

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

After two rounds of audits and several addendums from Dr. [REDACTED] the Claims Administrator denied Mr. [REDACTED] Claim on February 17, 2021. Doc. 232954. The Claims Administrator adopted the Appeals Advisory Panel (AAP) Member's conclusion that Mr. [REDACTED] could not fulfill the Settlement's functional impairment requirement because of his ongoing involvement in his family's restaurant business and other activities. *Id.* It explained, quoting the AAP Member's report:

In conclusion, although the Player's [neuropsychological] testing results suggest a severe cognitive decline, the description of the Player in the medical records is not that of a person with the requisite level of severity of functional impairment due to cognitive difficulties consistent with a qualifying diagnosis. Accordingly, the diagnosis made by Dr. [REDACTED] is not generally consistent with the Settlement criteria for the Qualifying Diagnosis of Level 2 or Level 1.5 Neurocognitive Impairment.

Id. at 2-3.

Mr. [REDACTED] did not appeal.

Rather, the following year, he began pursuing his second Claim through the Baseline Assessment Program (BAP).

On November 5, 2022, Mr. [REDACTED] underwent neuropsychological testing with BAP neuropsychologist Dr. [REDACTED]. Doc. 273144. This new testing revealed overall Level 1.5 Neurocognitive Impairment. *Id.* at 4. Dr. [REDACTED] concluded that the testing was valid. *Id.* at 8. However, in his report, Dr. [REDACTED] noted Mr. [REDACTED] substance use:

[Mr. [REDACTED] reports drinking four to five beers or two beers and two cocktails per night. He reported marijuana use, usually smoking three joints per day. He last smoked marijuana on the morning of this exam, smoking one joint. He uses mushrooms about two to three times a week and last did this about 10 days ago.

Doc. 273461 at 2.

With respect to Mr. [REDACTED] marijuana use on the morning of his examination, Dr. [REDACTED] wrote that it "cannot be ruled out as a factor in [Mr. [REDACTED] current presentation." *Id.* at 3. Dr. [REDACTED] concluded:

[Mr. [REDACTED] endorses significant emotional distress and acting out behaviors. He endorsed feeling sad, anxious and having a history of antisocial behavior. He notes neurological problems and cognitive problems. He endorses a significant history of substance abuse, a history of aggressive behavior and disliking being around others.

[...]

[Mr. ██████ meets criteria for Level 1.5 impairment overall. However, he endorses substantial psychological distress as well as ongoing substance use. These factors cannot be ruled out as possible contributing factors to his cognitive performance.

Id. at 4.

On February 8, 2023, Mr. ██████ was examined by BAP neurologist Dr. ██████. Doc. 289412. Dr. ██████ produced three documents in connection with this examination: an informal report, an official BAP Provider Report, and a CDR assessment form. Docs. 289412; 277695; 289376.

None of these documents mention Dr. ██████ nor do they indicate whether Dr. ██████ reviewed his report as part of her evaluation. Even so, in both the informal report and in the Provider Report, Dr. ██████ acknowledged Mr. ██████ substance use:

Alcohol- daily drinks beers 3-5 daily. Sometimes hard liquor (owns a bar) drinks about 6-8 drinks a week. Works at the family bar 2-3x a week. Wife is not aware of what he drinks while he is at the restaurant. Uses Weed and ingests mushrooms.

Docs. 289412 at 2; 277695 at 6 (cleaned up).

Dr. ██████ completed the CDR assessment form using information provided by Mr. ██████ wife.¹ Doc. 289376 at 1. Dr. ██████ assigned Mr. ██████ a CDR score of 1.0 in Community Affairs:

[Mr. ██████ used to give talks to youth on occasions or host children at his restaurant. He does not do this anymore. He once had several friends however, now, only has 4-5 people with whom he associates. He does not like to be around large groups of people. If he is in a situation where he is obligated to be around a large crowd of people, he will need to smoke weed to help him deal with the anxiety. He has used weed for the last 12-15 years to help calm him.

Id. at 2 (cleaned up).

Dr. ██████ assigned Mr. ██████ a CDR score of 2.0 in Home & Hobbies:

[Mr. ██████ no longer engages in hobbies. He once liked being outside, going on hikes but does not do this anymore. He would always find a hiking trail whenever they vacationed but not anymore. Now, when his wife and kids are going for a walk, he will join them out of obligation. They used to sit outside by the fire pit and talk with friends. They do not do this anymore. He prefers to sit in his chair and watch television now.

¹ While Mr. ██████ examination took place on February 8, 2023, the CDR assessment form is dated September 19, 2023, over seven months later. Doc. 289376 at 4. It is not clear why.

He experiences depression, anxiety, crying spells. Wife has to let him know that she can support him. She is the one who encouraged him to seek help from a therapist. She believes that is working well for him. She notices how, as stated above, he will come home and “check out.” During this time, he is difficult to be around. Family is constantly asking what is wrong. He will finally say, “I don’t know. I don’t want to feel like this.” He is not able to control it. He says it is not easy but is trying to do a better job of shielding his family from his behavior than in the past.

His wife noticed that he has anxiety and is afraid to get excited about things even if it appears like something may be going well. He does not want to set himself up for disappointment. He has a difficult time enjoying happiness. Forgetfulness: He walks away and leaves the stove on, does not but things away, will start the car remotely and re-enter the house several times because he forgot something, wife must give several reminders.

Drives himself around during the day. He is unable to drive long distances due to migraines. His wife handles all bills because he is no longer able to do this. She stated that she feels he no longer has the bandwidth to manage anything difficult anymore. Thankfully, they have financial advisors and a CPA.

Id. at 2-3 (cleaned up).

Finally, Dr. [REDACTED] assigned Mr. [REDACTED] a CDR score of 0 in Personal Care, noting simply that Mr. [REDACTED] “is able to dress and groom with no issues.” *Id.* at 3.

From these scores, Dr. [REDACTED] assigned Mr. [REDACTED] an overall CDR score of 1.0, with no explanation. *Id.*

Dr. [REDACTED] notably left blank that section of the CDR assessment form that directs clinicians to “determine whether the functional decline in a Player from a previous usual level was due to cognitive loss, and not due to other factors . . . address whether the Player has . . . other conditions and clearly explain whether they have any effect on the functional impairment.” *Id.* at 3-4.

Meanwhile, in her Provider Report, Dr. [REDACTED] summarized her CDR findings:²

This is a 39 year old male with severe anxiety, depression, irritability, memory loss and poor judgement. This was first noticed by his wife during his time in the NFL

² Presumably, “CDR RANKING: 1.5” is a typo. Not only did Dr. [REDACTED] assign a different score on her CDR assessment form (an overall CDR score of 1.0), but importantly, such a score does not exist on the CDR scale. *See Frequently Asked Questions: FAQ #111* (How are diagnosing physicians to apply the Clinical Dementia Rating (CDR) scale to Level 1.5 and Level 2 Neurocognitive Impairment Qualifying Diagnoses?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.

and has continued to progress. He experiences confusion and frustration about his mental state and apologizes to his family for not being fully present. During his visit today, I noticed how he would zone out and not be present. I was able to draw him back in to the moment by asking him a question. I believe there is a direct correlation between his past head trauma while playing professional football and his current state. CDR RANKING: 1.5

Doc. 277695 at 7 (cleaned up).

Dr. [REDACTED] then offered two recommendations: “I would advise Mr. [REDACTED] to continue to see the counselor. I would also advise him to seek the help of a psychiatrist as he may benefit from a prescription medication to help with what he is experiencing.” *Id.* at 8.

In her informal report, which was uploaded with Mr. [REDACTED] Claim, Dr. [REDACTED] offered a similar analysis. Doc. 289412 at 3. That informal report misidentifies Mr. [REDACTED].³

46-year-old man with depression, anxiety, feelings of pessimism about the future, suicidal ideations, low tolerance level for frustration, irritability and impulsivity on the backdrop of a history of multiple blows to the head. In this mental state, he has been unable to make good judgement calls concerning his future and needs assistance with maintaining his daily schedule and remaining focused.

[. . .]

Mr. [REDACTED] [sic] should be receiving issue-focused therapy and may benefit from medication to manage the depression and anxiety.

Id.

On February 14, 2023, six days after Mr. [REDACTED] examination with Dr. [REDACTED] his friend, Mr. [REDACTED], completed a Third-Party Sworn Statement describing Mr. [REDACTED] functional impairment. Doc. 300795. This statement, along with Mr. [REDACTED] records from Dr. [REDACTED] were uploaded to the Claim Portal in late 2023 and early 2024. *Id.*

Having received these documents, the Claims Administrator sent an email to Dr. [REDACTED] on March 8, 2024 asking for clarification:

You evaluated Mr. [REDACTED] on 2/8/2023 and diagnosed him with Level 1.5 Neurocognitive Impairment; however, you did not indicate in your neurological report whether you reviewed the neuropsychological testing completed by Dr. [REDACTED] on 11/05/2022, or the Third-Party Sworn Statement completed by the

³ There are two possibilities: (1) Dr. [REDACTED] mistakenly copied this text from another patient’s report and it is therefore irrelevant to Mr. [REDACTED] or (2) this text substantively refers to Mr. [REDACTED] and Dr. [REDACTED] use of another patient’s name and age was merely a typo. Both seem plausible.

Player's friend, [REDACTED]. Additionally, you assigned a CDR of 1 but the Player reportedly owns a business, drives, can independently cook, wash clothes and dishes, do yardwork, use the telephone, and grocery shop. Please upload an addendum clarifying whether you reviewed the neuropsychological testing and the Third-Party Sworn Statement and clarifying your medical reasoning for assigning a CDR score of 1 in light of the described functional abilities not being consistent with a CDR score of 1.

Doc. 318138.

Dr. [REDACTED] did not respond to this inquiry.

The Level 1.5 Diagnosis, which was agreed upon by both Qualified BAP Providers—Dr. [REDACTED] and Dr. [REDACTED]—was published through the BAP on January 6, 2025. Doc. 372516.

On January 7, 2025, Mr. [REDACTED] submitted his Claim for Level 1.5 Neurocognitive Impairment. Doc. 372664. Doctors [REDACTED] and [REDACTED] signed his BAP Diagnosing Physician Certification Form. Doc. 372517 at 2. The Diagnosis dates to February 20, 2023, shortly after Mr. [REDACTED] examination with Dr. [REDACTED] *Id.*

On January 14, 2025, the Claims Administrator contacted Mr. [REDACTED] to (again) clarify his involvement in his family's restaurant business. Doc. 373726. Mr. [REDACTED] responded one week later:

In June 2024, you re-opened [REDACTED]

Please describe in detail what your role and responsibilities were in this re-opening and what your current roles and responsibilities are for this business. When did you begin working on this re-opening? Please also provide the approximate number of hours you work for this business, including any hours that are unpaid.

My mother retired from running her restaurant as she wanted to step back from having to be involved in all of the duties of running and operating a restaurant. We wanted to keep my mother's legacy going by trying to re-open the restaurant in a different location with proper staff (manager and employees) to do so to reduce the burden on my mother. As far as the re-opening I invested money into the re-opening and am a business partner in the venture and also agreed to go on TV to try and promote the re-opening of the restaurant since I am a retired NFL football player to help get the business off the ground. For the TV spot it was edited in a way to make it seem that I am involved in regular food prep and interacting with guests. This is not the case. My regular role is being the face of the restaurant, but my mother still remains active behind the scenes in terms of creating recipes, making nearly all of the food and handling the prep in the morning each day. She is no longer involved

in client interaction and now has staff to support the regular operation of the business.

On the day to day I have a manager and employees that run the restaurant. My duties are generally limited to responding to outreach to the business (emails and so forth) to try and drive traffic to the restaurant. I have limited in person day to day interaction with customers because I am easily irritated and I don't want people to know that I have a tendency to forget things. Right now, I am involved with the restaurant 2-3 hours per day on average for 4-5 days per week and am an owner in the business.

Doc. 374390 (emphasis in original).

Upon review, an AAP Member concluded that Mr. [REDACTED] met diagnostic criteria (i), (ii), and (iv) for a Diagnosis of Level 1.5 Neurocognitive Impairment under the Settlement. Doc. 401961. However, the Member advised that criterion (iii), pertaining to Mr. [REDACTED] functional impairment, was not satisfied:

Dr. [REDACTED] reported that the Player worked at a restaurant he owned and hired managers and employees to assist him with it, continued to drive but was unable to drive long distances (although this was because it would trigger migraines rather than due to cognitive decline), no longer gave talks or hosted children at his restaurant, was less social, no longer engaged in hobbies such as hiking, and his wife managed the finances along with financial advisors and a CPA because he was no longer able to do this, and the Player no longer worked out regularly. Dr. [REDACTED] reported a CDR ranking of 1.5 (presumably an overall CDR score of 1). The CDR Assessment form reported a score of 1 for Community Affairs, 2 for Home/Hobbies, and 0 for Personal Care, with an overall CDR score of 1, and listed similar problems/difficulties with activities as reported by Dr. [REDACTED] and in the third-party affidavit.

Additional information from the Player clarified that he invested money in the restaurant, was a business partner in the venture, and went on TV to promote the restaurant. The Player's role was being the face of the restaurant, and his mother remained active behind the scenes. A manager and employees ran the restaurant. The Player responded to outreach, had limited in person day to day interactions with customers, was involved with the restaurant 2-3 hours per day for 4-5 days per week, and was the owner of the business.

The third-party affidavit by [REDACTED] corroborated that the Player worked at a restaurant but with problems/difficulties, continued to drive but with problems, shopped less, was less social, was no longer involved with a non-profit, no longer went to events or engaged in public speaking, no longer mentored youth athletes, no longer worked out, had problems getting along with family members, and his

wife managed all household chores. The Player let dirty dishes pile up in the sink, no longer fixed things around the house, had problems with cooking, no longer engaged in hobbies of woodworking and gardening, had a decline in appearance, re-wore clothing with holes/stains, needed reminders to bathe/clean-up, and his wife helped him pick what to wear.

Overall, the information would support a rating of 0.5 for Community Affairs since the Player is still able to work and drive, even with problems, which would clearly indicate the continued ability for independent functioning outside the home; a score of 1 for Home/Hobbies since there is report of definite problems with household chores and abandonment of hobbies, and a score of 1 for Personal Care due to needing reminders to bathe/clean-up and change clothing due to re-wearing clothing with holes/stains.

While Dr. [REDACTED] reported that the Player drank 3-5 beers per day, used weed, and ingested mushrooms, there was no explanation what effect these substances had on cognitive impairment. The substances could have an effect on ability to perform everyday tasks such as household chores and personal care and could serve as a likely explanation for the apparent discrepancy between the level of functioning for Community Affairs compared to Home/Hobbies and Personal Care. Effects of these substances likely have accounted for at least some of the functional impairment rather than cognitive decline. Consequently, a score of 1 for Home/Hobbies would no longer be supported and instead I would recommend a score of 0.5. Similarly, for Personal Care, I would also recommend a score of 0.5 rather than a score of 1. Because the scores for Community Affairs, Home/Hobbies, and Personal Care are all now equal to 0.5 there would no longer be an apparent discrepancy between the scores for the three relevant CDR categories and the overall CDR score would now be 0.5. Therefore criterion (iii) is not fulfilled.

Id. (breaks added).

Adopting the AAP's findings, the Claims Administrator denied Mr. [REDACTED] Claim on August 5, 2025. *Id.* Mr. [REDACTED] timely appealed.⁴ Doc. 404745.

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. Mr. [REDACTED] argues that the Claims Administrator and the AAP improperly reduced his CDR scores upon review, and should have instead deferred to Dr. [REDACTED] determination regarding his level of functional impairment.

⁴ On October 28, 2025—after the submission of Mr. [REDACTED] Appeal and before the submission of the NFL Parties' opposition brief—investigators working for Claims Administrator contacted Mr. [REDACTED] one of Mr. [REDACTED] friends and business partners, about his business affairs. Doc. 412573. The information provided by Mr. [REDACTED] is largely consistent with the other functional impairment documentation in the record.

There are four diagnostic criteria for a Diagnosis of Level 1.5 Neurocognitive Impairment under the Settlement.⁵ Only criterion (iii) is in dispute.⁶ It requires that Mr. ██████ “exhibit[] functional impairment generally consistent with the criteria set forth in the National Alzheimer’s Coordinating Center’s Clinical Dementia Rating (CDR) scale Category 1.0 (Mild) in the areas of Community Affairs, Home & Hobbies, and Personal Care.”⁷

Dr. ██████ determined that Mr. ██████ had an overall CDR score of 1.0. Doc. 289376. The AAP Member, asked to advise the Claims Administrator, determined that the underlying records did not sufficiently support that determination. Doc. 401961.

This Settlement is “built around layered deference to expertise.”⁸ 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.”⁹ But deference is not automatic. It requires a diagnosing neurologist to have “*carefully* considered the relevant evidence.”¹⁰ That is, they must “provide[] an articulated and holistic justification” for their CDR scoring for it to have significant weight.¹¹

The record shows that Mr. ██████ engages in significant substance use and has issues with depression and motivation. While Dr. ██████ acknowledged these facts in her report, she made no effort to explain the role they played in Mr. ██████ functional impairment. The CDR assessment form specifically instructed Dr. ██████ to isolate functional decline due to cognitive loss alone. Doc. 289376 at 3. By leaving this section blank, and offering no explanation elsewhere, Dr. ██████ has failed to provide an articulated justification for her conclusion that Mr. ██████ has an overall CDR score of 1.0. Accordingly, 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).

Mr. ██████ argues on appeal that his substance use—particularly mushrooms—does not impede, but rather improves, his function. Evaluating that claim turns on the kind of medical

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

⁶ If I were disposed to grant Mr. ██████ Appeal, the NFL Parties would request a remand for reconsideration of criterion (ii), Mr. ██████ neuropsychological testing. Doc. 412377 at 3 n.3. They argue that Mr. ██████ marijuana use on the morning of his neuropsychological testing calls into question the validity of his test results. *Id.* I have ordered a remand under similar circumstances before. *See* Special Master Ruling on Substance Use, at 5 (Dec. 2, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=substance_use_sm.pdf (“Without information regarding the dosing and frequency of [the Claimant’s] marijuana intake, the medical experts have indicated that it is not possible to discern the substance’s impact on his test results on the day of his neuropsychological evaluation.”) But given this Appeal’s disposition, a remand is unnecessary.

⁷ Settlement Agreement, Exhibit A-1(1)(a)(iii).

⁸ Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_sm.pdf.

⁹ Special Master Ruling on Validity and Deference, at 8-9 (Sept. 15, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_deference_sm.pdf.

¹⁰ *Id.* (emphasis added).

¹¹ *Id.* at 9.

judgment that Dr. [REDACTED] needed to (contemporaneously) make. An explanation provided on appeal by Mr. [REDACTED] attorney—two and a half years after his examination—will not suffice, however articulate it may be. Of course, it's true that a player's use of alcohol, marijuana, mushrooms, or any other substance does not prevent them from receiving an Award under the Settlement. However, if the player's substance use is a potential contributor to their functional impairment (as will often be the case, especially with heavy use), then their diagnosing neurologist (not their attorney) must *attempt* to separate out these effects from those caused by cognitive loss. The records' deficit is highlighted here, as Mr. [REDACTED] diagnosing neuropsychologist, Dr. [REDACTED] was concerned that these confounding factors produced the very declines in cognitive function he observed.

On appeal, I requested an additional AAP review of Mr. [REDACTED] medical record. Doc. 420077. The AAP's review was thorough and I adopt their conclusions, which largely mirror my own:

The concomitant issues reported elsewhere in the records include psychological factors (“depression, anxiety, crying spells”), physical findings (“Focusing on anything for too long causes his head to hurt. He also endorses blurred vision if he attempts to concentrate”), and psycho-active substance use (“Alcohol- daily drinks beers 3-5 daily... Uses Weed and ingests mushrooms”).

Without discussing her reasoning, Dr. [REDACTED] reported that these substances are not exclusively associated with the player's cognitive deficits. However, Dr. [REDACTED] specifically stated, “His marijuana use cannot be ruled out as a factor in his current presentation.” Since this was raised by the psychologist whose testing she relied upon, there is a failure to articulate the reasoning to dismiss any role they may have in reduced daily function. Notably, frequent marijuana use is associated with high rates of apathy and anhedonia [Skulien et al 2023], which are major characteristics of the player's behavior and daily functional deficits.

[...]

These reports indicate that the player's disengagement and reduced daily function are associated with volitional components. Dr. [REDACTED] does not address or “attempt to isolate” the cognitively-mediated inability to carry out the functions as is required by CDR scoring rules. In contrast, the role of unwillingness, rather than inability to function, is clearly identified by Dr. [REDACTED] in her passage:

He no longer **engages** in hobbies. He once liked being outside, going on hikes but does not do this anymore. He would always find a hiking trail whenever they vacationed but not anymore. Now, when his wife and kids are going for a walk, **he will join them out of obligation.**”

Thus, rather than clearly articulating that mood and motivation issues have been considered and discounted as causative factors in the player's reduced daily function, the opposite is true, i.e. Dr. [REDACTED] has described, considered, and identified the clear contribution of motivation when the player's physical and cognitive capacity allow for the function to be executed.

Whether the player has cognitive deficits, as required by Criterion (ii), is not the point in question. Losses in cognition are supported by the neuropsychological test results and elements of history obtained from the player, his spouse, and the third-party affiant. However, the contemporaneous medical records do not demonstrate or clearly articulate the reasoning to support that those deficits are sufficient to account for the player's reduced functional ability as reflected in CDR scoring.

Id. (quoting Doc. 289376 at 3) (emphasis in original, cleaned up, and breaks added).¹²

Overall, the Claims Administrator appropriately applied the Settlement's review standards, and did not err in concluding that Mr. [REDACTED] had failed to satisfy the requirements for a Level 1.5 Award.

CONCLUSION

The Claims Administrator concluded that Mr. [REDACTED] failed to satisfy the requirements for a Diagnosis of Level 1.5 Neurocognitive Impairment and denied his Claim. As Mr. [REDACTED] has not shown by clear and convincing evidence that this determination was in error, I deny his Appeal.

Date: February 11, 2026



David A. Hoffman, Special Master

¹² Though I am not persuaded that Mr. [REDACTED] Appeal has shown by clear and convincing evidence that there was error in the Denial, he correctly points out that it is not the AAP's role to *determine* his functional impairment. The AAP's job is to help the Claims Administrator assess whether a Claim is sufficiently supported by the medical record, not to re-do an assessment that is holistic and clinical.