

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

Appeal 2026-9

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

Special Masters denied all 153 Claims relying on Dr. [REDACTED] testing, including Mr. [REDACTED]. *Id.* at 1.

Mr. [REDACTED] filed his second Claim on April 12, 2018, again asserting a Diagnosis of Level 2 Neurocognitive Impairment, this time through the MAF. Doc. 167132. Then-Qualified MAF Neurologist Dr. [REDACTED], with support by neuropsychologist Dr. [REDACTED], made a Diagnosis dated December 13, 2017. Doc. 166606. Between 2018 and 2019 Mr. [REDACTED] Claim was audited, denied, appealed, remanded, approved, and then audited again. Docs. 177642, 194376, 199786, 200288, 204324, 206013. On October 2, 2019, part way through this second audit, Mr. [REDACTED] withdrew his second Claim. Doc. 214864.

The following month, on November 18, 2019, Mr. [REDACTED] underwent a second neuropsychological evaluation with Dr. [REDACTED], apparently as a part of a new BAP process. Doc. 366493 at 2-4. At that evaluation, “Mr. [REDACTED] presentation was bizarre, mood was labile, and his behavior was erratic and difficult to manage.” *Id.* at 2. Dr. [REDACTED] concluded that Mr. [REDACTED] neuropsychological test results were invalid. *Id.* It is not clear from the record whether Mr. [REDACTED] underwent a neurological exam through the BAP.

Nearly five years later, Mr. [REDACTED] began pursuing his current Claim.

On April 5, 2024, Mr. [REDACTED] returned to Dr. [REDACTED] a third time. Doc. 366493. Dr. [REDACTED] described Mr. [REDACTED] reported concerns of functional impairment:

[Mr. [REDACTED]] shared that his wife (or other family members) assists him with most of his instrumental activities of daily living. Mr. [REDACTED] indicated that his son often drives him places. However, he elaborated that he drives himself to the grocery store or the gym without GPS because they are “seconds” away from his house. Otherwise, he relies on his phone’s GPS because he loses his focus, zones out, and misses turns.... Regarding household chores, Mr. [REDACTED] noted that he assists with taking out the trash or vacuuming. He reported enjoying gardening or listening to podcasts to keep himself busy.

Id. at 4.

During this appointment, Mr. [REDACTED] apologized for his behavior during the previous exam, telling Dr. [REDACTED] that he was “on a lot of medications that made him not feel like himself and act all drugged out.” *Id.* at 5 (cleaned up). Based on Mr. [REDACTED] updated neuropsychological testing, Dr. [REDACTED] reported an overall rating of Level 2 Neurocognitive Impairment. *Id.* at 8. Dr. [REDACTED] concluded that the testing was valid. *Id.* at 6.

On July 26, 2024, Qualified MAF Neurologist Dr. [REDACTED] evaluated Mr. [REDACTED]. Doc. 366488. Dr. [REDACTED] reviewed his medical history and third-party statements from [REDACTED] and [REDACTED], and conducted a Montreal Cognitive Assessment (MoCA), and a Clinical Dementia Rating (CDR) assessment. *Id.* In his report, Dr. [REDACTED] wrote:

[Mr. █████] spends his day doing house chores, helping out with the kids. He says his wife organizes his life. He says he has some issues with OCD, spends time organizing things in color, shape, and size. Examples include sorting laundry, clothes, food, and dishes. He cannot buy groceries or do shopping. He can order food or take out, but does not cook. He can make supplement shakes. He cannot plan or organize travel, that is done by his wife. He is not allowed to try to fix things, they end up broken. He likes to workout. He works out every day. He used to like mountain biking, but he quit 4 years ago, but he would get lost and disoriented on the trails. He uses the [P]el[o]ton at home now.

Id. at 1.

Dr. █████ reported that Mr. █████ was independent in all “functional activities of daily living,” including eating, bathing, dressing, toileting, transferring (walking), and he remained continent. *Id.* at 2. However, Dr. █████ reported that Mr. █████ was not independent in various “instrumental activities of daily living,” including paying bills and taxes, shopping, playing games, preparing food or coffee, tracking current events, engaging with television or books, remembering appointments and other dates, and traveling out of the neighborhood by driving or on public transportation. *Id.*

Summarizing his findings, Dr. █████ assigned Mr. █████ an overall CDR score of 2.0 and a Diagnosis of Level 2 Neurocognitive Impairment:

Mr. █████ is a 46 year old man with a history of seizures, ADHD, depression, mood disorder, and repetitive head injuries who presents for evaluation of behavioral change over the past 14 years. Mr. █████ has had a deterioration in memory and cognitive function, along with personal relationships, and difficulty with basic activities of daily living. He reports he is unable to work and is dependent on his wife for all life activities. His neurological exam is notable for cognitive impairment on MoCA screening predominantly in language and memory domains. Mr. █████ recently completed neuropsychological testing that also reports cognitive impairment in language, memory and executive function.

CDR: 2

Community Affairs: 2

Home and Hobbies: 2

Personal Care: 2

Diagnosis:

Level 2 cognitive impairment

Id. at 5-6.

Dr. [REDACTED] certified his Diagnosis of Level 2 Neurocognitive Impairment on November 11, 2024, dating it to his July 26 examination. Doc. 366495. Mr. [REDACTED] submitted his Claim the next day. Doc. 366725.

On November 22, 2024, the Claims Administrator informed Mr. [REDACTED] that it was seeking additional review from the Appeals Advisory Panel Leadership Council (AAPLC). Doc. 368011. It then sent several questions about Mr. [REDACTED] functional impairment to his wife, [REDACTED]. Doc. 376638. Ms. [REDACTED] responded on February 3, 2025:

My name is [REDACTED], and I've been [REDACTED] wife for over 21 years. I've reviewed the questions, and I can certainly confirm what [REDACTED] has shared with the doctors regarding his cognitive decline is generally correct.

1. Does the player continue to drive.

Yes, [REDACTED] still drives—but let's not mistake that for driving well. I can't stop him from getting behind the wheel but at least he sticks to familiar places. When traveling with others to further or newer locations, it is my son or myself who will take him where he needs to go. He relies on both his phone and watch GPS to keep him on track. Even for short trips when he is driving by himself, like the grocery store to get a personal beverage or snack (I do the family shopping) which are very close he will get there, but both locations are a mere mile or two from the house. There are also times where [he] has a habit of driving aimlessly without GPS, which lines up with what he's said about getting lost or 'zoning out' and missing turns. I believe these activities by [REDACTED] are consistent with what he told the doctors.

2. Does the player continue to participate in hobbies such as working, gardening and listening to Podcasts.

Sort of, if "gardening" is defined as trimming bushes in 100-degree Arizona heat while listening to podcasts, then sure, [REDACTED] gardens but there are no vegetables to tend to. Keeping busy helps him, so he often spends time outside trimming roses and bushes while listening to podcasts.

He also works out, but let's be clear—it's not like when he played in the NFL. His work outs are like Pilates, stretching, and treadmill workout. This is combined with therapeutic routine includes Red-Light Therapy, NAD IV infusions, Cryotherapy, Cold-Water Therapy, Sauna Therapy, Cupping, Chiropractic visits at home, and some other things. He is not out jogging or lifting big heavy weights. He maintains a healthy regimen because his doctors have told him staying active may help slow his cognitive decline. He spends about three hours a day on these 'work-out' activities, plus an hour lying down in compression boots in our son's room—often napping. Very low impact holistic work-out type activities.

The facilities he uses for this are within a few miles of our home. If he misses a session, his body aches, and his mood shifts dramatically. Again, this appears consistent with what he told the doctors.

3. Is the player able to perform household chores, such as sorting laundry, taking out the trash and vacuuming.

Yes, [REDACTED] helps with chores—if by “helps,” you mean doing them excessively once reminded which is consistent with doctor’s statement. [REDACTED] again zones out with his earbuds in and vacuums endlessly until I have to tell him, “Honey, the floors are clean.” Laundry is the same—I will tell him to help with the laundry and he will spend hours organizing clothes by color and obsessing over how they are folded. Even when I tell him to take out the trash it turns into a project; he meticulously lines up the cans, then washes them multiple times a week.

These are [REDACTED] daily activities that I helped set-up for him. As long as he sticks to his routine, in a singular fashion, he functions relatively well. But when that routine is disrupted, his mental state and mood take a noticeable downturn.

Id. (emphasis in original).

Upon review of the record, including Ms. [REDACTED] responses, an AAPLC Member concluded that Mr. [REDACTED] met diagnostic criteria (i), (ii), and (iv) for a Diagnosis of Level 2 Neurocognitive Impairment under the Settlement. Doc. 389277. At the same time, the Member advised that criterion (iii), pertaining to Mr. [REDACTED] functional impairment, was not satisfied. *Id.* The Member explained (as quoted by the Claims Administrator):

Dr. [REDACTED] reported (Doc ID# 366492) that the Player no longer worked; lived with his wife and children; spent his day doing household chores and helping out with his kids; spent time sorting laundry, clothes; food, and dishes; was not able to shop or buy groceries; was able to order food but not cook; was able to make supplement shakes; could not plan travel; was not allowed to fix things, liked to work out and worked out every day as a hobby, no longer went mountain biking due to getting lost/disoriented, used Peloton at home, was less social, had problems getting along with friends and family, misplaced items, needed assistance with balancing a checkbook and managing finances, was not able to shop independently, was not able to cook or prepare meals, was not independent for travel, but was independent for eating, bathing, dressing, toileting, and transfers, and did not have incontinence. He listed scores of 2.0 for Community Affairs, Home/Hobbies, and Personal Care, and an overall CDR score of 2.0.

Dr. [REDACTED] reported (Doc ID# 366493) that the Player needed assistance with the majority of instrumental activities of daily living, let his wife handle finances and appointments, was not able to reliably complete household chores or cook, needed

reminders to eat and to take medications, had limited driving due to blackouts and confusion, and was no longer allowed to drive the children. The Player reported that he continued to drive to the grocery store and gym without GPS, was less social, no longer participated in mountain biking, was able to exercise with a Peloton bike at home, was able to assist with taking out the trash and vacuuming, enjoyed gardening and listening to podcasts, and went to the gym every day.

The third-party affidavit by [REDACTED] corroborated that the Player was forgetful, forgot codes, misplaced items such as his wallet and keys, had problems getting along with family members and other people, no longer went to Church or family gatherings, and had problems remembering names. The third-party affidavit by [REDACTED] corroborated that the Player forgot items, was less social, needed help with cleaning/decluttering his house, setting up furniture, applying touch up paint, and other small household tasks, and had difficulty getting along with people.

There were several discrepancies with the reports of Dr. [REDACTED] and Dr. [REDACTED]. Dr. [REDACTED] reported the Player was not independent for traveling out of the neighborhood and driving and was not able to reliably complete household chores, while Dr. [REDACTED] reported that the Player continued to drive and spent his day doing household chores. The score of 2.0 for Home/Hobbies was not consistent with the reports that the Player went to the gym every day and enjoyed gardening and listening to podcasts, and the score of 2.0 for Personal Care conflicted with reports that the Player was independent for eating, bathing, dressing, toileting, and transfers, and did not have incontinence. The Claims Administrator asked the Player to clarify the information about his activities. In response, the Player's wife clarified that the Player continues to drive but with problems; was able to go to the grocery store and purchase a personal beverage or snack; trimmed bushes; listened to podcasts; worked out for about 3 hours per day; did chores at home including cleaning floors, sorting the laundry, and taking out the trash; and was able to accomplish daily activities in a routine but had trouble if the routine was disrupted.

Overall, the information supports a rating of 0.5 for Community Affairs since the Player is still able to drive and purchase items from the grocery store, which indicates a continued ability to function independently outside the home despite having some problems and difficulties; a score of 0.5 for Home/Hobbies since the Player was able to perform household chores and continued hobbies of working out, gardening/trimming bushes, and listening to podcasts; and a score of 0 for Personal Care since the Player was not reported to need either reminders or assistance to perform activities such as dressing, bathing, and toileting. Consequently, the available information is generally consistent with an overall CDR score of 0.5 (Questionable), but not 2 (Moderate) or 1 (Mild). Therefore criterion (iii) is not fulfilled.

Id.

Adopting the AAPLC's findings, the Claims Administrator denied Mr. [REDACTED] Claim on April 25, 2025. *Id.* Mr. [REDACTED] timely appealed. Doc. 415546.

RESOLVING THIS APPEAL

To prevail on appeal, Mr. [REDACTED] must show by clear and convincing evidence that the Claims Administrator's denial was in error.² His argument has two parts. Mr. [REDACTED], disputing the AAPLC's analysis, charges that it failed to defer to Dr. [REDACTED] judgment that Mr. [REDACTED] retained function was consistent with a Qualifying Diagnosis. At the same time, he says, the Claims Administrator erred relying on his wife's affidavit submitted late in the claim review process, because Dr. [REDACTED] did not have an opportunity to review or respond to that evidence. In support of these contentions, Mr. [REDACTED] submitted a "rebuttal" letter from Dr. [REDACTED], dated July 31, 2025. Doc. 415544 at 8-10.

To sufficiently establish a right to payment for Level 2 Neurocognitive Impairment, Mr. [REDACTED] needed to "exhibit functional impairment generally consistent with the criteria set forth in the National Alzheimer's Coordinating Center's Clinical Dementia Rating (CDR) scale Category 2.0 (Moderate) in the areas of Community Affairs, Home & Hobbies, and Personal Care."³ As I have explained:

Level 2 Neurocognitive Impairment is defined by a profound loss of function. In Community Affairs, a score of 2 implies "[n]o pretense of independent function outside home"; in Home & Hobbies, "poorly maintained" and "very restricted interests, while the patient can perform only simple chores"; while in Personal Care the patient "[r]equires assistance in dressing, hygiene, [and] keeping of personal effects."⁴

Dr. [REDACTED] determined that Mr. [REDACTED] met this level of functional impairment across all three CDR categories. The AAPLC Member, by contrast, concluded that the underlying records did not support that determination. When this sort of disagreement arises, the Settlement's well-rehearsed principles of deference dictate its disposition:

This Settlement is built around layered deference to expertise. With respect to conclusions about the CDR, the views of diagnosing neurologists who've carefully considered the relevant evidence of functional impairment merit some weight. But deference is not automatic. It requires a diagnosing neurologist to have *carefully*

² As Mr. [REDACTED] points out, the NFL Parties' very short response to his Appeal was submitted late. Docs. 423928; 424554. Even so, it remains Mr. [REDACTED] burden on appeal to demonstrate clear and convincing evidence of error.

³ Settlement Agreement, Exhibit A-1(2)(a)(iii).

⁴ Special Master Ruling on Functional Impairment and Alternative Causation, at 4 (Mar. 29, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_alt_cause_SM.pdf.

considered the relevant evidence. That is, they must provide an articulated and holistic justification for their CDR scoring for it to have significant weight.⁵

The record evidence of Mr. █████ functional impairment is muddled, and Dr. █████ reasoning sheds little light. Despite acknowledging that Mr. █████ retained certain core functional abilities, Dr. █████ utterly failed to explain why severe CDR scores were warranted. For example:

- Dr. █████ reported that Mr. █████ was independent in eating, bathing, dressing, toileting, transferring (walking), and that he remained continent. Doc. 366488 at 2. Yet, several pages later, without explaining the discrepancy, he assigned Mr. █████ a CDR score of 2.0 in Personal Affairs, which would imply that Mr. █████ “[r]equires assistance in dressing, hygiene, [and] keeping of personal effects.”⁶ *Id.* at 6.
- Dr. █████ wrote that Mr. █████ “spends his day doing house chores” and “works out every day.” *Id.* But again, without any accompanying explanation, Dr. █████ assigned Mr. █████ a CDR score of 2.0 in Home & Hobbies, which would imply that Mr. █████ has only “poorly maintained and very restricted interests,” and “can perform only simple chores.”⁷

By offering no explanation for the wide gap between the functional ability he reports and the functional impairment he assigns on the CDR, Dr. █████ failed to provide an articulated justification for his conclusion that Mr. █████ has an overall CDR score of 2.0. Therefore, “as I have repeatedly written, it was not error for the Claims Administrator to inquire further and ultimately conclude that [Mr. █████] medical records do not satisfy the Settlement’s functional impairment requirement under criterion (iii).”⁸

Dr. █████ post-denial letter does not unsettle that conclusion. In it, Dr. █████ argues that Mr. █████ exercising, gardening, and housework are not hobbies and chores indicating a retention of cognitive capacity, but are instead obsessive or compulsive behaviors exhibiting disfunction instead of function. Doc. 415544 at 8-9.

That may be right, but Dr. █████ late-2025 theory explaining Mr. █████ function is absent from the 2024 documentation that the Claims Administrator used to evaluate the Claim. Dr. █████ wrote his “rebuttal” over a year after examining Mr. █████, presumably at the request of Mr. █████ attorney to aid in his Appeal. As I have explained before, “the Agreement’s system of review turns on deference to contemporaneously created and articulated medical judgments.”⁹ Here, Dr. █████ letter represents “late-arriving reasoning,” which “cannot substitute for the actual

⁵ Special Master Ruling on Functional Impairment and Deference, at 9 (Feb. 11, 2026), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_deference_sm.pdf (emphasis in original, cleaned up, and quotations omitted).

⁶ Special Master Ruling on Decision Functional Impairment and Alternative Causation, at 4 (Mar. 29, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_alt_cause_SM.pdf.

⁷ *Id.*

⁸ Special Master Ruling on Functional Impairment and Deference, at 9 (Feb. 11, 2026), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_deference_sm.pdf.

⁹ Special Master Ruling on Post-Diagnosis Evidence, at 5 (June 8, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=post_diagnosis_evidence_sm.pdf.

reasoning that [Dr. █████] offered at the time of his [CDR] determination.”¹⁰ Once again, I must emphasize that “no deference is due to clinician’s letters produced on Appeal.”¹¹

Second, despite urging the Claims Administrator to more heavily consider Dr. █████ late arriving letter, Mr. █████ charges that the Claims Administrator should not have relied on his wife’s statements about his function, because that evidence was submitted in the appeals process and was not part of Dr. █████ original judgment. He thinks that it constitutes “late arriving evidence” which “should be used to undermine (or buttress) a Diagnosing Physician’s clinical judgment only rarely.”¹² As I wrote last year, concerning a different Appeal, the Claims Administrator denial “rest[ed] too heavily on—and ma[de] unwarranted inferences from—facts gathered after the Claim’s submission” that “seem[ed] to indicate a post-diagnosis change in [the] claimant’s function.”¹³ Such overreliance “does not promote accuracy, but, rather, threatens it.”¹⁴

That is not what has happened here. Ms. █████ response did not demonstrate a post-diagnosis change in Mr. █████ functional ability. Rather, she repeatedly confirmed that her views were “consistent with what [Mr. █████] told the doctors.” Doc. 376638. While Dr. █████ complains (over a year later) that “its absence from the initial record represents a gap in the documentation available to inform my clinical scoring,” he acknowledges that Ms. █████ response does little more than “corroborate the functional limitations described by other informants and observed during my exam.” Doc. 415544 at 9.

Given that Ms. █████ response covers very little new ground, it comes as no surprise that the Claims Administrator (adopting the AAPLC’s conclusions) did not (in fact) over-rely on the response in making its determination. In fact, the Notice of Denial only refers to Ms. █████ response once, as part of its summation of the record. Doc. 389277. In no way does this glancing reference constitute clear and convincing evidence of error.

¹⁰ Special Master Ruling on Neuropsychological Testing and Validity, at 8-9 (Mar. 17, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=np_testing_and_validity_sm_2.pdf.

¹¹ *Id.* at 9 n.1. *See also* Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 11 (Oct. 21, 2020) (“[A] letter offered in support of an Appeal is no substitute for a medical judgment created contemporaneously with an exam, in a setting where expressing such a judgment, and not post hoc advocacy, is the order of the day.”). I’d also note that Dr. █████ letter focuses on Mr. █████ continued ability to exercise and complete chores, explaining why these activities are the product of a highly structured environment rather than retained functional ability. While this certainly touches upon Mr. █████ CDR score in Home & Hobbies, it does not bridge the gap in his judgment about Mr. █████ Personal Care, which remains mysterious.

¹² Special Master Ruling on Late Arriving Evidence and Deference, at 12 (Apr. 8, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=late_evidence_deference_sm.pdf.

¹³ *Id.* at 11.

¹⁴ *Id.*

CONCLUSION

The Claims Administrator concluded that Mr. [REDACTED] failed to satisfy the requirements for a Diagnosis of Level 2 Neurocognitive Impairment and denied his Claim. Because Mr. [REDACTED] has not offered clear and convincing evidence that this determination was in error, I deny his Appeal.

Date: April 17, 2026



David A. Hoffman, Special Master