

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

Appeal 2026-20

THIS DOCUMENT RELATES TO:
APPEAL OF REPRESENTATIVE
CLAIMANT [REDACTED]
REGARDING CALCULATION OF
MONETARY AWARD

No restricted diffusion seen to suggest an acute infarction. Moderate chronic ischemic white matter changes. Old lacunar infarcts seen in the right thalamus. Old infarct and encephalomalacia seen in the right frontal and parietal lobe. Generalized atrophy and multiple foci of hemosiderin related to remote hemorrhage.

Doc. 420046 at 3.

On June 12, 2023, Mr. [REDACTED] underwent Supplemental BAP testing with neuropsychologist Dr. [REDACTED]. Doc. 379981. Although Dr. [REDACTED] discussed the September 28, 2022 MRI in his report, he did not comment on if the strokes caused the decline in function. *Id.* at 2. After the examination, Dr. [REDACTED] concluded that:

Mr. [REDACTED] met Level 2.0 impairment criteria in all domains assessed and/or attempted. Overall, these findings are consistent with information collected from Mr. [REDACTED] and his wife. As a result, per the BAP Clinician's Interpretation Guide, Mr. [REDACTED]'s overall impairment rating is Level 2.0. Per the new settlement rules, these findings need to be corroborated by a CDR administered by a BAP-approved neurologist in the settlement program.

Id. at 6.

Mr. [REDACTED] was scheduled to visit neurologist Dr. [REDACTED] on April 1, 2024, to complete the Qualifying Diagnosis, but he passed away on [REDACTED]. Docs. 427346; 379681. Following Mr. [REDACTED]'s death, Ms. [REDACTED] was appointed to be her late husband's Representative Claimant on [REDACTED]. Doc. 379939.

Dr. [REDACTED] the original BAP neurologist, then re-reviewed Mr. [REDACTED]'s medical records, including the 2023 [REDACTED] Report. Doc. 379688 at 1. Dr. [REDACTED] concluded that "Mr. [REDACTED] has/had a Major Neurocognitive Disorder (Level 2.0) that was likely multifactorial in origin. While repetitive head trauma from his professional football career has played a role, other factors—including metabolic, and vascular comorbidities—could have contributed to his cognitive impairment." *Id.* at 2.

Then, on March 13, 2025, Dr. [REDACTED], a neuropathologist, undertook a posthumous biopsy of Mr. [REDACTED]'s brain. She concluded that "[h]is impulsive behavior, memory loss, language difficulties, apathy, slowed movements, and dementia were likely caused by the combined effects of CTE, stage 3; severe vascular disease, with multiple small strokes; and, to a lesser degree, Alzheimer's disease." Doc. 420046 at 5.

Ms. [REDACTED] filed a Claim asserting a Level 2 Qualifying Diagnosis on February 24, 2025. The Claim Form denied that Mr. [REDACTED] had ever suffered a Stroke.¹ Doc. 379686, at 4. On July 16, 2025, the Claims Administrator asked for additional information because "the medical records

¹ I capitalize "Stroke" here because the Form refers to the Settlement's bespoke definition of that term.

[] submitted show evidence of a Stroke.” Doc. 399402 at 1. Ms. [REDACTED] submitted additional medical records, including the MRI report from 2022.

On March 16, 2026, the Claims Administrator approved Ms. [REDACTED]’s Claim for benefits based on a Qualifying Diagnosis of Level 2 Neurocognitive Impairment. Doc. 427335 at 1. However, the Administrator applied a 75% offset to the Monetary Award because Mr. [REDACTED] had a medically diagnosed Stroke prior to his Qualifying Diagnosis. *Id.* at 6.

The Appeals Advisory Panel (AAP) offered an explanation of their use of the Stroke offset:

The Settlement Agreement directs that the word Stroke is defined by the World Health Organization’s International Classification of Diseases, 9th Edition (ICD-9) or the World Health Organization’s International Classification of Diseases, 10th Edition (ICD-10). To apply the Stroke offset, the Claims Administrator must: (a) find evidence of the event in the medical records, and (b) determine that the Player suffered a Stroke under the Settlement’s precise meaning of that term. If the Claims Administrator determines the medical records show the Player suffered a Stroke, the Player has the burden of showing by clear and convincing evidence that his Qualifying Diagnosis was not causally related to the Stroke.

...

There is report of Strokes and vascular brain damage being present from multiple independent sources. Dr. [REDACTED] reported on 6/1/2018 (Doc ID 379984) that records from Dr. [REDACTED] beginning in 11/14/2016 and ending on 10/23/2017, reported that a brain imaging study done for research purposes showed vascular damage to the brain, including a chronic hemorrhage in the right hemisphere and several hyperintensities largely at the gray-white junction but also in the deep white matter.

Dr. [REDACTED] also reported on 6/1/2018 (Doc ID 379984) that the Player indicated he never had any Strokes. However, the new/additional information (Doc ID 420046) included a clinic visit note by Dr. [REDACTED] dated 2/6/2017, which reported the Player had a hemorrhagic lesion (presumably indicating a Stroke) that was reported to have been seen on a brain MRI scan. A brain MRI scan report dated 9/28/2022 (Doc ID 397951) reported information about Strokes and vascular changes, including that there was no acute infarct, there were old lacunar infarcts in the right thalamus, an old infarct with encephalomalacia was present in the right posterior frontal and parietal lobes, there were moderate chronic ischemic white matter changes, and multiple foci of hemosiderin were present in the cerebellum, right frontal lobe, and occipital lobes bilaterally.

Dr. [REDACTED] reported on 6/15/2023 (Doc ID 379981) that a brain MRI report dated 9/28/2022 showed evidence of multiple Strokes and vascular disease, including

moderate chronic ischemic white matter changes, old lacunar infarcts in the right thalamus, an old infarct with encephalomalacia in the right frontal and parietal lobes, and multiple foci of hemosiderin related to remote hemorrhage.

The pathology report by Dr. [REDACTED] dated 3/13/2025 (Doc ID 397951) reported presence of Strokes and vascular damage in the brain, including that three lacunar infarcts were present in the right putamen, thalamus, and caudate, multiple microinfarcts were present in the pons, and severe white matter changes were present. Since Strokes and vascular brain damage were definitely present, it is appropriate to consider if these contributed to the cognitive decline, which would make them causally related to the Qualifying Diagnosis.

Dr. [REDACTED] concluded that it was unlikely that concussions were the sole or primary cause of the cognitive impairment and noted that the brain imaging findings were consistent with multiple potential etiologies, which included vascular-related changes. Also, the Death Certificate (Doc ID 379681) reported a diagnosis of dementia secondary to cerebral infarction which would also support that the Strokes contributed to the Player's cognitive decline and overall neurocognitive impairment. Consequently, there is report of both presence of Strokes and that the Strokes likely contributed to the cognitive decline. Therefore, there is not clear and convincing evidence in the Claim file to indicate that the Qualifying Diagnosis was not causally related to the Stroke.

Doc. 427346 at 2-3.

Ms. [REDACTED] now appeals this application of the Stroke offset.

RESOLVING THIS APPEAL

To succeed in her appeal, Ms. [REDACTED] must show by clear and convincing evidence that the Claims Administrator erred in applying the Stroke offset. The Settlement itself sets out the relevant standard for when the offset must be applied:

If the Retired NFL Football Player receives a Qualifying Diagnosis subsequent to a medically diagnosed Stroke or a medically diagnosed Traumatic Brain Injury, and if the Settlement Class Member demonstrates, by clear and convincing evidence, that the Qualifying Diagnosis was not causally related to the Stroke or the Traumatic Brain Injury, then the 75% Offset will not apply.²

I have previously interpreted this burden as follows:

[T]he Claims Administrator's task was to evaluate whether the available evidence produced a firm belief or conviction—in other words, that it is highly probable or

² Settlement Agreement, Section 6.7(d) (emphasis added).

reasonably certain—that Mr. [REDACTED]’s [S]trokes did not cause his Qualifying Diagnosis. To succeed on appeal, [Ms. [REDACTED]] must show that there is a high degree of probability that the Claims Administrator was wrong in determining [she] had not met that burden, and therefore in applying the 75% stroke offset.³

After reading the underlying record, I was struck by its repeated references to a remote and chronic “hemorrhage” in the brain. Because “Stroke” for the purposes of the Settlement Agreement does not include *hemorrhagic* events,⁴ it was concerning that neither party discussed the possibility that the Stroke Offset should not apply on this ground. I asked for an additional AAP review to focus on this particular question. The Member wrote:

The MRI report of 9/28/2022 identifies “Old lacunar infarcts seen in the right thalamus. Old infarct and encephalomalacia seen in the right frontal and parietal lobe.” It separately reports evidence of hemosiderin accumulation in other areas, which is consistent with microhemorrhages.

Dr. [REDACTED]’s report of 2/9/17 mentions “a hemorrhagic lesion that showed up on his advanced MRI in a context of a study that was done through [REDACTED],” without clarification of its location, size, symptomatic presentation, or whether the hemorrhage was identified as a primary intracerebral bleeding event or consequence of an ischemic stroke (known as hemorrhagic transformation). The latter would best be classified as stroke and hemorrhage rather than being mutually exclusive.

Dr. [REDACTED]’s neuropathological report of March 13, 2025 also specifically reports “lacunes, remote, three” and includes localization to the right thalamus, which matches the MRI report. Notably, Dr. [REDACTED]’s diagnostic summary does not include any statements about cerebral hemorrhage. (MRI is more sensitive to evidence of microscopic quantities of blood products so the discrepancy between MRI and neuropathology reports is medically appropriate).

Per ICD-10-CM guidelines the diagnostic code for lacunar infarction is I63.81 (Other cerebral infarction due to occlusion or stenosis of a small artery). This reflects typical medical usage of the terms lacune, lacunar stroke, and lacunar infarction which do not include brain hemorrhages. Lacunar, non-hemorrhagic strokes are readily distinguishable on MR imaging and neuropathologic examinations from cerebral hemorrhage, which is defined as bleeding directly into the cerebral tissue, and is coded in the I61.xx series.

Summary and Conclusion: The medical records support the presence of multiple ischemic “strokes,” i.e. lacunar cerebral infarctions, independent of cerebral

³ In re: Appeal of SPID # 950013381, 2022-8, at 7 (Apr. 25, 2022), at https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=stroke_sm_2.pdf.

⁴ In re: Appeal of SPID # 100011944, 2020-11 (July 15, 2020), at https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=stroke_sm.pdf

hemorrhage, prior to 9/28/22 and the date of the qualifying diagnosis on 6/15/2023. The location of at least one of the lacunes (right thalamus), is recognized to be associated with cognitive impairments [1]. I therefore concur that use the Stroke Offset is medically appropriate.

Doc. 446073 (breaks added).

I accept this well-reasoned explanation. It amply justifies the Claims Administrator's finding that Mr. [REDACTED] suffered a "Stroke," as the Settlement defines it, at some point prior to the exams that resulted in his Qualifying Diagnosis.⁵

Ms. [REDACTED], noting that both Dr. [REDACTED] and Dr. [REDACTED]'s reports concluded that her husband's decline was likely produced by multiple causes, argues that the AAP was wrong to "infer" that strokes caused Mr. [REDACTED]'s decline. But that presumption is the Settlement's, not the AAP's. To avoid the offset in the face of a prior Stroke, Claimants must establish that their records provide clear and convincing evidence—that is, making it highly probable or reasonably certain—of the *absence* of a causal relationship.

Here, both reports discuss evidence of Stroke and indicated that it could have caused the impairments. Dr. [REDACTED] found that "vascular comorbidities—could have contributed to his cognitive impairment." Doc. 379688 at 2. And Dr. [REDACTED] stated that his symptoms could be caused by "severe vascular disease, with multiple small strokes." Doc. 420046 at 5. The AAP referred to these medical records in concluding "there is report of both presence of Strokes and that the Strokes likely contributed to the cognitive decline." Doc. 427346 at 3.

There is no clear and convincing evidence in the medical records that Mr. [REDACTED] did not suffer a Stroke prior to his Qualifying Diagnosis, or that his cognitive decline was independent of it. The Claims Administrator did not err in applying the offset.

CONCLUSION

Because Ms. [REDACTED] did not show by clear and convincing evidence that the Claims Administrator erred in applying the Stroke offset to her late husband's Monetary Award, I deny her Appeal.

Date: September 11, 2026



David A. Hoffman, Special Master

⁵ Ms. [REDACTED] argues that since there is no evidence of a Stroke between the initial BAP examinations in 2018 and the subsequent evaluation in 2023, the decline in function leading to the Qualifying Diagnosis must not have been caused by the Stroke. Doc. 434069 at 2. She then asserts that the AAP erred in considering the 2022 MRI showing evidence of a Stroke, since it was not a new or ongoing stroke. *Id.* However, the Settlement does not make these distinctions, as the offset applies after any prior Strokes.