Claim and dismissed the addendum as a restatement of her past report that “offers no new information.” Doc. 267478. The Consultant upheld its previous determination that Mr. [REDACTED] did not meet the criteria for Level 1.5 based on the suboptimal performance validity test scores and inconsistency between his test performance and cognitive history noted, writing:

Dr. [REDACTED] confuses “below cut-off” scores on performance validity tests with scores that are actually worse than chance. The only way to score worse than chance is to intentionally pick the wrong answers. Contributions from genuine cognitive impairment and lifelong learning disability won’t do it!... Dr. [REDACTED] states that

there is no inconsistency between the patient's neurocognitive test performance and his clinical history. This is clearly incorrect. This gentleman works full time in medical product sales. He might have some more assistance than previously, but he has had no adverse evaluations. He does household chores, shops (with a list), works out at the gym 3x per week, etc. He is also very adept at using effective compensatory strategies, including smartphone apps.

*Id.* As has been increasingly the practice of the AAPC, all three AAP Consultants reviewed the Claim as a panel and unanimously confirmed the initial AAPC's view that Mr. [REDACTED] did not meet the criteria for Level 1.5 or Level 2 Neurocognitive Impairment. Doc. 268793.

The Claims Administrator denied Mr. [REDACTED] Claim on October 28, 2022. Doc. 272440. In its explanation, it emphasized the AAPC panel's determination that Mr. [REDACTED] "worse than chance" scores on performance validity measures "suggest[] deliberate underperformance rather than cognitive difficulties." *Id.* at 2.

Mr. [REDACTED] timely appealed on November 18, 2022. Doc. 273528.

### DISCUSSION

Mr. [REDACTED] latest round of testing, performed outside of the BAP, must produce a Diagnosis generally consistent with the Settlement's Injury Definitions.<sup>2</sup> The Claims Administrator concluded that evidence in Mr. [REDACTED] Claim was not generally consistent with the second of the four criteria for Level 1.5 Neurocognitive Impairment. Doc. 272440. It reasoned that, per the AAPC's report, indicators of invalid performance prevent "evidence of moderate to severe cognitive decline [in his Claim from being] in accordance with the standardized neuropsychological protocol." *Id.* at 1. On appeal, Mr. [REDACTED] must show by clear and convincing evidence that this conclusion was in error.

Mr. [REDACTED] Appeal relies on Dr. [REDACTED] July 24, 2022 addendum, in which she offers justifications for considering his neuropsychological testing valid despite suboptimal performance validity test scores and reported discrepancies between test performance and documented background history. Doc. 273527. Mr. [REDACTED] argues first that because she has provided a "well-reasoned and medically sound" justification for considering his neuropsychological testing valid despite suboptimal performance validity test scores, her judgement is entitled to deference. *Id.* at 3. But I have previously held that a clinician's conclusion that scores are not "suboptimal" is not entitled to deference when those scores indicate a "high likelihood of invalid performance" according to the Clinician's Interpretation Guide:<sup>3</sup>

Based on the Traumatic Brain Injury comparison group that is part of the ACS package, 2 of 5 test scores falling below either the 10th percentile of the Clinical

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<sup>2</sup> Settlement Agreement, Exhibit A-1 (1)(b).

<sup>3</sup> Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing (Oct. 21, 2020), [https://www.nflconcussionsettlement.com/Docs/slick\\_validity\\_testing\\_sm.pdf](https://www.nflconcussionsettlement.com/Docs/slick_validity_testing_sm.pdf).

Sample Base Rates, or 3 of 5 test scores falling below the 15th percentile would indicate high likelihood of invalid performance.<sup>4</sup>

Here, Mr. [REDACTED] scored below the 10<sup>th</sup> percentile on one ACS Effort test and below the 2<sup>nd</sup> percentile on three more. Doc. 239345. Four of his five ACS test scores therefore fall below the 10<sup>th</sup> percentile and correctly triggered a finding by the AAPC that the first *Slick* criteria was suboptimal, despite Dr. [REDACTED] opinion to the contrary.

Additionally, Dr. [REDACTED] explanations for Mr. [REDACTED] suboptimal performance validity scores do not address the foundation of the AAPC's report: that Mr. [REDACTED] scores were *so* low that they were "worse than chance." Doc. 268793. The AAPC reasoned, and the Claims Administrator noted in the denial, that such scores cause "concern regarding deliberate underperformance." Doc. 272440. Although Dr. [REDACTED] accounted for several factors that may contribute to suboptimality in Mr. [REDACTED] validity testing (a history of learning difficulties and his diagnosis of dementia per Dr. [REDACTED], among others), she did not address the *severity* of his underperformance as identified by the AAPC. Doc. 267295.

Dr. [REDACTED] similarly addressed the AAPC's peripheral concerns about discrepancies between Mr. [REDACTED] testing and documented background history while missing their core. She cited Mr. [REDACTED] need for work accommodations and need for a strict routine while driving, for example, as factors that unify the impairment indicated by his testing with his reported behavior. Doc. 267295. But she did not tackle the AAPC's contention that Mr. [REDACTED] ability to work full-time (albeit with assistance), assist with household chores, and otherwise fulfill activities of daily living is fundamentally inconsistent with the level of impairment indicated by his testing. Doc. 268793. Mr. [REDACTED] reassertion of Dr. [REDACTED] reasoning on appeal is insufficient to show by clear and convincing evidence that the Claims Administrator erred in rejecting it.<sup>5</sup>

### CONCLUSION

Because Mr. [REDACTED] has not offered clear and convincing evidence that the Claims Administrator erred, I deny his Appeal.

Date: March 1, 2023



David A. Hoffman, Special Master

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<sup>4</sup> Retired NFL Football Players' Baseline Assessment Program: Neuropsychologists Handbook (the Clinician's Interpretation Guide), at 11.

<sup>5</sup> Mr. [REDACTED] counsel also argues that because Dr. [REDACTED] noted consistency between Mr. [REDACTED] 2017 BAP and 2020 MAF testing and because the former results were treated as valid for the purposes of rescoring, Mr. [REDACTED] 2020 results must also be valid. Doc. 273527. Mr. [REDACTED] 2017 testing was not subject to the same scrutiny as his most recent Claim. It's notable that Mr. [REDACTED] fell below the 2<sup>nd</sup> percentile on three ACS Effort tests in 2017. Doc. 273527. Regardless, Mr. [REDACTED] present Claim must stand on its own two feet.