

**UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA**

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

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No. 2:12-MD-02323-AB

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MDL No. 2323

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HON. ANITA B. BRODY

THIS DOCUMENT RELATES TO:
APPEAL OF SETTLEMENT CLASS
MEMBER [REDACTED]
REGARDING DENIAL OF
MONETARY AWARD

[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 Alzheimer's Disease.

The Claims Administrator denied Mr. [REDACTED] Claim because his medical records did not adequately support the conclusion that his symptoms were better explained by Alzheimer's Disease than another disorder such as depression.

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

CLAIM HISTORY

This is Mr. [REDACTED] second filed Claim.

Mr. [REDACTED] filed his first Claim in 2018. Doc. 174009. He asserted a Qualifying Diagnosis of Level 2 Neurocognitive Impairment dated January 31, 2018 and certified by MAF Neurologist Dr. [REDACTED]. *Id.* Over the next four years, from 2018 until 2022, Mr. [REDACTED] and his counsel thoroughly litigated this Claim.¹ Ultimately, on July 27, 2022, after multiple rounds of denials, appeals, and remands, Judge Brody denied Mr. [REDACTED] remaining objections and affirmed the (third) denial of his Claim. Doc. 267474.

Less than a year later, Mr. [REDACTED] began pursuing his current Claim for a Qualifying Diagnosis of Alzheimer's Disease.

¹ For a more detailed account of this sequence of events, see Docs. 225185 at 2; 267474 at 1-3.

On May 10, 2023, MAF Neurologist Dr. [REDACTED] evaluated Mr. [REDACTED] Doc. 328366. As part of his evaluation, Dr. [REDACTED] administered a Mini Mental State Examination (MMSE). *Id.* at 3. Mr. [REDACTED] received an MMSE score of 8/30, which represented “a severe degree of impairment.” *Id.* Dr. [REDACTED] also assessed CDR scores of 3.0 in Community Affairs, 3.0 in Home & Hobbies, and 3.0 in Personal Care. *Id.* at 8.

In his report, Dr. [REDACTED] first summarized Mr. [REDACTED] existing medical records:

Initial Neurological Evaluation Note dated 10/28/2010 by [REDACTED], MD

At the time of this evaluation, the patient reported constant tinnitus and headaches and noted that the headaches began one year after starting to play in the NFL. He also noted difficulty falling and staying asleep and problems with memory, concentration, and focus. On exam, he scored 30/30 on the mini mental status exam (MMSE) and the remainder of the examination was reported as being within normal limits (WNL). Diagnoses were as follows: 1. Post traumatic headache syndrome 2. Disorder of sleep and arousal. He was considered at 7% whole person impairment and with a Clinical Dementia Rating (CDR) of 0.5. The plan was to perform a sleep study, brain MRI, and monitor his memory difficulties.

Initial Neurological Evaluation Note dated 01/13/2018 by [REDACTED], MD
Patient presented with a chief complaint of severe decline in cognitive function. Reported were poor memory, severe headaches, disorientation, and lack of interest in his daily activities and leaving his home. On examination the patient was reported to have limited neck ROM and cervical paraspinal tenderness and spasm and on the MMSE he scored 25/30. The CDR score was 2.0 and was diagnosed with a level 2 neurocognitive impairment rating.

Third Party Statement dated 10/22/2018 by [REDACTED]

The third-party statement requested that there be a review of functioning in community affairs, home & hobbies, and personal care. Mr. [REDACTED] had been a friend for the past 12 years since the time they became neighbors. He reported seeing the patient decline over the past 10 years. In the area of community affairs, Mr. [REDACTED] noted that the patient had lost interest in attending events outside of his home. For example, he stopped attending BBQs at Mr. [REDACTED] home to watch football games. He also noted a decrease in his driving requesting that Mr. [REDACTED] do all the driving. Prior to the decline, the patient never refused an invite or failed to attend a football-related gathering with his friend. As far as personal care, Mr. [REDACTED] reported a decreased interest in his grooming and appearance over the prior 3 years. Mr. [REDACTED] also noted memory decline affecting his overall grooming and ability to carry on a conversation as well.

Third Party Statement dated 05/04/2023 by [REDACTED]

Mr. [REDACTED] stated that he has been friends with the patient since childhood and they attended the same high school. Over the past 10 years, Mr. [REDACTED] noted a decrease in attendance of events outside the home and over the past 6-7 years becoming “isolated from society.” Mr. [REDACTED] stated that his mental functioning and processing had been declining and observed that he lacked the assistance and support to maintain his home.

The patient was reported to not have driven a car over the past 5 years getting lost even within the neighborhood. He had also lost his ability to be gainfully employed, shop, and maintain healthy relationships with his wife and friends. He had stopped cleaning after himself and performing basic household chores such as taking out the garbage, yard work, and home repairs. He no longer cared about his appearance and went days without showering or changing his clothes. He was unable to shave safely and Mr. [REDACTED] or his wife would assist with this. Furthermore, the patient told his friend that he was having problems with occasional bed-wetting.

Employment History and Social and Community Activity Form by a Knowledgeable Informant, younger brother, [REDACTED], dated 05/03/2023

The form requested that the informant provide information regarding the patient’s employment history over the past 5 years and it was responded that the patient had no employment history during this time period. Furthermore, in terms of social and community activity, the informant reported that the patient had not driven a car over the past 5 years and had not attended social activities.

Id. at 1-3 (emphasis in original).

Next, Dr. [REDACTED] described Mr. [REDACTED] “physical, neurocognitive, and neurobehavioral symptoms”—including those that Mr. [REDACTED] reported and those that Dr. [REDACTED] directly observed:

Physical

- problems with balance affecting his ability to perform his ADLs
- headaches

Neurocognitive

- diminished ability to communicate
- inability to watch and follow movies, an activity previously enjoyed
- inability to drive
- psychomotor slowing with decrease in processing speed and reaction time
- diminished memory

Neurobehavioral

- limited interaction with family and friends not leaving his house to visit them
- increased frustration over the loss of interests and abilities
- fearful and anxious with daily panic attacks
- avoidant behavior and social isolation
- hypervigilant
- apathetic
- restlessness

Id. at 3.

Dr. [REDACTED] noted that Mr. [REDACTED] had a past diagnosis of “[d]epression.” *Id.* at 4. Similarly, Dr. [REDACTED] described Mr. [REDACTED] as exhibiting a “[d]ysthymic mood visibly vegetative and depressed.” *Id.* at 7. Even so, Dr. [REDACTED] concluded:

The patient meets all six criteria for a major neurocognitive disorder per DSM-V criteria. The first criterium involves **complex attention**. The patient is unable to hold information presented to answer simple questions or carry on a conversation. This was clear during the interview with delayed processing speed as well as pauses with initiation and between words when answering questions. His **executive abilities** have substantially declined as well. He needs assistance with the completion of ADLs and is unable to live independently. The patient’s **memory** is limited for recent and remote recall. Noted unable to provide an adequate history of his football career in college or in the NFL and not even recall if he enjoyed playing the game. The patient was also unable to recall three objects on the MMSE examination. Clear **language** limitations were present with the use of few words, need to repeat simple questions, and pauses between words. In the area of **visual perception**, the patient has not been able to drive for several years and needs to rely on others for transportation. Noted are psychomotor slowing and delayed reaction time impeding his ability to drive safely. Finally, **social cognition** was difficult to assess with the patient’s limited use of words and insight. However, it is reported that he rarely leaves his home and, again, requires assistance for the completion of ADLs such as dressing.

[...]

Given this presentation, the patient qualifies for the diagnosis of major neurocognitive disorder, likely Alzheimer’s type. To this end, Amyloid and Tau protein PET scans are being requested which are often positive in Alzheimer’s dementia.

There are no confounding factors, such as substance abuse, alcoholism, or history of stroke(s), that are attributable to the symptomatic findings in this patient. Furthermore, there are no other degenerative neurocognitive diseases with a configuration of symptoms that would explain those exhibited by the patient.

Since his previous neurological examination in 2018, the patient has continued to progressively decline. This is evidenced by his complete inability to now provide any history regarding his college and football career, loss of contact with his children, other family members, and friends, and MMSE score of 8/30 versus 25/30 in 2018. A score of 25 is indicative of mild cognitive impairment while 8 is consistent with severe impairment. Therefore, the severity of his neurocognitive disorder prohibits neuropsychological testing and would lead to invalid results.

Id. at 7-8.

On March 13, 2024, Mr. [REDACTED] received the brain scans that Dr. [REDACTED] had requested. Doc. 328373. In the accompanying report, the attending physician—Dr. [REDACTED]—wrote that the “[f]indings may be related to traumatic brain injury, however cannot exclude superimposed frontotemporal pattern of dementia.” *Id.* at 2.

Upon review, Dr. [REDACTED] added an addendum to his original report confirming his earlier conclusions:²

FDG PET scan confirms severity in decline of metabolism consistent with his clinical neurological examination. Based upon DSM-V criteria, he meets the required criteria for Alzheimer's dementia. He has significant cognitive impairment together with very severe decline in his ability to complete Activities of Daily Living and in his ability to function independently in the community. Given his young age and history of repeated concussion/TBI, he meets criteria for severe dementia likely of the Alzheimer's type based upon the pattern of fronto-temporal involvement on PET scan and clinical neurological examination.

Doc. 328366 at 9.

Shortly thereafter,³ Dr. [REDACTED] certified a Qualifying Diagnosis of Alzheimer's Disease, dating it to Mr. [REDACTED] initial evaluation on May 10, 2023. Docs. 328360; 328376. With this Diagnosis in hand, Mr. [REDACTED] filed his Claim on May 22, 2024. Doc. 330054.

On June 26, 2024, the Claims Administrator informed Mr. [REDACTED] that it was seeking input from the Appeals Advisory Panel Leadership Council (AAPLC). Doc. 345726. It conveyed that

² While Dr. [REDACTED] did not date this addendum, it was presumably added between March 13, 2024, the date of the brain scans, and April 18, 2024, the date Dr. [REDACTED] certified the Diagnosis.

³ Dr. [REDACTED] signed two MAF Diagnosing Physician Certification Forms, one on April 18, 2024 and the other on May 20, 2024. Docs. 328360; 328376. There is no meaningful difference between them.

feedback to Dr. [REDACTED] on August 26, 2024 and requested that he provide an addendum further explaining his reasoning:

Please review the feedback provided below by one of our Appeals Advisory Panel Leadership Council (AAPLC) neurologists and provide an addendum addressing the following: (1) Provide your articulated medical reasoning for excluding other causes such as depression/major depressive disorder, insomnia, and pain in the Player's cognitive and functional decline. (2) Provide your articulated medical reasoning for excluding the alternative diagnoses of traumatic brain injury and frontotemporal dementia identified by Dr. [REDACTED] PET scan; and (3) How a steadily progressive gradual decline in cognition without extended plateaus was established when the functional deficits reported from 2018 to 2023 are more similar than different.

The clinical history and findings reported by Dr. [REDACTED] are insufficient to support a valid diagnosis of Alzheimer's disease. There are clearly described findings consistent with major depressive disorder. The PET scan findings are more highly consistent with depression and past brain trauma than Alzheimer's disease and the official interpretation does not mention AD; these facts are omitted from the medical decision making. Also the roles of insomnia and pain (as described as early as 2010) on cognitive and functional losses are not addressed. Symptoms and functional losses rated as consistent with moderate dementia were reported in 2018, with a symptom duration of 10 years. A similar level of disability is reported in 2023. Therefore, the rapidly progressive course of decline expected with early onset Alzheimer's disease (with symptom onset at around age 36) is not evident. In the absence of other measures of symptom and performance validity, cognitive screening tests like the MMSE is insufficient to stand alone as a valid measure of progression.

Doc. 355399 at 2.

Dr. [REDACTED] responded to the Claims Administrator's request on January 6, 2025 with a brief addendum reaffirming his Diagnosis of Alzheimer's Disease:

The diagnosis of Alzheimer's disease is a clinical diagnosis and can only be confirmed at autopsy. There remains significant controversy in neuroscience literature regarding differentiation of Alzheimer's diseases from other forms of dementia. Unfortunately, MAF criteria in concluding Alzheimer's disease versus other forms of dementia remains challenging.

As clinical measures and standards are in keeping with the basic presentation of the patient, there is no other option than making a diagnosis of Alzheimer's disease (AD) once other forms of dementia have been ruled out. Using DSM-V criteria and Clinical Dementia Rating and abnormal PET scan with elevated Tau protein (more commonly associated with AD secondary to TBI) and amyloid protein (associated with AD and TBI), on a diagnostic basis given the young age of this patient, the diagnosis is most consistent with Alzheimer's disease due to traumatic brain injury (TBI).

Clinical features of depression and insomnia are often seen in patients with AD. Regardless of whether this is situational versus part of AD, it is difficult to attribute this to a mental health disorder given the clinical course. Rapid progression of AD is secondary to the young age of this patient.

In this setting with the severity of impairment, it is not so remarkable that there is the inability to obtain valid neuropsychological testing. The diagnosis of AD is not limited to the results of the Mini Mental Status Examination (MMSE); limited neuropsychological data, clinical examination, history of the patient, and third-party statements were also utilized in making the Alzheimer's disease diagnosis.

Doc. 372489.

Upon review of Mr. [REDACTED] entire medical file, including this latest addendum, the AAP concluded that Dr. [REDACTED] Diagnosis of Alzheimer's Disease did not meet the requirements for such a diagnosis as outlined in the ICD-10 and the DSM-5. Doc. 375330. The AAP report—dated January 26, 2025—began by summarizing those requirements: “Paraphrased, [the ICD-10 and the DSM-5] require the presence of a dementia syndrome affecting two or more domains of cognition and/or behavior, a steadily progressive course of cognitive and functional decline, and exclusion of other causes of the clinical syndrome.” *Id.* Applied to Mr. [REDACTED] medical records, the AAP explained:

The player has longstanding concerns of impaired cognition, dating to at least 2011 when he reported complaints of difficulty with memory, concentration, and mental focus to Dr. [REDACTED]. The player achieved an MMSE score of 8/30 with Dr. [REDACTED] in 2023. Prior MMSE scores were 30/30 in 2011 and 23/20 in 2018. These scores would nominally fulfill the criteria for a progressive decline in cognition, but limited task engagement appears to adversely affect the 2023 score.

Dr. [REDACTED] reported that impaired balance affected the player's abilities to conduct daily activities. A third-party statement from 5/4/23 identified losses in daily function including home and hobby, community affairs and self-care. A third-party statement from 2018 identified similar losses and behavioral patterns. Apathy and lack of motivation are prominently described in both statements, but cognitive

losses as the basis of the declines in function are not identified. An overt pattern of progressive losses between the two third party assessments is not supported.

In 2023 Dr. [REDACTED] also describes decreased processing speed, response latency, reduced mental flexibility, limited speech production, and limited social engagement. Notably, Dr. [REDACTED] describes the player as “visibly vegetative,” anxious, depressed, and demonstrating restricted range of affect. Therefore, neither Dr. [REDACTED] 2023 documentation nor his 2025 addendum provides a reasonable basis to exclude other causes of the clinical syndrome. Dr. [REDACTED] evaluation in 2010 found sleep disturbance and excessive fatigue. Dr. [REDACTED] does not address these. Dr. [REDACTED] own documentation fulfills criteria for a DSM-5 diagnosis of Major Depressive Disorder. His records include descriptions of 1) depressed mood, 2) apathy, 3) insomnia, 4) psychomotor retardation, and 5) diminished ability to think or concentrate. The lack of a knowledgeable informant at the 2023 evaluation means information potentially important to medical decision-making regarding observations cognition, mood, motivation, and sleep was not available.

Furthermore, the FDG-PET scan of the brain obtained in 2024 was interpreted as consistent with past traumatic brain injury or frontotemporal dementia. The interpreting nuclear medicine specialist did not mention Alzheimer’s disease in the interpretation. Dr. [REDACTED] statement regarding PET scan results with elevated Tau and amyloid protein is irrelevant in this player’s situation because FDG-PET does not show those pathologies, and no documentation of tau or amyloid PET scans is identified in the available records.

Conclusion: The claim for Alzheimer’s disease is not supported by the available documentation. The evidence does not demonstrates a steadily progressive course of objective cognitive and functional decline. The third-party statements of 2018 and 2023 identify losses that are more similar than different. Symptoms of Major Depressive Disorder are clearly documented and supported by the third-party statements; these provide a better explanation for the overall syndrome.

Id. (emphasis in original)

Relying on the AAP’s findings,⁴ the Claims Administrator denied Mr. [REDACTED] Claim on March 28, 2025. Doc. 385368. Mr. [REDACTED] timely appealed. Doc. 393796.

RESOLVING THIS APPEAL

The record is dense and in parts repetitive, but its basic conflict is straightforward: Dr. [REDACTED] reads the medical history as evidence of a progressive neurodegenerative disease, while the

⁴ Indeed, the Claims Administrator quoted almost the entire AAP report in its Notice of Denial. *Compare* Doc. 375330, *with* Doc. 385368.

AAP finds the documentation more consistent with depression and without clear evidence of progression. The issue before me is factual—whether this record sufficiently supports a qualifying diagnosis under the Settlement.

To prevail on appeal, Mr. [REDACTED] must show by clear and convincing evidence that the Claims Administrator’s denial was in error. His argument has two prongs. First, he thinks that the Claims Administrator improperly applied the DSM-5 standard, rather than the DSM-5-TR. Second, he argues that Dr. [REDACTED] Diagnosis of Alzheimer’s Disease represents a documented, articulated medical judgment, and therefore, the Claims Administrator should have given it greater deference. I will consider each issue in turn.

1. DSM-5 vs DSM-5-TR

The Settlement’s injury definition for Alzheimer’s Disease states: “For living Retired NFL Football Players . . . a diagnosis of Major Neurocognitive Disorder due to probable Alzheimer’s Disease as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).”⁵

Earlier this year, the District Court asked me to determine whether the “reference to the ‘DSM-5’ mean[s] the current version of the DSM-5—called the ‘DSM-5-TR’—which includes text revisions that postdate the Settlement’s formation? Or does ‘DSM-5’ mean only those diagnostic techniques found in the precise text operative as of the Agreement’s effective date, at least until the parties agree otherwise?”⁶

In my March 10, 2025 responsive opinion, I concluded “that ‘DSM-5’ in the Settlement means the most current version of the DSM-5, text revisions included.”⁷ But relying on guidance from the AAPLC, I found that “this particular text revision require[d] no change to the Program’s diagnostic practices.”⁸ As I explained:

Under the AAP’s settled approach, the examining physician must determine that Alzheimer’s Disease, not depression or any other concurrent condition, is the predominant reason for a Player’s cognitive decline, because that’s what defines the disease itself. That is the process still required by Criterion C of the Alzheimer’s definition in the DSM-5-TR. The latest DSM-5-TR thus crystalizes the Program’s diagnostic status quo, eliminating even the appearance of tension between the Long Form Notice and the Injury Definitions.

[. . .]

⁵ Settlement Agreement, Exhibit A-1 (3)(a).

⁶ Special Master Ruling on Alzheimer’s Disease Diagnosis Criteria, at 1 (Mar. 10, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_criteria_sm.pdf.

⁷ *Id.* at 3.

⁸ *Id.*

In other words, the DSM-5-TR's recent edit recognizes that "ruling out" alternative etiologies is not sensible. Rather, the DSM-5-TR codifies what the AAPLC has sought in review and almost all MAF physicians have long been providing: documentation explaining why Alzheimer's is the better explanation for what a doctor is seeing in cases where many potential pathologies are present. Conforming the DSM-5's text to the best medical practice, the DSM-5-TR requires no change to our primary diagnostic systems or to what the Claims Administrator does on review.⁹

In Mr. ██████ case, a hotly contested question is the degree to which his depression (and other non-Alzheimer's pathologies) is responsible for the symptoms that Dr. ██████ observed. As my March 10, 2025 opinion clarified, the proper terminology when conducting this inquiry is whether Alzheimer's Disease is the "better explanation" or the "predominant reason" for a Player's cognitive decline.¹⁰ But again, the nature of the inquiry itself did not change on March 10, 2025. The practices endorsed by the DSM-5-TR were already in effect under the Program's settled approach.

Here, the AAP report is dated January 26, 2025, roughly a month and a half before my March 10, 2025 opinion was published. Doc. 375330. While the Notice of Denial came a few weeks after, on March 28, 2025, it largely quotes that earlier AAP report. Doc. 385368. The result, as Mr. ██████ points out, is that the AAP—at times—uses the arguably outdated language of "exclusion" in reference to Mr. ██████ depression. Docs. 375330; 385368.

But the occasional use of this language is not clear and convincing evidence of error in the Claims Administrator's ultimate judgment. Mr. ██████ has not shown that the AAP and Claims Administrator's review process strayed from the Program's settled approach in any meaningful way. Nor could he, as the AAP report (and hence, the Notice of Denial) employs the proper standard in its concluding and summative paragraph: "[Mr. ██████ [s]ymptoms of Major Depressive Disorder . . . provide a *better explanation* for the overall syndrome." *Id.* (emphasis added). This is yet more evidence that formally applying the DSM-5-TR wrought no substantive change at all to the Program's diagnostic approach. As the Claims Administrator's denial ultimately applied the appropriate "better explanation" standard, Mr. ██████ has no basis for reversal or remand.

2. Deference

It is often the case that a Player who receives a Diagnosis of Alzheimer's Disease will also show signs depression or other similar pathologies.¹¹ For that reason, "the presence of depression

⁹ *Id.* at 17-18 (quoting Special Master Ruling on Mixed Etiology for Alzheimer's Disease Diagnosis, at 5 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf) (cleaned up).

¹⁰ *See id.* at 20 ("These are two verbal formulations of the same substantive criterion.").

¹¹ *See* Special Master Ruling on Mixed Etiology for Alzheimer's Disease Diagnosis, at 5 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf ("Alzheimer's is a terrible, wasting disease which may be co-morbid with, or even cause, depression.").

alone cannot and does not preclude an Alzheimer's Diagnosis."¹² Rather, the Player must satisfy the DSM-5-TR's requirement that "[t]he disturbance is not better explained by cerebrovascular disease, another neurodegenerative disease, the effects of a substance, or another mental, neurological, or systemic disorder."¹³ In other words, "while [Dr. █████] was not required to rule out depression in his diagnosis of [Mr. █████] he did need to explain why Alzheimer's Disease, not depression, was the better explanation for [Mr. █████] symptoms."¹⁴

To that end, Mr. █████ is correct in observing that "[w]hen examining physicians document the bases for their judgment that Alzheimer's is the predominant reason for cognitive decline, the Claims Administrator will ordinarily defer to them."¹⁵ But when—as is the case here—a physician's explanation is "woefully deficient,"¹⁶ then it does not "merit that same deference."¹⁷ The Program's review process assumes deference only where the physician's reasoning is sufficiently articulated to allow verification; when it is not, the Claims Administrator's evaluation controls. While Mr. █████ touts Dr. █████ nine-page report and later addendum as evidence of this documentation, neither meaningfully accounts for Mr. █████ depression when making his Diagnosis.

During the May 10, 2023 evaluation, Dr. █████ wrote that Mr. █████ was "[f]eeling nervous, anxiety, depression, and insomnia," and described his mood as "[d]ysthymic mood visibly vegetative and depressed." Doc. 328366 at 5, 7. His report includes depression both in the list of past medical diagnoses and in the list of assessments. *Id.* at 4, 7. But several pages later, when diagnosing Mr. █████ with "major neurocognitive disorder, likely Alzheimer's type," Dr. █████ made no mention of depression and expressly denied the relevance of any other factors or diseases: "There are no confounding factors, such as substance abuse, alcoholism, or history of stroke(s), that are attributable to the symptomatic findings in this patient. Furthermore, there are no other degenerative neurocognitive diseases with a configuration of symptoms that would explain those exhibited by the patient." *Id.* at 8.

Naturally, this prompted AAPLC concern. Yet, when the Claims Administrator explicitly requested that Dr. █████ provide his "articulated medical reasoning" regarding Mr. █████ depression, all Dr. █████ wrote was:

Clinical features of depression and insomnia are often seen in patients with AD.
Regardless of whether this is situational versus part of AD, it is difficult to attribute

¹² *Id.*

¹³ AMERICAN PSYCHIATRIC ASSOCIATION, *DSM-5-TR® Update: Supplement to Diagnostic Manual of Mental Disorders, Fifth Edition, Text Revision*, at 11 (Sept. 2024), <https://www.psychiatry.org/getmedia/2ed086b0-ec88-42ec-aa0e-f442e4af74e6/APA-DSM5TR-Update-September-2024.pdf>.

¹⁴ Special Master Ruling on Alzheimer's Disease Diagnosis Criteria, at 19 (Mar. 10, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_criteria_sm.pdf.

¹⁵ *Id.* at 17.

¹⁶ *Id.*

¹⁷ Special Master Ruling on Mixed Etiology for Alzheimer's Disease Diagnosis, at 6 (July 16, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=alz_diagnosis_sm_3.pdf.

this to a mental health disorder given the clinical course. Rapid progression of AD is secondary to the young age of this patient.

Doc. 372489.

This offers no meaningful explanation. Dr. [REDACTED] addendum does nothing to explain *why* Mr. [REDACTED] “clinical course” makes it “difficult to attribute [his symptoms] to a mental health disorder.” As such, Dr. [REDACTED] has failed to meet the requirement that he explain why Alzheimer’s Disease, not depression, provides the better explanation for Mr. [REDACTED] cognitive decline. Left with nothing substantive to defer to, the Claims Administrator’s reliance on the AAP’s reasoned conclusion—that Major Depressive Disorder better explains Mr. [REDACTED] symptoms—was not in error. The denial thus reflects the ordinary operation of the Settlement’s evidentiary framework, not a new interpretation of it.¹⁸

CONCLUSION

The Claims Administrator concluded that Mr. [REDACTED] failed to satisfy the requirements for a Diagnosis of Alzheimer’s Disease and denied his Claim. Since Mr. [REDACTED] has not shown that this determination was in error at all, let alone by clear and convincing evidence, I deny his Appeal.

Date: November 11, 2025



David A. Hoffman, Special Master

¹⁸ Mr. [REDACTED] also objects to the Claims Administrator’s conclusion—adopted directly from the AAP report—that “Dr. [REDACTED] statement regarding PET scan results with elevated Tau and amyloid protein is irrelevant in this Player’s situation because FDG-PET does not show those pathologies, and no documentation of tau or amyloid PET scans is identified in the available records.” Doc. 385368. On appeal, Mr. [REDACTED] continues to maintain that his brain scan showed “elevated tau and amyloid proteins.” Doc. 393793 at 2, 6, 8. The AAP advises to the contrary. While Dr. [REDACTED] did apparently order “Amyloid and Tau protein PET scans,” the only scan that Mr. [REDACTED] actually received was an FDG-PET scan. Doc. 328366 at 8-9. As the AAP noted, an FDG-PET scan “does not show” amyloid and tau proteins. Doc. 375330. It is no surprise, therefore, that the report accompanying Mr. [REDACTED] FDG-PET scan makes no mention of amyloid or tau proteins. Doc. 328373. It is not clear why or how Dr. [REDACTED] could made a judgment based on Mr. [REDACTED] “abnormal PET scan with elevated Tau protein . . . and amyloid protein.” Doc. 372489. I rely on the AAP’s judgment in concluding that there are no biomarkers in the medical files supporting the asserted diagnosis.