

IN RE: NATIONAL FOOTBALL LEAGUE PLAYERS' CONCUSSION INJURY LITIGATION	No. 2:12-md-02323
	Appeal 2026-18
	SPID 100014070
THIS DOCUMENT RELATES TO: APPEAL OF SETTLEMENT CLASS MEMBER [REDACTED] REGARDING CALCULATION OF MONETARY AWARD	

A few months later, in April of 2026, the Claims Administrator, approving Mr. ██████'s Qualifying Diagnosis, did two things that substantially reduced his Monetary Award. Rejecting backdating the Diagnosis to 2003, it found that the earliest sufficiently supported date of Diagnosis was August 21, 2025, when Mr. ██████ attended the MAF evaluation which led to his Claim. It then further reduced the Award by 75% because Mr. ██████ survived a medically diagnosed Stroke prior to his Qualifying Diagnosis.

CLAIM HISTORY

On August 11, 2022, Mr. ██████ went to the emergency room with quickly worsening word finding difficulties and “symptoms concerning for possible TIA versus stroke, now at greater than 12 to 18 hours duration.” Doc. 406987 at 136. In the emergency room, the consulting neurologist recommended Mr. ██████ for “stroke protocol.” *Id.* at 162. The next day, a different neurologist described an “MRI noted to have small left hippocampus stroke.” *Id.* at 163. She added “[a]cute ischemic stroke” to a list of clinical impressions. *Id.* at 138.

And yet Mr. ██████'s doctors were not convinced of the diagnosis. They saw something abnormal on MRI, but it was "not really c[onsistent] w[ith] ischemic stroke." *Id.* at 143. He remained in the hospital a total of eight days to explore what could be causing his symptoms, from "autoimmune encephalitis, herpes simplex encephalitis [to] stroke." *Id.* at 150. And when he left the hospital, that lack of diagnostic clarity persisted. His doctors recommended that he see a neuro-oncologist to ensure the abnormality on his imaging was not cancer. *Id.* at 122.

On October 11, 2022, Mr. ██████'s medical team provided him with more concrete guidance. The hyperintensive region in his hippocampus was resolving, which indicated it was a "seizure or vascular insult, but fortunately was not a neoplastic lesion." *Id.* at 370-71. That is, something more transient, like a stroke, rather than permanent, like cancer. But, the MRI evidenced a new "punctate possible subacute infarct [Stroke]." *Id.* The team referred him to the "Stroke Clinic." *Id.*

On December 8, 2022, then-qualified MAF Physician, Dr. Carl Billian wrote a report describing his March 29, 2022, evaluation of Mr. ██████. *Id.* at 1.¹ He highlighted the apparent Stroke between his initial evaluation and his December 2022 note. He explained that Mr. ██████'s brain MRI showed a "Left hippocampus/Para hippocampal gyrus diffusion restriction, likely representing light acute infarct [Stroke]." *Id.* at 4. Noting a series of "acute neurologic events, each superimposed on a continuing trend of decline." *Id.* at 6. Ultimately, he made a diagnosis of Alzheimer's, dated to March 29, 2022. *Id.*

On August 21, 2025, Mr. ██████ saw a new MAF neurologist, Dr. ██████. Doc. 407364.² Dr. ██████, reviewing Mr. ██████'s medical history, highlighted the presence of Level 2 Neurocognitive Impairment and again diagnosed Alzheimer's Disease, however this time, dated to 2003. *Id.* at 4. That date turned entirely on reporting from Mr. ██████ and his wife of cognitive impairment "slowly getting worse" starting in that year. *Id.* at 1. Dr. ██████ did, however, then accept that Mr. ██████ had suffered a Stroke:

The patient had MRIs of the brain, last one on April 6, 2023, that showed mild T2 hyperintensity within the left centrum semiovale at the site of the previous seen DWI hyperintensity, likely reflecting expected evolution of small subcortical infarct [Stroke]. However, he was later seen by a vascular specialist at Mass General and it was felt that he did not have any stroke. He was also seen by a neuro-oncology on September 16, 2022, and it was felt that he does not have any brain tumor, possible CTE.

¹ Dr. Billian explained that prior to this appointment, Mr. ██████ had a BAP evaluation in 2018. Doc. 406987 at 2. However, the report from this evaluation is not in the file, and I do not have access to it. Mr. ██████'s Claim Package does include non-Settlement medical records dating back to examinations for chest pain in 2004 and a 2012 neurologist appointment highlighting headaches and sleep disturbances in the context of a dispute with the ██████. Doc. 406987 at 356, 392.

² Between these two MAF appointments, Mr. ██████ underwent a separate clinical journey which resulted in his August 16, 2023, approval for NFL Player Disability Benefits for a diagnosis of Dementia by neuropsychologist, Dr. Charlene Bang. Doc. 407232. He also continued to see his Massachusetts General neurologist, Dr. David Caplan, from his August 2022 discharge through October of 2024. Doc. 406987 at 389.

Id. at 2.

Dr. [REDACTED] did not report reviewing Mr. [REDACTED]'s October 11, 2022, referral to long term Stroke care. Nor did he offer a judgment on how Mr. [REDACTED]'s history of Stroke may have impacted his Alzheimer's Disease symptoms.

On October 7, 2025, Mr. [REDACTED] submitted his Claim relying on a Diagnosis by Dr. [REDACTED] of Alzheimer's Disease dated to January 1, 2003. Doc. 409113 at 1-2. That Claim Form attested that he had not suffered a Stroke prior to his Qualifying Diagnosis. *Id.* at 4.

The Claims Administrator contacted Dr. [REDACTED] on November 12, 2025, for additional information supporting his Diagnosis. Doc. 413626. As it noted, an Appeals Advisory Panel (AAP) Member questioned if an Alzheimer's Diagnosis was supported given Mr. [REDACTED]'s imaging. *Id.*

On December 8, 2025, Dr. [REDACTED] responded:

The patient had a brain FDG PET scan in August 2022 that did not show finding typical of Alzheimer's disease or frontotemporal dementia, but it does not rule them out. He had a CSF testing that was borderline for tau/amyloid. I think the patient meets clinical diagnosis of Alzheimer's disease based on his history and clinical finding on exam. Chronic traumatic encephalopathy is possible, but this cannot be determined definitely at this point.

Doc. 416988 (cleaned up).

The Claims Administrator then contacted Mr. [REDACTED] on January 23, 2026, for more information about his claimed impairment. Doc. 421823. Specifically, it asked about his current involvement with multiple corporate entities, his previous employment, and his social activities posted on Instagram and Facebook. *Id.* In due course, Mr. [REDACTED] responded, denying that he was as independently active as it would have otherwise appeared. Doc. 423415.

Notwithstanding the absence of a confirmatory PET scan and the mixed record of Mr. [REDACTED]'s functioning, on April 6, 2026, the Claims Administrator approved Mr. [REDACTED]'s Claim for benefits based on a Qualifying Diagnosis of Alzheimer's Disease. Doc. 429677 at 1. However, the Claims Administrator calculated Mr. [REDACTED]'s Monetary Award based on a date of Diagnosis of August 21, 2025, when Dr. [REDACTED] saw him. Doc. 429701. It also reduced the Award by 75% because of Mr. [REDACTED]'s medically diagnosed Stroke prior to his Qualifying Diagnosis. *Id.* That decision rested on the AAP's extensive review of the available medical records.³

³ The AAP wrote:

Information from provider notes in Doc ID 406987 indicated several strokes had occurred and that cognition was affected by the strokes. An outpatient note by Dr. David Caplan dated 11/3/2020 (p.

On May 5, 2026, Mr. [REDACTED] timely appealed both of these deflationary choices. Doc. 432924.

RESOLVING THIS APPEAL

To prevail, Mr. [REDACTED] must offer clear and convincing evidence that the Claims Administrator erred either in not dating the Diagnosis back to 2003 or in applying the Stroke offset.

363-366) reported that the Player had MRI findings concerning for a punctate subacute infarct (Stroke) in the superior vermis and that the Player had been having cognitive problems, including forgetting names and trouble recalling recent events.

A Physician Discharge Summary by Dr. Prashanth Rajarajan dated 8/19/2022 (p. 51-67) reported a brain MRI scan showed mild DWI hyperintensity with ADC correlate in the right cerebellum without FLAIR hyperintensity, which was concerning for a small area of acute infarct (Stroke), as well as generalized volume loss. An area of left hippocampal restricted diffusion was reported to be suggestive of a low-grade glioma (brain tumor), and symptoms included word-finding difficulty as an active problem at the time of discharge, a history of mild-cognitive impairment at the time of admission, and presentation with acute worsening of word finding difficulties, forgetting names and trouble with recall of recent events . . .

Neuro-oncology notes (p. 68- 74) concluded the left temporal lobe imaging changes were not suggestive of cancer and instead likely reflected sequelae from prior injury with superimposed seizure or vascular insult (Stroke). Clinic notes dated 9/16/2022 (p. 89-94) indicated the Player had persistent memory problems with some improvement.

Multiple brain imaging studies, also in Doc ID 406987, were performed which also showed evidence of Strokes and that vascular white matter damage had also occurred. A brain MRI scan dated 7/25/2022 (p. 273-274) reported that the Player had a possible small infarct (Stroke) in the right cerebellum, but no evidence of larger Strokes at that time. A brain MRI scan report dated 11/15/2022 (p. 83-85) reported a new subacute subcortical infarct (Stroke) in the left centrum semiovale and that the prior signal abnormality in the left hippocampus had resolved, which would indicate etiologies such as postictal change (seizure) and infection/inflammatory causes. Dr. Caplan's note included a brain MRI scan report dated 4/6/2023 (p. 375-376), which indicated a mild signal abnormality in the left centrum semiovale, likely reflected expected evolution of a small subcortical infarct (Stroke). Additionally, white matter vascular damage was reported as well. A CT scan of the brain dated 10/12/2007 (p. 359-360) reported no evidence of Stroke at that time, but presence of mild chronic microangiopathic white matter disease. A brain MRI scan report dated 11/12/2012 (p. 452) indicated there was no acute infarct at that time, but some mild nonspecific foci of T2 hyperintensity involving the deep white matter of the frontal lobes bilaterally.

Overall, the information describes many of the clinical features included in the criteria for both the ICD-10 definition of Alzheimer's Disease and the DSM-5 definition of Major Neurocognitive Disorder due to probable Alzheimer's Disease.

Consequently, the information meets the Settlement criteria for a Qualifying Diagnosis of Alzheimer's disease as of Dr. [REDACTED]'s MAF evaluation dated 8/21/2025. Additionally, the available medical records indicate that vascular disease and multiple Strokes contributed to the Player's cognitive impairments and 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.

I'll start with the date of Mr. [REDACTED]'s Diagnosis.⁴ The Settlement itself, contrary to Mr. [REDACTED]'s lawyer's brief, does not explicitly permit backdating Diagnoses to before Settlement-sanctioned exams. However, the Program has long permitted, with the Court's approval, diagnosticians to date their Diagnoses to before they examine Claimants. The relevant FAQ describes that practice as exceptional, when "[t]he unique facts and circumstances of a particular claim may allow."⁵ As it further explains:

[T]he physician making a diagnosis may conclude, in the exercise of his or her sound medical judgment, that he or she has enough information from personal examination, medical records from other healthcare providers, medical history, corroborating evidence from non-family members and other information that medical specialists rely on in their clinical practices, to form a sound medical judgment that the Player met the diagnostic criteria for a Qualifying Diagnosis at a date earlier than the date of a personal examination of the Player by the physician making the diagnosis and signing the Diagnosing Physician Certification Form. The Settlement Class Member is best served by having the doctor who made an earlier diagnosis sign the Diagnosing Physician Certification Form. But there may be situations where the diagnosing physician can pinpoint an earlier date that is based on sound clinical judgment and best medical practices.

Any such diagnosis will be strictly scrutinized in the claims review process. The Claims Administrator may request additional information and/or documents to support the claimed diagnosis date and prevent misrepresentations of material fact in connection with the claim.⁶

Mr. [REDACTED] emphasizes that the Program normally defers to treating physicians.⁷ But as the FAQ records, backdating *at all*, let alone more than twenty years before an exam, is always "strictly scrutinized." Here, the Claims Administrator appropriately concluded that Dr. [REDACTED]'s attempted backdating did not meet that high standard.

Dr. [REDACTED] did not meet or examine Mr. [REDACTED] until August 21, 2025. Doc. 407364. As the AAP explains, Dr. [REDACTED] did document Mr. and Mrs. [REDACTED] reporting a decline in memory "since around 2003." Doc. 429701 at 2. But those self-reported, vague, symptoms do not establish the asserted Diagnosis of Alzheimer's. Nor do they provide clear and convincing

⁴ As Mr. [REDACTED] points out, if 2003 was the appropriate date of Diagnosis, then the Alzheimer's Disease Diagnosis would predate the Stroke(s) and the offset would be inapt.

⁵ Frequently Asked Questions: FAQ #107 (How is the date of a Qualifying Diagnosis determined?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

⁶ *Id.*

⁷ See, e.g., In re: Appeal of SPID #100007575, 2024-10, at 1 (Nov. 20, 2024), at https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=diagnosis_date_sm_2.pdf.

evidence that the Claims Administrator erred in applying the ordinary strict scrutiny to the dating of Mr. ██████'s Diagnosis.⁸

Thus, any Stroke Mr. ██████ suffered prior to August 21, 2025, implicates the Stroke offset.

Mr. ██████ argues that “there is no qualifying stroke under the Settlement.” Doc. 432919 at 2. But an extensive review of Mr. ██████'s medical records led the AAP and the Claims Administrator to the opposite conclusion. Relaying the medical records in detail, it concluded there was a medical history of at least one, and probably multiple, Strokes. Doc. 429701. It did so noting that at least some neurologists were not sure if they were infarcts or some other neurological insult. *Id.*

On Appeal, once the Claims Administrator concludes that the Stroke offset should apply, the “very heavy burden of avoiding the Stroke offset” falls on Mr. ██████.⁹ Objecting to the Claims Administrator's findings by pointing to different lines in the medical record without refuting the evidence relied on by the AAP and the Claims Administrator does not meet that burden. Further, in a letter produced on appeal, Dr. ██████ himself confirmed the presence of a “subacute left centrum semiovale stroke.” Doc. 432921. Thus, Mr. ██████ has not proven by clear and convincing evidence that he did not suffer a medically diagnosed Stroke.

Mr. ██████'s backup argument is that even if he suffered a Stroke, it did not cause his impairment.¹⁰ Here, his burden on appeal is steeper still. Mr. ██████ first had the burden of showing, by clear and convincing evidence, that his Alzheimer's symptoms were not causally related to his Stroke in order to avoid the offset.¹¹ Now, after the Claims Administrator was unconvinced and applied the offset, Mr. ██████ faces the additional hurdle of showing to a “high degree of probability” that the Claims Administrator was wrong.¹² His double burden proceeds as follows:

[I]n this case, the 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 reasonably certain—that [Mr. ██████'s Stroke] did not cause his Qualifying Diagnosis. To succeed on appeal, [Mr. ██████] must show that there is a high degree of probability that the Claims Administrator was wrong in

⁸ FAQ 107 necessitates medical exams, records, or history or “corroborating evidence from non-family members.” A husband and wife reporting symptoms beginning around 2003 does not meet that test. And it is additionally problematic that a different neurologist had, just a few years before, dated an Alzheimer's Diagnosis only to 2022.

⁹ In re: Appeal of SPID #100009148, 2026-13, at 6 (May 19, 2026), at https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=Appeal_100009148_2026_13.pdf.

¹⁰ Much of this argument relies on Mr. ██████'s proposed 2003 date of Diagnosis. Doc. 432919 at 5-6.

¹¹ Settlement Agreement, Section 6.7(d).

¹² 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.

determining he had not met that burden, and therefore in applying the 75% stroke offset.¹³

In the same letter produced on appeal, Dr. [REDACTED] reports, “[t]o a reasonable degree of medical certainty I may state that Mr. [REDACTED]’s neurocognitive condition is not related to any prior stroke.” Doc. 432921. This is the only information provided in Mr. [REDACTED]’s Claim regarding the connection, or lack thereof, between his Stroke and his Alzheimer’s.

Dr. [REDACTED] provided no reasoning to support his interpretation of Mr. [REDACTED]’s symptoms. He also provided no reasoning as to why the Claims Administrator’s interpretation was wrong. Dr. [REDACTED]’s naked assertion does not show that it is highly probable or reasonably certain that the AAP and Claims Administrator were in error in applying the Stroke offset. So, Mr. [REDACTED] has not met his burden in challenging the Stroke offset.

CONCLUSION

As Mr. [REDACTED] did not show by clear and convincing evidence that the Claims Administrator erred either in adopting August 21, 2025 as the date of Diagnosis or in applying the Stroke offset, I deny both parts of his Appeal.

Date: July 24, 2026



David A. Hoffman, Special Master

¹³ *Id.*