

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

Hon. Anita B. Brody

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Test, ██████ obtained scores of 90% on Immediate Recall, 92.5% on Delayed Recall, and 87.5% for Consistency. These scores are above the cutoff for adequate effort. On the ACS Word Choice test, he obtained a score that is obtained in more than 25% of the overall clinical sample. Using the guidelines for evaluating performance validity on the ACS, an a priori criterion of 3 of 5 scores falling below the 15 % cutoff was used. Overall, he obtained two of five scores that were obtained in less than 15% of the overall clinical sample. This finding is seen in 9% of the TBI sample. On the ACS Logical Memory Recognition, he obtained scores below the 5% cutoff score. On Verbal Paired Associates Recognition, his scores were above the 25% cutoff. Finally, on the Visual Reproduction Recognition test, he scored below 10% of the clinical sample.

Id. at 5-6. She concluded that he did not meet any of the *Slick* criteria, writing,

In sum, ██████ appears to have given adequate effort on the majority of embedded and standalone effort measures. He did have some difficulty on a few tasks, that may reflect fatigue or his high level of depression interfering with his ability to give optimal effort at that time. He was cooperative, persisted on all tasks, and was given and took breaks appropriately. Given that there is no pervasive pattern of impaired test performance across neuropsychological measures, it is unlikely that ██████ was deliberately trying to appear more impaired than he is. Per the *Slick* criteria, ██████ testing demonstrated no evidence of inconsistency with known patterns of brain dysfunction, clinical observation, collateral reports, and/or known patterns of test performance. Therefore, the current neuropsychological test data is considered to represent optimal effort.

Id. at 7.

Dr. ██████ rather than Dr. ██████ completed Mr. ██████ CDR assessment. Doc. 236376. She assigned him CDR scores of 2.0 in Community Affairs and Home & Hobbies and 1.0 in Personal Care. *Id.* at 11.

The interplay between Mr. ██████ mental illness and his neurocognitive impairment was the subject of extensive back-and-forth in the claims review process in the latter half of 2021. The Claims Administrator requested that Dr. ██████ provide her medical reasoning “regarding whether the impairments on the neuropsychological testing and functional abilities are due to the Player’s psychiatric disorder rather than due to cognitive decline.” Doc. 238160 at 2. After a phone call with the Claims Administrator on October 4, 2021, Dr. ██████ revised her initial evaluation, writing that in the absence of an affidavit to support functional impairment, she now believed that Mr. ██████ should receive a CDR score of 0.0 for Community Affairs, Home & Hobbies, and Personal Care. Doc. 238875.

Several affidavits from neighbors and friends were subsequently added to Mr. ██████ Claim. Docs. 241592; 241787; 241949; 241950. And his neuropsychological testing was rescored

using the New Method on May 20, 2022, after which his scores reflected Level 2 Impairment in language and Level 1.5 Impairment in learning and memory. Doc. 265008.

The AAPC reevaluated his Claim in light of his rescored neuropsychological testing and my then-recent ruling on functional impairment and cognitive decline.¹ In that report, the AAPC clarified that the Settlement does not require the exclusion of psychotic symptoms for a Diagnosis of neurocognitive impairment:

In routine clinical practice, the diagnosis of “dementia” or “major neurocognitive disorder” -- whether due to Alzheimer’s disease, cerebrovascular disease, traumatic brain injury, etc. -- requires that other causes of the patient’s symptoms be excluded. Thus, a patient with severe schizoaffective disorder with psychosis would typically not be diagnosed with dementia even though his/her functional decline is severe and incapacitating.

In the BAP, however, the Qualifying Diagnoses we are considering are “Level 1.5 and Level 2 Neurocognitive Impairment,” not DSM-defined “dementia.” Although these are highly similar constructs, they are not identical. The Settlement Program requires only that four criteria be met: (i) documented concern for severe cognitive decline, (ii) evidence of moderate to severe cognitive decline on standardized neuropsychological testing, (iii) documentation of functional impairment generally consistent with scores of at least 1 (mild dementia) in the CDR domains of Community Affairs, Home & Hobbies, and Personal Care, and (iv) cognitive deficits do not occur exclusively in the context of a delirium, acute substance abuse, or as a result of medication side effects. Note that ruling out other mental illnesses as a cause of the patient’s cognitive decline is not required. Therefore, the etiology of this former player’s cognitive impairments is not relevant.

Doc. 266861 at 2 (emphasis in original). The AAPC also reiterated its opinion that Mr. [REDACTED] failure to score above the cut-offs on some performance validity tests was attributable to his “severely decompensated mental state” rather than inadequate effort: “He cannot reliably muster the mental energy and concentration to perform well on these tests.” *Id.* Based on those considerations, the AAPC revised its prior judgment and concluded that Mr. [REDACTED] met the criteria for a Diagnosis of Level 1.5 Neurocognitive Impairment. *Id.*

After these records, on December 8, 2022, the Claims Administrator denied Mr. [REDACTED] first Claim. Doc. 274262. The denial turned not on validity but rather Dr. [REDACTED] ultimate conclusion that Mr. [REDACTED] CDR scores were 0 across all domains “because the functional impairments were attributed to the severity of the Player’s mental illness rather than being due to cognitive impairment/decline.” *Id.* at 2.

¹ Special Master Ruling on Functional Impairment/Cognitive Decline (Sept. 7, 2021), https://www.nflconclusionsettlement.com/Docs/functional_impairment_sm_5.pdf.

Mr. [REDACTED] appealed; I remanded his Appeal on March 10, 2023, and ordered additional assessment of the CDR issues by Mr. [REDACTED] diagnosing neurologist, Dr. [REDACTED] Docs. 276188; 278816. After discussion with the Claims Administrator, Mr. [REDACTED] withdrew his Claim on March 16, 2023. Doc. 279191.

He then submitted this (second) Claim for Level 1.5 Neurocognitive Impairment diagnosed through the MAF on March 21, 2023. Doc. 279402. His Claim includes a new evaluation by Dr. [REDACTED] as well as Dr. [REDACTED] 2018 neuropsychological testing. Doc. 278928. For this Claim, Dr. [REDACTED] completed a CDR assessment for Mr. [REDACTED] based on an interview with Mr. [REDACTED] mother and supported by third-party affidavits from friends and neighbors. Doc. 278666. He assigned Mr. [REDACTED] CDR scores of 1.0 in Community Affairs, Home & Hobbies, and Personal Care. *Id.* Summarizing Mr. [REDACTED] functional impairment, Dr. [REDACTED] wrote,

At the time of evaluation in 2018 Mr. [REDACTED] acknowledged memory difficulty. He is uncertain if his memory is worse, although his mother who was present clearly feels that his memory difficulty has progressed. He presently lives alone although his mother lives nearby and is not contact with him on a daily basis. His mother will prepare his meals but occasionally [REDACTED] will drive locally to eat out. He does very little of his own cooking. His mother now oversees his finances and supervises payment of all of his bills. His utility bills are now on an autopay program as his electricity was briefly disconnected for nonpayment. [REDACTED] mother states that he only socializes when friends come to visit and never leaves the house on his own except to eat. He no longer attends the gym and exercises on his own at home. He has a housecleaner as previously [REDACTED] was living in squalid conditions. He may occasionally do a load of his laundry although most of it is done by his mother and the housekeeper.

Doc. 279404 at 1 (cleaned up). At this reevaluation, Mr. [REDACTED] scored 21/30 on the MoCA. *Id.* at 2.

Dr. [REDACTED] also documented Mr. [REDACTED] psychiatric history: “[REDACTED] psychiatric history is fairly significant for schizophrenia. He previously had psychiatric hospitalizations approximately 3 times annually although his mental health has been better controlled since he has been receiving injectable Haldol once monthly. His psychiatric care is presently monitored or supervised by the courts.” *Id.* at 1. Dr. [REDACTED] ultimately concluded that Mr. [REDACTED] CDR assessment and 2018 neuropsychological evaluation support a Diagnosis of Level 1.5 Neurocognitive Impairment “related solely to cognitive decline” and explained:

[REDACTED] is a retired NFL football with player with cognitive decline in the setting of a long history of football play combined with a diagnosis of schizophrenia. Mr. [REDACTED] neuropsychological evaluation completed in 2018 documented level 2 neurocognitive impairment with satisfactory performance on measures of validity. Mr. [REDACTED] CDR assessment supports level 1 impairment.

Mr. █████ schizophrenia has recently been successfully treated with supervised monthly injection of Haldol, yet Mr. █████ continues to have significant impairment in CDR assessed activities.

Id. at 3 (break added; cleaned up).

On April 17, 2023, the Claims Administrator granted Mr. █████ Monetary Award for Level 1.5 Neurocognitive Impairment. Doc. 280894. The NFL Parties appealed. Doc. 284605.

DISCUSSION

On appeal, the NFL Parties must establish, by clear and convincing evidence, that the Claims Administrator erred in determining that Mr. █████ Claim was “generally consistent” with the Settlement’s Injury Definition for Level 1.5 Neurocognitive Impairment.² The central thrust of their Appeal is that symptoms of Mr. █████ mental illness—variably diagnosed as schizophrenia, schizoaffective disorder, and persistent depressive disorder with psychotic features—compromise his testing and Diagnosis. Doc. 284605.

Before addressing the specifics, I pause to set out the Program’s approach to this difficult and sensitive problem. Previously, when considering the relationship between symptoms of mental illness and functional impairment,³ I held that “the Settlement does not require the exclusion of psychiatric etiologies for functional loss.”⁴ In parsing psychiatric symptoms from cognitive and functional impairment on appeal, as in many applications of the Settlement’s “layered deference to expertise,”⁵ a diagnosing physician’s “articulated consideration” of confounding factors is typically sufficient to establish that a Player’s impairment is generally consistent with the Settlement’s requirements.⁶

I apply this same logic to Mr. █████ neuropsychological testing and criterion (ii) of the Injury Definition. The plain text of the Settlement demands that neuropsychological testing provide “evidence of a moderate to severe cognitive decline from a previous level of performance.”⁷ It also requires that the Claimant’s cognitive deficits “not occur exclusively in the context of a delirium. . . .”⁸ To be generally consistent with these rules, the examining neuropsychologist must consider a Player’s psychiatric condition and its relationship to his performance across the measured cognitive domains, just as an examining neurologist must consider its relationship to his functional impairment.

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

³ Special Master Ruling on Functional Impairment/Cognitive Decline (Sept. 7, 2021).

⁴ Special Master Ruling on Functional Impairment/Cognitive Decline (Sept. 7, 2021) at 10.

⁵ Special Master Ruling on Validity Testing (Jul. 14, 2023) at 4, https://www.nflconcussionsettlement.com/Docs/validity_testing_11_sm.pdf (citing Special Master Ruling on Pre-Diagnosis Evidence (Jul. 2, 2020) at 6).

⁶ Special Master Ruling on Functional Impairment/Cognitive Decline (Sept. 7, 2021) at 10.

⁷ Settlement Agreement, Exhibit A-1 (1)(a)(ii).

⁸ Settlement Agreement, Exhibit A-1 (1)(a)(iv).

Dr. [REDACTED] has done so here. She devoted several pages of her evaluation to Mr. [REDACTED] psychiatric history and treatment records. Doc. 241590. There is no evidence that Mr. [REDACTED] cognitive deficits occur exclusively in the context of delirium. Dr. [REDACTED] extensive description of Mr. [REDACTED] psychiatric confounding factors and conclusion that his neuropsychological testing nevertheless supports his Diagnosis was generally consistent with what the Settlement requires. And, as the AAPC has now confirmed, that articulated explanation is worthy of deference it received, notwithstanding several sharp challenges on appeal.

For example, the NFL Parties argue that because Dr. [REDACTED] completed her examination only two months after Mr. [REDACTED] was discharged from inpatient psychiatric treatment, his mental health was too unstable to yield a valid neuropsychological profile. Doc. 284605. But the AAPC, weighing in at my request, wrote that Mr. [REDACTED] “mental instability is likely to be a *trait* rather than a *state* characteristic.” Doc. 289544. It continued: “In other words, one could argue that the patient’s mental health would be optimal after being treated with supervised medication during an inpatient hospitalization. It is unclear whether testing and any other time would yield ‘more valid’ results.” *Id.* I agree.

Next, the NFL Parties point to several failed neuropsychological tests—which Dr. [REDACTED] attributed to Mr. [REDACTED] severe mental illness—as instead indicative of malingering, lack of effort, or “an uncooperative test taking approach.” Doc. 284605 at 3 (internal citation omitted). They claim that Mr. [REDACTED] performance validity testing triggers the first *Slick* criterion and undermines his Claim.⁹ *Id.* But AAPC disagreed:

Even if we grant the failure of 2/5 ACS PVT’s at the 5% base rate level, Dr. [REDACTED] is not obligated to invalidate the entire neurocognitive protocol. Yes, the patient performed very poorly on these tests, but Dr. [REDACTED] concludes, and I agree, that this is not due to malingering or lack of effort. The patient’s cognitive impairment due to his severe mental illness is responsible.

Doc. 289544 at 3. I defer to this expert medical judgment. Overall, the textual foundation for the validity testing exercise is to determine if the neuropsychological results are a “valid reflection of [Claimant’s] optimal level of neurocognitive functioning.”¹⁰ The AAPC advises that this concern is orthogonal to validity testing failures resulting from severe mental illness.¹¹

⁹ The NFL Parties allege that Dr. [REDACTED] erred in reporting that two of Mr. [REDACTED] five ACS performance validity test scores fell below the 15% base rate cut-off, and that they in fact fell below the 5% cut-off. Doc. 284605. Mr. [REDACTED] responds that it is unclear whether the base rate score or the raw score was erroneous. That dispute cannot be factually resolved as Dr. [REDACTED] lost Mr. [REDACTED] raw scores during a computer malfunction. Doc. 283793. But I agree with the AAPC that the point is ultimately irrelevant: Dr. [REDACTED] provided an articulated explanation of Mr. [REDACTED] failure of two tests, regardless of cut-off, through the lens of his mental illness. Because her reasoning is adequate and convincing, Mr. [REDACTED] testing is not invalidated by his two test failures.

¹⁰ Settlement Agreement, Exhibit A-2 (2).

¹¹ The NFL Parties also raise concerns about Mr. [REDACTED] scores on the Word Memory Test. The AAPC concluded that they misinterpreted individual scores within that test by attributing detection of inadequate effort to measures which are instead sensitive to genuine memory impairment. I again adopt this expert judgment.

The NFL Parties then focus on the second *Slick* criterion, citing Mr. [REDACTED] extremely low score on the BDAE Complex Ideational Material Test as inconsistent with his observed behavior. Doc. 284605. The AAPC agrees with the NFL Parties that such a low score usually would “signal noncooperation or low effort” in someone who, like Mr. [REDACTED] does not have aphasia. But in the context of Mr. [REDACTED] schizophrenia diagnosis, his low score is intelligible, instead, as symptomatic: “Impairment in language is a prominent feature of schizophrenia.” Doc. 289544 at 3.

Finally, the NFL Parties take issue with Mr. [REDACTED] MMPI-2-RF, which Dr. [REDACTED] invalidated because of Mr. [REDACTED] excessively fixed “true” responses. Doc. 236376. They argue that Mr. [REDACTED] score on one measure (VRIN-r) indicates that he did understand the test items and that his failure was therefore the result of “a volitional attempt to be uncooperative.” Doc. 284605 at 3. The AAPC again advises that the NFL Parties misinterpret the test’s measures, pointing to three other scores (on F scales) that were extremely elevated. Doc. 289544. Taken as a whole, says the AAPC, Mr. [REDACTED] MMPI-2-RF supports Dr. [REDACTED] decision to invalidate it not on the basis of noncooperation but because his mental illness inhibited his ability to respond to the questions. *Id.* In other words, “Although the patient is endorsing an excess of unusual and, perhaps, unlikely symptoms, there is no indication that he is intentionally being uncooperative.” *Id.* at 4. I adopt this independent advice.

The effects of mental illness on a Player’s neuropsychological testing are not clear and convincing evidence of error when, as here, the neuropsychologist has accounted for those effects in her thorough and, according to the AAPC, reasonable analysis. Mr. [REDACTED] Claim sufficiently documents impairment satisfying his Qualifying Diagnosis, notwithstanding his persistent and severe psychiatric disorder; the Settlement does not require that the acuity of the latter bar him from recovering for the former.

CONCLUSION

Because the NFL Parties have not offered clear and convincing evidence that the Claims Administrator erred, I deny their Appeal.

Date: October 16, 2023



David A. Hoffman, Special Master