

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

Appeal 2026-5

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

Thank you for providing the UPDRS motor exam score sheet. It appears that the exam was done approximately 4 hours after the player's last dose of carbidopa/levodopa (2 PM dose, 6 PM exam).

The score sheet gives two sets of values for both columns "on" and "off" despite what appears to be a single exam. Please clarify.

Although the narrative portion of your exam makes no comment regarding tremor, noting no abnormal movements of the right leg, the UPDRS reports a slight to mild tremor in both legs that is greater on the right. The narrative of your exam also states that tone is normal in the left leg, while your UPDRS indicates mild to moderate rigidity. Please clarify.

Doc. 408778.

Two weeks later, Dr. [REDACTED] responded:

Re the on/off measurements on UPDRS, with this patient I only did one examination with him in the on state (as much as he could be) or [sic] the PURPOSES of the UPDRS. The "off" segment was based on the patient/player's own report of his condition. There were only slight differences, and both columns indicated the presence of likely Parkinson's disease.

You also noted some distinctions in my narrative report that are of a subtle nature. He did not complain of lower extremity tremor, which indicates that he was unaware of the tremor I noted in the UPDRS. The situation is fairly common in Parkinson's disease patients. A similar situation exists re the differences in rigidity complained of and seen in my narrative report/examination. The examination section of my note does not indicate he had normal tone in the legs, because he did not have normal tone. The UPDRS report indicates he did have rigidity in his legs. I should have noted the presence of rigidity in both sections of the report.

Doc. 410315.

On November 6, 2025, the Claims Administrator notified Dr. [REDACTED] that he had been terminated from the MAF Program. It had concluded that his diagnostic practices too often did not follow the Program's requirements, and its attempts to train him to conform his analyses to the Settlement's Injury Definitions had been unavailing.

On December 4, 2025, the Claims Administrator denied Mr. [REDACTED] Claim. It offered a fulsome explanation:

The Player was evaluated by the MAF neurologist, Dr. [REDACTED] on 7/21/2025, and was diagnosed with Parkinson's Disease with a diagnosis date of 8/29/2024.

The Rules Governing Qualified MAF Physicians provide the Claims Administrator with the discretion to have members of the Appeals Advisory Panel (AAP) Leadership Council review claims based on diagnoses made by Qualified MAF Physicians to determine whether the diagnoses comply with the Settlement Agreement and the Rules Governing Qualified MAF Physicians. Under this authority, we sought input from a member of the AAP Leadership Council (AAPLC) for a medical opinion regarding the diagnosis.

The Settlement Agreement mandates the Qualifying Diagnosis of Parkinson's Disease to be made "as defined by" ICD-9 or ICD-10. However, the ICD system provides classifications rather than diagnostic criteria. The Settlement Agreement's definition also includes the diagnosis of Major Neurocognitive Disorder probably due to Parkinson's Disease, as defined in the DSM-5. A diagnosis of Major Neurocognitive Disorder probably due to Parkinson's Disease cannot be made in the absence of a prior diagnosis of Parkinson's Disease.

The general US standard for a diagnosis of Parkinson's Disease at the time of the Settlement Agreement negotiations was the "Gelb Criteria" (Gelb DJ et al. Arch Neurol 1999; 56:33-9), which were adopted by the Special Master in a 1/16/2024 decision. These are based on identifying four primary clinical features by history and examination. These are resting tremor, rigidity, bradykinesia and asymmetric onset. Three features must be present to establish a diagnosis of probable Parkinson's Disease. Additional clinical findings can further support the diagnosis including, but not limited to, hypomimia, shuffling gait, reduced stride length, postural instability, and response to dopaminergic pharmacotherapies. As a neurodegenerative disease, insidious onset and progressive worsening of the clinical features are typical.

The AAPLC member first reviewed the file in September 2025 and determined that there were inconsistencies between the narrative portion of the report and the UPDRS motor exam score sheets in rating of severity that needed to be clarified prior to a determination. Additionally, although the MAF evaluation notes that the Player was previously diagnosed with Parkinson's Disease by both Dr. [REDACTED] and Dr. [REDACTED], there was no stated rationale for using the initial evaluation by Dr. [REDACTED] as the claimed diagnosis date. The documentation by Dr. [REDACTED] on the claimed date of diagnosis, nor on any of the follow up visits or documentation by Dr. [REDACTED] support a Qualifying Diagnosis of Parkinson's Disease using the Gelb criteria.

The Claims Administrator contacted Dr. [REDACTED] on 10/2/2025 to address the issues identified above. Dr. [REDACTED] clarified that only a single examination of the Player occurred four hours after taking medication. Although the UPDRS motor exam score sheet is clearly intended to capture exam related information, the MAF

Physician inappropriately entered historical information without identifying it as such in the OFF column. In an attempt to clarify inconsistencies between the narrative portion of the neurological exam and the UPDRS score sheet, Dr. [REDACTED] conflated historical information with exam documentation. In an attempt to clarify why the narrative portion of his exam narrative made no comment regarding tremor or abnormal movement of the right leg, while the UPDRS reported a slight-mild tremor in the right leg that is greater on the left, Dr. [REDACTED] noted that since the Player did not complain of a lower extremity tremor, and thus was unaware of it, it was only observed and documented in the UPDRS. However, the fact that the Player may be unaware of a leg tremor or rigidity has no bearing on why neither tremor nor rigidity of the legs was reported in the narrative account of the exam and raises concerns about the reliability of exam documentation.

This concern is heightened by the fact that the UPDRS-OFF motor score sheet indicates leg tremor, even though Dr. [REDACTED] stated this is based on the Player's own report of a tremor, of which he was previously noted to be unaware. Dr. [REDACTED] also clarified the examination section of his note omitted the presence of rigidity in the Player's legs. The statement in the Neurology/Spine exam LLE (left lower extremity) followed by "normal tone" is another documentation error. These clarifications appear to be on the basis of the MAF neurologist's best recollection of an exam over two months before, which also makes the additional information of limited value.

It appears that the UPDRS score sheet ON column is the most reliable account of the Player's exam findings. This score sheet indicates a tremor that has equal severity at both rest and with action is not typical of the primarily resting tremor of Parkinson's Disease, so that this Gelb criterion is not fulfilled. The medical records as a whole, including the UPDRS score sheet, support the Gelb criteria of bradykinesia and rigidity. However, the inconsistencies in historical information regarding the onset of tremor do not support fulfillment of the Gelb criterion of asymmetric onset. The severity of the exam while under treatment with carbidopa/levodopa also does not support the Gelb criterion of a clear and sustained response to dopaminergic therapy.

The Special Master's 7/1/2025 Decision explains that, in the context of the system of layered deference which guides the Settlement Program, it is easy for the AAP to defer to a neurologist who carefully relays their observations from a patient's physical exam in their notes, and who has had multiple visits. It is hard if not impossible to defer and approve a diagnosis when that same neurologist simply relays the views of others, who may or may not be trained, and may or may not be talking about those diagnostic signs the Gelb criteria make stigmatic. This deference cannot be extended here because of the concerns about the reliability of exam documentation and reliance on non-MAF approved providers' prior diagnoses.

At this time, the medical records as a whole, including the recently added documentation, do not support the claimed diagnosis of probable Parkinson's Disease using Gelb criteria. As noted earlier, the documentation by the non-MAF neurologists is not adequate to support the Qualifying Diagnosis or the claimed date of diagnosis of 8/29/24

Doc. 416234 (additional line breaks added for clarity).

Mr. [REDACTED] timely appealed this Denial.

RESOLVING THIS APPEAL

Mr. [REDACTED] argues that the Claims Administrator wrongly denied his claim. Though he acknowledges “documentation inconsistencies” in the file, he asserts that Dr. [REDACTED] contemporaneous exam sufficiently supports a Qualifying Diagnosis using the Gelb Criteria. He also alleges that the Claims Administrator inappropriately discounted Dr. [REDACTED] judgment, as well as those of his prior diagnosing physicians.

Mr. [REDACTED] arguments are primarily buttressed by a short letter from Dr. [REDACTED] whose letterhead describes his practice as “forensic neurologic services,” and notes the participation of a “legal assistant,” [REDACTED]. In that letter, Dr. [REDACTED] generally describes two exams of Mr. [REDACTED] in January and March 2025, and reiterates his view that Mr. [REDACTED] suffers from Parkinson's Disease.

As I wrote in September 2025, Mr. [REDACTED] burden on appeal is heavy: he must show that “the medical records he appended to his Claim so obviously meet[] the requirements for a Qualifying Diagnosis of Parkinson's Disease that it was ‘reasonably certain’ that any contrary conclusion must be a mistake.”¹ And, as I have explained:

[T]he Settlement works best when the Claims Administrator and its advisory experts are able to defer to treating physicians' reasoned diagnostic practices, which in turn requires those physicians to create contemporaneous records which fully and adequately capture the factual bases for their diagnoses.²

Here, as the Denial Notice explained in painstaking detail, there are material inconsistencies within Dr. [REDACTED] contemporaneous findings which make them unreliable records of Mr. [REDACTED] symptoms. The Claims Administrator, properly applying the Program's system of layered deference, asked Dr. [REDACTED] for clarification of his views, and found his response wanting. Nothing in the Appeal rebuts those conclusions or identifies any deviation from the

¹ Special Master Ruling on Parkinson's Disease and Deference, at 5-6 (Sept. 15, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=pd_deference_sm.pdf.

² Special Master Ruling on Parkinson's and Deference, at 11 (July 1, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=parkinsons_disease_deference_sm.pdf.

Program's regular processes. I adopt the AAPC's view (incorporated in the Denial) that the records do not sufficiently support the asserted Qualifying Diagnosis.

The documentation provided by Dr. [REDACTED] on appeal does not come close to unsettling the Claims Administrator's judgment. Indeed, the letter raises new red flags which validate precisely why a non-Program, non-treating physician's letter on appeal "is entitled to no weight . . . let alone weight sufficient to demonstrate clear and convincing evidence of error."³ Dr. [REDACTED] writes in his capacity as a forensic neurologist, and appears to be engaged in a business making diagnoses for various medical/legal systems. I do not know what role, if any, his "legal assistant" plays in writing these letters. Dr. [REDACTED] appears to be unfamiliar with the Program's practices of review, or anti-influence rules. Neither the Appeal nor Dr. [REDACTED] himself disclose how much he was paid to make the original diagnosis or write the later letter.

This non-treating, "forensic," foundation for Mr. [REDACTED] diagnosis raises serious concerns, as it appears to arbitrage around the careful rules governing the conduct of MAF and BAP neurologists. Ultimately, Dr. [REDACTED] report is not the product of an ordinary course of treatment in a neurologist's office, but rather two privately-paid visits that appear to have been scheduled for the purposes of creating a record that a Program doctor could then rely upon. Even were Dr. [REDACTED] report to be otherwise internally coherent, his reliance on Dr. [REDACTED] views would have materially (if not entirely) undermined his conclusions.⁴

I'm charged to evaluate whether the records Mr. [REDACTED] submitted in 2025 sufficiently evidenced a Qualifying Diagnosis under the Settlement to justify a payable award. The Claims Administrator concluded they did not, and the Settlement Agreement instructs me to sustain that finding unless there is clear and convincing record evidence that the Administrator's judgment was erroneous. No such evidence exists.

I find as a matter of fact that Mr. [REDACTED] has not met his burden of demonstrating his entitlement to an Award. He remains free to submit a new Qualifying Diagnosis in the future.

CONCLUSION

I deny Mr. [REDACTED] appeal.

Date: March 23, 2026



David A. Hoffman, Special Master

³ Special Master Ruling on Parkinson's Disease and Deference, at 7 (Sept. 15, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=pd_deference_sm.pdf.

⁴ Special Master Ruling on Parkinson's and Deference, at 10, n. 9 (July 1, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=parkinsons_disease_deference_sm.pdf.