

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

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

Dr. [REDACTED] continued:

[Mr. [REDACTED] was noticed having an increasing tremor on right arm and hand for last 2 years. The right side tremor was persistently and worse at rest. The resting tremor is getting progressively worse and became constant[] over last 4 months. He is noticed having slow movements, slurred speech, stiffness on arms and legs, unsteadiness and increasing incidences of fallings.

Id.

In the “Objective” Section of his report, Dr. [REDACTED] reported that a neurological exam “showed right hand resting tremor with increased tone.” *Id.* He added that Mr. [REDACTED] displayed an “[u]nsteady gait and mild shuffling.” *Id.*

Overall, Dr. [REDACTED] concluded that:

Mr. [REDACTED] has a progressive memory loss and cognitive dysfunction for many years. Recently he presented with increasing right arm and hand resting tremor, associated with bradykinesia, rigidity, postural instability and unsteady gait.

His clinical presentations included resting tremor (shaking), bradykinesia (slowness of movement), rigidity (stiffness), and posturing instability (unsteady gait), these are four cardinal clinical features of Parkinson’s disease.

Based on previous documented history, current interviews, clinical symptoms and neurological examination, his clinical presentation consists with the diagnosis of Parkinson’s disease per the criterial of ICD-10. Using sound medical judgment and best medical practices, his motor dysfunctions, cognitive impairments, and impairments in activities of daily livings are due to repeat traumatic brain injury while playing NFL football.

Id. at 2.

In Dr. [REDACTED] treatment plan, he advised that Mr. [REDACTED] “continue close follow up with a neurologist.” *Id.* at 2.

On June 7, 2023, the Claims Administrator requested more information from Mr. [REDACTED] related to his Claim. Doc. 284061. Specifically, the Claims Administrator asked Mr. [REDACTED] if he had, in fact, received any follow-up care since his evaluation by Dr. [REDACTED] *Id.* Mr. [REDACTED] replied affirmatively, providing evidence that he attended an appointment with Dr. [REDACTED] on May 31, 2023, during which time Dr. [REDACTED] prescribed Mr. [REDACTED] with Levodopa. *Id.*; Doc. 284064.

After receiving this information, the Claims Administrator referred Mr. [REDACTED] Claim to an Appeals Advisory Panel (AAP) Member for review. Doc. 287946. The AAP Member, in turn,

requested additional documentation, because “[s]everal aspects of [Dr. ██████] overly brief report need[ed] to be clarified.” Doc. 299569. Specifically, the AAP Member requested elaboration regarding:

- 1) The duration by history of the slowed movements and limb stiffness.
- 2) The relative severity of the reported tremor, bradykinesia and increased tone (mild, moderate or severe)
- 3) The distribution of increased tone (right hand only?)
- 4) What aspects of movement were slowed on exam (finger taps, hand opening foot tapping?) and what specific aspects of the exam led to the assessment of bradykinesia.
- 5) Treatment with levodopa is mentioned, but no information is given regarding a response.
- 6) Slurred speech is mentioned in the history, but no comments regarding speech are mentioned for the exam

Id. at 2.

The AAP Member also noted that “[w]ith only one Gelb criterion clearly positive this further information is important to making a determination.” *Id.*

In response, Mr. ██████ submitted three different reports from Dr. ██████ one dated August 30, 2023, one dated September 21, 2023, and one dated February 13, 2024. Docs. 314715, 314716, 314718. These reports were effectively identical to each other, and largely contained information already written in Dr. ██████ initial report from April 2023. *Compare* Doc. 282935 *with* Docs. 314715, 314716, 314718.

In fact, the only apparent new information these reports contained was an update that Mr. ██████ “tremor [was] stable with medicines.” Docs. 314715, 314716, 314718 at 3.

After receiving this response, the Claims Administrator once again referred the Claim to an AAP Member. At this point, the AAP Member recommended denial, finding that Dr. ██████ initial report and subsequent notes did not adequately support a finding of Parkinson’s disease. The Claims Administrator, denying Mr. ██████ Claim on June 24, 2024, adopted the AAP’s member’s reasoning about the Gelb criteria. Doc. 345315. It follows:

- 1) Resting Tremor: Dr. ██████ reports a history of the right arm tremor for two years, worse at rest. Dr. ██████ notes a right hand resting tremor on exam. This criterion is fulfilled.
- 2) Bradykinesia: Dr. ██████ reports a history of slow movements (of unspecified duration). Although his assessment refers to bradykinesia (slowness of movement), there are no comments in the initial or any follow-up exam (8/30/2023, 9/21/2023, 2/13/2024) to support this assessment, such as what specific tasks or settings revealed slow movements. This criterion is not fulfilled.

3) Rigidity: Dr. [REDACTED] reports a history of stiffness of arms and legs (of unspecified duration). He documents increased tone in the right hand only of unstated severity. This criterion is not clearly fulfilled.

4) Asymmetric Onset: Dr. [REDACTED] reports that the tremor by history is worse on the right and documents asymmetry of tremor and increased tone on exam. This criterion is fulfilled.

5) Describe any other supporting factors: Dr. [REDACTED] describes an unsteady gait with mild shuffling, while his assessment mentions only postural instability (unsteady gait) rather than shuffling. Although Dr. [REDACTED] as well as some published work considers postural instability to be a “cardinal” feature of Parkinson’s Disease, it does not usually occur early in the disease, and for this reason is not a Gelb criterion and may actually suggest an alternative diagnosis. With regard to a response to treatment with levodopa, all three follow-up notes have extremely brief neurological exams that appear verbatim of the exam from the date of diagnosis. Although the follow-up notes have a statement that the tremor is stable on medication, this does not well support a response to levodopa since the expected result is improvement rather than stability after treatment.

Id.

Thus, the Claims Administrator concluded, “only two Gelb criteria are clearly fulfilled, and in general, the documentation of objective signs of Parkinson’s Disease is not adequate to meet the Settlement criteria for the Qualifying Diagnosis.” *Id.* Accordingly, Mr. [REDACTED] Claim was denied. *Id.*

On October 9, 2024, Mr. [REDACTED] timely appealed. Doc. 361954. To support his Appeal, Mr. [REDACTED] attached a letter from the NFL Players’ Association (NFLPA), dated August 12, 2024, indicating that Mr. [REDACTED] was entitled to benefits for Parkinson’s disease under the 88 Plan. Doc. 361951. He also attached additional reports from Dr. [REDACTED] dated July 23, 2024, and April 29, 2024. Doc. 361952.

Upon receiving this new evidence, I remanded Mr. [REDACTED] Claim back to the Claims Administrator on October 16, 2024. Doc. 362818.

On January 31, 2025, the Claims Administrator once again issued a Notice of Denial. Doc. 376320. As the Claims Administrator explained:

The AAP previously determined that two of the four key elements of the Gelb Criteria, bradykinesia and rigidity, were not fulfilled, for the reasons described in the 6/24/2024 Denial Notice.

Since the original review new information has been provided. Doc ID 361951 is a letter dated 8/8/2024 from the NFL 88 Committee stating that the committee determined that the Player is eligible for benefits under the plan for Parkinson's disease. The relevance of this determination to the asserted diagnosis under the

NFL Concussion Settlement is uncertain, since no information is provided regarding the criteria for the diagnosis of Parkinson's disease used by the 88 Committee and how it compares to the Gelb Criteria used by the Settlement.

Doc ID 361952 is an office note from a follow-up evaluation by Dr. [REDACTED] on 7/23/2024, when he was no longer an approved Qualified MAF Physician for the Settlement Program. This note under "Subjective" appears to be text from the 6/24/2024 Denial Notice with no additional comments or clarifications from Dr. [REDACTED]. Both historical information and the description of the neurological examination again appear to be identical to the other previous follow-up notes and provide no new medical documentation to support the asserted diagnosis of Parkinson's Disease.

Id. at 2 (breaks added).

The Claims Administrator went on:

A follow-up note by Dr. [REDACTED] from a 4/29/2024 telemedicine visit (also when he was no longer an approved Qualified MAF Physician for the Settlement Program) is also included with historical information that again appears identical to the previous visits. The neurological examination is also identical to previous visits, including comments regarding muscle strength and tone that cannot be assessed using telemedicine and undermine confidence in the reliability of the documentation. This note also does not provide any new medical documentation in support of the asserted diagnosis of Parkinson's Disease.

Id.

Thus, "in conclusion, the medical documentation, including the new documentation provided, is not sufficient to fulfill either of the Gelb Criteria of bradykinesia or rigidity, and in general, the documentation of objective signs of Parkinson's Disease is not adequate to meet the Settlement criteria for the Qualifying Diagnosis." *Id.*

On April 29, 2025, Mr. [REDACTED] timely appealed. Doc. 389675. With this Appeal, Mr. [REDACTED] newly attached the report of Dr. [REDACTED], along with a copy of Dr. [REDACTED] curriculum vitae. Docs. 389671, 389672. Dr. [REDACTED] report ultimately concludes that Mr. [REDACTED] "history and examination are most consistent with the diagnosis of Parkinson's disease." Doc. 389671 at 9.

RESOLVING THIS APPEAL

On appeal, I determine if Mr. [REDACTED] has identified clear and convincing evidence that the Claims Administrator wrongly denied him relief. This standard places the burden on Mr. [REDACTED] to 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 Finding that Mr. [REDACTED] has not met this high burden, I affirm.

As I recently explained in detail how the Claims Administrator reviews Parkinson's claims, I will not repeat that analysis here.² The key piece of that discussion for today's Appeal is this one:

the 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.³

In this case, the treating physician did not fulfill this mandate. Instead, when it came to Gelb criteria 2, bradykinesia (slowness in movement), and Gelb criteria 3, rigidity, Dr. [REDACTED] repeatedly declined to provide the information necessary to support Mr. [REDACTED] Diagnosis of Parkinson's and, ultimately, his Claim for benefits.

Starting with bradykinesia. In all six reports submitted, Dr. [REDACTED] only documented Mr. [REDACTED] reported history of slow movements, without any additional notes describing the duration of this history or explaining "what specific tasks or settings revealed slow movements." Doc. 345315 at 2. While Dr. [REDACTED] referenced bradykinesia in his report, this reference was conclusory, with Dr. [REDACTED] noting only that Mr. [REDACTED] "clinical presentations include[d] bradykinesia" and his tremor was "associated with bradykinesia." Doc. 282935.

Similarly, when describing rigidity, Dr. [REDACTED] merely concludes that Mr. [REDACTED] "presented with increasing right arm and hand resting tremor associated with . . . rigidity" and lists rigidity as one of his clinical presentations. *Id.* at 2. He does not provide any other details about this symptom, beyond a brief mention that Mr. [REDACTED] presents with "increased tone" in his right hand. *Id.* at 1.

When rendering any Qualifying Diagnosis under the Settlement, physicians are tasked with clearly articulating their clinical judgments. Indeed, the Settlement's system of "layered deference to expertise" relies on them to do so.⁴ This process, while inherently deferential, requires that physicians do more than just conclude that a Player meets a certain criterion or presents with a certain symptom. Physicians must, at bottom, provide *something* more.

And, here, Dr. [REDACTED] failed to do so at multiple junctures. When asked for additional information, Dr. [REDACTED] repeatedly submitted documents nearly indistinguishable from his initial, insufficient report and identical to each other. This was true even in a report from a telemedicine visit, despite an AAP Member's finding that "muscle strength and tone . . . cannot be assessed

¹ Special Master Ruling on Parkinson's and Deference, at 8 (July 1, 2025), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=parkinsons_disease_deference_sm.pdf.

² *Id.* at 9-10.

³ *Id.* at 11.

⁴ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 5 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=slick_validity_testing_sm.pdf (internal citations omitted).

using telemedicine.” Doc. 376320 at 2. The last report Dr. [REDACTED] submitted, lacking additional explanations for his findings, instead contained a copied and pasted segment of the AAP Member’s evaluation of his report.

Accordingly, given these persistent deficiencies, the Claims Administrator properly concluded that Dr. [REDACTED] reports did not adequately support a diagnosis of Parkinson’s disease under the Settlement.

Dr. [REDACTED] report does not fundamentally change this analysis. Under the Settlement, *only* Qualified MAF Physicians may render Qualifying Diagnoses of Parkinson’s disease.⁵ Dr. [REDACTED] as all agree, is not a Qualified MAF Physician. Additionally, there is no evidence that Dr. [REDACTED] relied on or even has seen Dr. [REDACTED] report. Thus, because Dr. [REDACTED] is not the diagnosing physician—nor could he be—his report is entitled to no weight on appeal, let alone weight sufficient to demonstrate clear and convincing evidence of error.⁶

Therefore, given the deficiencies of Dr. [REDACTED] reports and the inapplicability of Dr. [REDACTED] report, it is not “reasonably certain” that contemporaneous medical records support a diagnosis of Parkinson’s disease using the Gelb criteria.

CONCLUSION

Upon review, I find that Mr. [REDACTED] has not sufficiently shown that, based on the medical records he appended to this Claim, he has fulfilled the Settlement’s requirements for a Qualifying Diagnosis of Parkinson’s disease. I therefore deny his Appeal.

He remains free to file anew, based on new clinical reports. Given the record before me, I would encourage him to do so.



Date: September 15, 2025

David A. Hoffman, Special Master

⁵ Settlement Agreement, Section 6.3(b).

⁶ That is not to say that Dr. [REDACTED] is wrong, or even that Mr. [REDACTED] does not suffer from Parkinson’s Disease or a Parkinsonian syndrome. My review on appeal from a Denial isn’t diagnostic but rather constrained: does the evidence in the file compel the conclusion that the Claims Administrator was wrong given the information before it to deny the Claim. It does not. But that a different (and eminent) neurologist observed symptoms consistent with Parkinson’s might be probative in a fresh evaluation of Mr. [REDACTED] at a future date by a Qualified MAF neurologist. Of course, that wouldn’t obviate the need to personally observe the symptoms and document them in a report.

Similarly, Mr. [REDACTED] eligibility for 88 Plan benefits cannot supplant the Settlement’s requirements for contemporaneous medical records completed by a program physician. Should Mr. [REDACTED] file a new Claim, he may find it prudent to provide his records from the 88 Plan to his new Qualified MAF neurologist, who can then in turn evaluate their clinical relevance. *See Frequently Asked Questions: FAQ #25* (regarding the distinction between eligibility for the 88 Plan and a Qualifying Diagnosis under the Settlement Program), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com>.