

IN RE: NATIONAL FOOTBALL
LEAGUE PLAYERS' CONCUSSION
INJURY LITIGATION

MDL No. 2323

THIS DOCUMENT RELATES TO:
APPEAL OF SETTLEMENT CLASS
MEMBER [REDACTED]
REGARDING QUALIFYING
DIAGNOSIS AND DATE OF
DIAGNOSIS

Qualifying Diagnosis asserted in the Monetary Award Claim that relied on Dr. [REDACTED] evaluation.” *Id.* at 6.

Mr. [REDACTED] submitted a second Claim in 2019. Doc. 199670. The Claims Administrator denied that Claim on February 26, 2019, because it lacked a re-evaluation as required by the early audit decision. Doc. 201773.

Mr. [REDACTED] was then evaluated by MAF neurologist Dr. [REDACTED] on November 11, 2022. Doc. 280859. In his exam notes, Dr. [REDACTED] described Mr. [REDACTED] functional impairment:

He has less of a social life; they rarely go out, may sometimes go to people’s house for dinner or games. He used to cook as a hobby, and bar-bq, and fish, but that stopped around 2015 as it became hazardous - leaving eggs on the stove or not turning off the grill. He used to golf, but stopped. He says he sometimes needs help with self care. His wife helps shave his head, he may wear his shirt inside out but mostly can put on his clothes. He has lost continent and takes medicine for that. He has urgency, once had an accident in the car. He no longer drives, due to getting lost, and fear of having more blackouts.

Id. at 2.

Dr. [REDACTED] also completed a Clinical Dementia Rating (CDR) worksheet and assessment form, using information gathered from Mr. [REDACTED] informant [REDACTED], and the available medical records. Docs. 280877; 280875. On the worksheet, Dr. [REDACTED] circled scores of 1.0 in Community Affairs, 2.0 in Home & Hobbies, and 1.0 in Personal Affairs.¹ Doc. 280877 at 11. Meanwhile, on the assessment form, Dr. [REDACTED] provided a brief written description for each of these categories.² Doc. 280875 at 2-4.

For Community Affairs: “Markedly decreased social activity – goes out but rarely. No longer golfs. Requires assistance in self care.” *Id.* at 2 (cleaned up).

For Home & Hobbies:

- [REDACTED] spends most of his day at home. He does not drive. He no longer cooks. BBQ and cooking were some of his favorite hobbies.
- Movies were also a great hobby, but he can no longer finish or keep up watching movies or most TV shows.
- [REDACTED] takes numerous naps a day because he fatigues easily. (Headaches and dizziness).

¹ As for the three non-Program-relevant CDR categories, Dr. [REDACTED] circled scores of 2.0 in Memory, 1.0 in Orientation, and 1.0 in Judgement & Problem Solving. Doc. 280877 at 11.

² The varied handwriting style and first/third person point-of-view suggests that Dr. [REDACTED] may not have written all of the explanations himself, but rather, most plausibly, the Home & Hobbies and Personal Care explanations were written by the informant [REDACTED]. Compare Doc. 280875 at 2, *with id.* at 3.

- He likes to read/newspaper/comprehension is slow.

Id. at 3 (cleaned up).

For Personal Care:

- [REDACTED] does not cook so he eats mostly sandwiches and prepared food by me.
- I help him with prescriptions and appointments. (phone and/or calendar). I use sticky notes to help him remember.
- He doesn't do many chores. Mostly folding laundry and putting away dishes. Sweeps occasionally. Washes dishes as well.
- He really isn't capable of performing many routine tasks beyond that.

Id. (cleaned up).

At the end of the assessment form, Dr. [REDACTED] listed an overall CDR rating of 2.0. Doc. 280875 at 4. He confirmed this finding in his MAF provider report: "Abnormal level 1.5 on 4 items. Level 2.0 on 2 others. Overall level 2." Doc. 280858 at 7.

Having found the requisite degree of functional impairment for both a Level 1.5 and Level 2 Diagnosis under criterion (iii), Dr. [REDACTED] asked Mr. [REDACTED] to complete "neuropsychological testing to help discern whether [Level] 1.5 or 2.0" was met under criterion (ii). Doc. 280859 at 2.

Mr. [REDACTED] did so with neuropsychologist Dr. [REDACTED] on January 13, 2023. Doc. 280873. The testing revealed overall Level 1.5 Cognitive Impairment. *Id.* at 7.

Despite this result, on March 23, 2023, Dr. [REDACTED] certified a Diagnosis of Level 2 Neurocognitive Impairment. Doc. 280857. On May 22, 2023, Mr. [REDACTED] submitted his third Claim, asserting a Level 2 Diagnosis.³ Doc. 281518. While his Claim Form indicated a date of Diagnosis of November 13, 2019, Dr. [REDACTED] Diagnosing Physician Certification Form indicated a date of Diagnosis of February 25, 2023. *Compare* Doc. 281518 at 6, *with* Doc. 280857 at 3.

Mr. [REDACTED] neuropsychological testing triggered extensive correspondence between Mr. [REDACTED] Dr. [REDACTED] the Claims Administrator, and an Appeals Advisory Panel (AAP) Consultant about his suboptimal performance on performance validity measures. Docs. 284039, 286193, 286367, 286997. Those validity issues ultimately led to a Denial on December 18, 2023. Doc. 297365. As the Claims Administrator explained, based on the Consultant's review, although Dr. [REDACTED] had thoroughly articulated his reasoning, it was "too faulty to be reasonably determined and did not resolve the issues with invalid performance on multiple performance validity tests and with Slick Criteria 4, 5, and 7." *Id.* at 1-2.

³ Although [REDACTED] information was listed in the Representative Claimant section of the Claim Form, she was never officially substituted as a Representative Claimant for Mr. [REDACTED] Doc. 281518 at 4. Mr. [REDACTED] remains the Settlement Class Member.

At the same time, that notice also determined that Mr. [REDACTED] Claim (and Dr. [REDACTED] report) *did* provide sufficient evidence of functional impairment.⁴ *Id.* at 2. Its explanation was carefully considered and fulsome:

Dr. [REDACTED] reported the Player had less social life, rarely went out, sometimes went to other people's houses for dinner or games, used to cook as a hobby, as well as bar-b-q and fish but stopped these hobbies around 2015, used to golf but stopped, sometimes needed help with self-care, his wife helped shave his head, could mostly put on clothes but may put his shirt on inside out, no longer drove, had incontinence, and was not able to use a hammer or screwdriver. Dr. [REDACTED] Provider Report dated 11/11/2022 reported the Player had no employment for about seven years and had marked decline in social activities but may occasionally go out.

A CDR Worksheet reported the Player was no longer working and that memory/thinking problems contributed to the decision to retire, no longer drove, rarely/never was able to shop or carry out activities outside the home independently, was still able to do laundry, folding, sweeping, but only had limited functioning for household chores, had decreased ability to perform hobbies, and scores of 1 were circled for dressing and sphincter control, and scores of 0 were circled for washing/grooming and eating. A CDR Assessment Form indicated an overall CDR score of 2 based on information provided by the Player's girlfriend.

Documentary evidence included a letter from the NFL Player Benefits 88 Plan dated March 3, 2021, that indicated the Player was entitled to benefits under the Plan for Dementia. Documentary evidence also included medical records from [REDACTED], PA-C, [REDACTED], PA-C, and Dr. [REDACTED] at [REDACTED], which reported a diagnosis of memory impairment. Prior third-party affidavits dated 11/8/2017, 1/19/2018, and 1/18/2018 are outdated.

While memory impairment and dementia were corroborated by the documentary evidence, many of the functional impairments were not directly corroborated and so a new third-party affidavit was requested to corroborate the functional impairments. The new third-party affidavit by [REDACTED] dated 6/26/2023 corroborated the Player had not worked since 2016, no longer drove but it was attributed to poor night vision and blackouts, most outdoor activities were sitting/walking in a nearby park, was less social and visited family members less or had stopped visiting family members, occasionally attended Church, no longer engaged in fishing and golfing, no longer was able to keep up with events/workshops for charities, no longer cooked, was still able to fold laundry, had lost interest in

⁴ As part of the post-submission correspondence with the Claims Administrator, Mr. [REDACTED] also provided a Third-Party Sworn Statement from [REDACTED], dated June 26, 2023, to corroborate his functional impairment. Doc. 285408.

chess/poker, was not able to shave due to tremors, difficulty managing his weight, and had a loss of bladder control.

The information corroborated by the third-party affidavit is generally consistent with an overall CDR score of 2 and CDR scores of 2 for Community Affairs and Home/Hobbies, and a score of 1 for Personal Care. While the inability to drive is attributed to causes other than cognitive decline (poor night vision and blackouts), the other information is generally consistent with a score of 2 for Community Affairs (no longer working, limited outdoor activities, inability to keep up with charity events/workshops, being less social, and only occasionally attending Church). The information about Home/Hobbies activities indicated a loss of interest in hobbies and abandonment of hobbies, less interaction with family members, only simple household chores were preserved (not able to cook, but able to fold laundry), which could be consistent with a score of either 1 or 2 and the CDR rules indicate that when the information could be consistent with either of two adjacent scores that the higher score be assigned. For Personal Care, there is report of incontinence but the difficulty with shaving and grooming is attributed to tremor rather than cognitive decline, so overall the information would be most consistent with a score of 1 for this category. Because the information would be consistent with scores of 2 for two of the three relevant CDR categories, Dr. [REDACTED] determination of an overall CDR score of 2 is not clearly inaccurate and so I would defer to that determination.

Id.

Mr. [REDACTED] did not appeal that Denial, but rather sought a new neuropsychological evaluation by Dr. [REDACTED] on April 7, 2024. Doc. 321634. This new set of testing revealed overall Level 2 Cognitive Impairment. *Id.* at 5. And importantly, Dr. [REDACTED] concluded that it did not trigger any validity concerns:

Mr. [REDACTED] performed in the adequate range on all embedded and stand-alone measures of cognitive performance validity with the exception of WAIS Reliable Digit Span, which was found to be in the suboptimal range. This is consistent with the behavioral observations that Mr. [REDACTED] appeared inattentive partially due to slow information processing. Consequently, his performance was determined to be optimal according to the Slick criteria checklist. Thus, test results are considered to be a valid representation of Mr. [REDACTED] neurocognitive functioning at the time of the evaluation.

Id. at 3.

Mr. [REDACTED] submitted this Claim on June 26, 2024. Doc. 345891. He did so relying on the previous neurological evaluation from Dr. [REDACTED] and the new neuropsychological testing from Dr.

Doc. 325243. On September 3, 2024, Dr. [REDACTED] submitted an addendum explaining the sequence of events:

Since my original evaluation, the patient has gone back to Dr. [REDACTED] (neuropsychologist) who reexamined him. He explained that in his earlier report, although several individual tests for “validity” were “failed” by the player, that he nonetheless felt overall, that his examination results were valid. Dr. [REDACTED] previously assigned Mr. [REDACTED] Level 1.5. In his follow-up assessment in April, 2024, states that Mr. [REDACTED] had impairments in the same domains as in his prior assessment and that that findings provides evidence of “consistency in test performance over time (that) provides evidence of genuine cognitive impairment above and beyond validity test performance.” On this test, Dr. [REDACTED] assigned the player a Level 2.0 cognitive impairment, as did I. Therefore I believe he now meets all four criteria as per your note, including criteria number 3. Further, Dr. [REDACTED] assisted me in reaching this conclusion and I (partly) relied on his assessment in addition to my own.

Doc. 356157 (cleaned up).

Dr. [REDACTED] also submitted a new Diagnosing Physician Certification Form with a Diagnosis of Level 2 Neurocognitive Impairment on December 6, 2024, with a date of Diagnosis of November 11, 2022.⁵ Doc. 369395.

On March 10, 2025, the *same* AAP Member reviewed Mr. [REDACTED] new Claim and agreed that the validity issues with his prior Claim were now absent. Doc. 382020. The advising expert did, however, take issue with Mr. [REDACTED] asserted Qualifying Diagnosis and date of Diagnosis. *Id.* After summarizing the available CDR reports, the report continued:

Documentary evidence included a letter from the NFL Player Benefits 88 Plan dated 3/3/2021 that indicated the Player was entitled to benefits under the Plan for Dementia. Documentary evidence also included medical records from [REDACTED], PA-C, [REDACTED], PA-C, and Dr. [REDACTED] at [REDACTED], which reported a diagnosis of memory impairment.

⁵ On February 12, 2025—in the gap of time between the submission of Mr. [REDACTED] fourth Claim and the Claims Administrator’s award determination on March 10, 2025—Mr. [REDACTED] was evaluated by Dr. [REDACTED] *again*, this time, for concerns regarding Parkinson’s Disease. Doc. 379296 at 2. The record includes various documents associated with this visit. Docs. 379298; 379299; 379312. Of potential importance is a new CDR assessment listing an overall rating of 1.0, seemingly at odds with the overall rating of 2.0 that Dr. [REDACTED] found in 2022 and which is at the heart of this Appeal. Docs. 379300 at 10; 379310 at 4. On the same day as this evaluation, Dr. [REDACTED] certified a Diagnosis of Parkinson’s Disease, dated to November 15, 2024. Doc. 379314. It does not appear as if Mr. [REDACTED] has submitted a Claim (which would be his fifth) in connection with this Diagnosis. Neither the Claims Administrator nor the AAP reference this new visit in their March 10, 2025 findings, and it is similarly absent from the briefing submitted by both parties on appeal.

There is a third-party affidavit, but it is a checklist affidavit that does not include descriptions of the functional abilities and only subjectively ranks them as improved, not much change, worse, or much worse, and this affidavit was dated 11/8/2017 and so the information is also outdated. Additional third-party affidavits dated 1/19/2018 and 1/18/2018 are also outdated.

A third-party affidavit by [REDACTED] dated 6/26/2023 corroborated that the Player had not worked since 2016, did not drive (due to problems with night vision and blacking out), did not participate in hobbies of fishing/golfing/chess/poker, was able to walk and sit in a nearby park, had no relationship with his siblings, occasionally attended Church, was no longer involved with charities, no longer cooked, had problems changing a light bulb and operating a screwdriver due to tremor, was still able to fold laundry, had a decline in appearance, could not shave due to tremor, and had urinary incontinence for 5 years.

Consequently, overall the information would support a score of 1 for Community Affairs since the ability to walk and sit in a park would give at least the appearance of independent functioning outside of the home; a score of 2 for Home/Hobbies due to having limited functioning for chores, restricted interests and abandoned hobbies (fishing/golfing/chess/poker); and a score of 1 for Personal Care due to problems with dressing and having incontinence. Functional impairments such as no longer driving due to problems with night vision and blacking out, not being able to change a light bulb due to tremor, and not shaving due to tremor would not be included in the analysis since these functional limitations were due to non-cognitive factors.

In general, the Player appears to function at a higher level than would be indicated by an overall CDR score of 2 since he is able to walk/sit in a park, which would indicate at least the pretense of independent functioning outside the home and was not reported to require assistance with Personal Care activities despite having some urinary incontinence, so the information would be more consistent with an overall CDR score of 1. Therefore, criterion (iii) is not fulfilled for Level 2 Neurocognitive Impairment but would be fulfilled for Level 1.5 Neurocognitive Impairment as of 6/26/2023.

Id. at 2-3 (breaks added).

It also pinned Mr. [REDACTED] date of Diagnosis to his new neuropsychological evaluation by Dr. [REDACTED] which took place on April 7, 2024. *Id.*

Adopting the AAP's determinations, the Claims Administrator granted Mr. [REDACTED] a Monetary Award based on a Diagnosis of Level 1.5 Neurocognitive Impairment and a date of Diagnosis of April 7, 2024. Doc. 382000. Mr. [REDACTED] timely appealed. Doc. 384135.

RESOLVING THIS APPEAL

To prevail on appeal, Mr. [REDACTED] must show by clear and convincing evidence that the Claims Administrator’s decisions regarding his Diagnosis and date of Diagnosis were in error. I will consider each question in turn.

1. Qualifying Diagnosis

Whether a Diagnosis of Level 1.5 or Level 2 Neurocognitive Impairment is appropriate turns on Mr. [REDACTED] functional impairment under criterion (iii) of the Settlement. For a Diagnosis of Level 2 Neurocognitive Impairment, the Settlement requires that a Claimant diagnosed outside the BAP “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 in the areas of Community Affairs, Home & Hobbies, and Personal Care.”⁶ A Level 1.5 Diagnosis, meanwhile, requires general consistency with CDR scores of Category 1.0 (Mild) in the same areas.⁷

CDR scoring results from a “holistic judgment,” not a “mathematical exercise,” by the diagnosing neurologist.⁸ The diagnosis, in other words, “is not simply an average of the three scores” and “[t]here is no required minimum score on any of the three areas.”⁹ Here, Mr. [REDACTED] diagnosing neurologist, Dr. [REDACTED] provided a report and worksheet justifying CDR scores of 1.0 in Community Affairs, 2.0 in Home & Hobbies, and 1.0 in Personal Care—with an overall rating of 2.0. Docs. 280877, 280875.

A single member of the AAP has twice considered whether or not Dr. [REDACTED] reasoning, and Mr. [REDACTED] functional impairment, met that standard. Seemingly applying varying levels of deference, that member reached divergent conclusions. In Mr. [REDACTED] 2023 Notice of Denial, the Claims Administrator adopted the AAP Member’s initial judgment to conclude that Mr. [REDACTED] documented functional impairment supported a Level 2 Diagnosis. Doc. 297365. The following year, the same AAP Member, considering the same evidence—Dr. Jacobs’ findings, Mr. [REDACTED] medical records, and Ms. [REDACTED] affidavit—disagreed with himself. Doc. 382020. In this, Mr. [REDACTED] fourth-filed Claim, the Claims Administrator adopted the second judgment to reduce Mr. [REDACTED] Award to a Diagnosis of Level 1.5 Neurocognitive Impairment.

This Settlement is “built around layered deference to expertise.”¹⁰ That means, at the very least, that the views of diagnosing neurologists who’ve carefully considered the relevant evidence

⁶ Settlement Agreement, Exhibit A-1, 2(a)(iii).

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

⁸ Special Master Ruling on Functional Impairment, at 6 (Aug. 25, 2024), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_sm_8.pdf.

⁹ 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://nflconcussionsettlement.com>.

¹⁰ Special Master Ruling on Pre-Diagnosis Evidence, at 6 (July 2, 2020), https://www.nflconcussionsettlement.com/Docs/pre_diagnosis_evidence_sm.pdf.

of functional impairment merit some weight.¹¹ Dr. ██████ provided an articulated and holistic justification for his Level 2 Diagnosis. An independent advisory expert reached two different conclusions at two different points in time about whether that judgment was correct, though that Member never suggested it lacked consideration. That the same Member of the advisory panel reached conflicting answers is very strong evidence that Mr. ██████ Diagnosis results from an articulated, clinical, judgment about which reasonable medical minds could, and did, differ. Dr. ██████ views were not clearly erroneous and should have stood undisturbed.

The Claims Administrator’s judgment on Appeal must stand unless there is clear and convincing evidence that they were in error. Here, failing to apply the appropriate degree of deference given an articulated justification is evidence of that fault. And stepping back, sanctioning a shift in the Claims Administrator’s judgment between Mr. ██████ third and fourth Claims based on the same evidence would be simply unfair.¹² Mr. ██████ resubmitted Dr. ██████ testing for his fourth Claim after being informed, in the Notice of Denial for his third Claim, that he had demonstrated functional impairment sufficient to meet the diagnostic criteria for Level 2 Neurocognitive Impairment. Players are entitled to rely on the reasoning the Claims Administrator provides in its Notices of Denial, which form the basis for their appeals and informs their subsequent claims. A change in that reasoning, with no new information justifying a different result, impedes Class Members’ ability to proceed efficiently through the Settlement’s process.

2. Date of Diagnosis

The Settlement Agreement requires that a Class Member’s date of Diagnosis must be determined by their diagnosing physician.¹³ Further clarification is provided by FAQ 101, which explains:

The date of a Qualifying Diagnosis other than Death with CTE is when the diagnosing physician has enough information and materials, *including test results*, to be able to render a medically sound and reliable judgment that all criteria for the

¹¹ Special Master Ruling on Neuropsychological Testing: *Slick* Criteria and Validity Testing, at 10 (Oct. 21, 2020), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=slick_validity_testing_sm.pdf (“The AAP should defer to a clinician’s Slick-criteria-based validity analysis when it results from reasoning completely articulated in contemporaneous reports, unless the analysis is clearly erroneous.”); Special Master Ruling on Functional Impairment, at 3 (Oct. 21, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_sm_7.pdf (noting that deference to functional impairment findings will wax with the report’s completeness). Reasonable and well-articulated medical judgments have been overturned in the past by late-arriving evidence that thoroughly undermined the basis for the judgment, but not based merely on a difference of opinion. Special Master Ruling on Functional Impairment and CDR Score (Nov. 12, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=functional_impairment_cdr_sm.pdf.

¹² One of my charges is to “make sure that claims administration is both fair and efficient.” Special Master Ruling on Validity Testing, External Evidence, and Functional Impairment, at 20 (Mar. 27, 2023), https://www.nflconcussionsettlement.com/ViewDoc.aspx?dp=validity_evidence_impairment_sm.pdf.

¹³ The Diagnosing Physician must certify the date of Diagnosis through the Diagnosing Physician Certification Form. Settlement Agreement, Section 2.1(gg).

Qualifying Diagnosis have been met, the way a physician normally does in his or her clinical practice.¹⁴

In certifying a Diagnosis, Dr. [REDACTED] dated it to November 11, 2022, when he evaluated Mr. [REDACTED] for his 2023 Claim. But the neuropsychological testing that Dr. [REDACTED] relied on to make that diagnosis was invalid. Thus, the *testing* required under FAQ 101 to meet the diagnostic criteria could not have been present at the time of Dr. [REDACTED] initial evaluation. Instead, it became available only after Mr. [REDACTED] re-evaluation by Dr. [REDACTED] which yielded valid results. That re-evaluation occurred on April 7, 2024; the Claims Administrator's decision to adopt that date of Diagnosis was consequently appropriate under FAQ 101.

Mr. [REDACTED] asserts that his Diagnosis should be backdated to a 2016 evaluation by Dr. [REDACTED]. It's true that when Dr. [REDACTED] was disqualified from the Settlement via audit, Special Masters Pritchett and Verrier wrote that affected Class Members who later receive Monetary Awards confirming Dr. [REDACTED] Diagnosis could receive a retroactive date of Diagnosis to the date in the Claim supported by Dr. [REDACTED] testing. Doc. 77943.

But the two pieces of Mr. [REDACTED] appeal are in tension with each other. Mr. [REDACTED] has argued on appeal that his Diagnosis has *changed* since his 2016 evaluation by Dr. [REDACTED] and is now Level 2 Neurocognitive Impairment. I have found that he has sufficiently supported that Diagnosis now. But that finding excludes him from the scope of the Special Masters' 2018 Audit Decision, which requires that Class Members receive the *same* Diagnosis as the one rendered by Dr. [REDACTED] which was for Level 1.5 impairment.

Because the 2016 Diagnosis covered by the Audit differs materially from the one for which he is approved today, the Claims Administrator did not err in denying its applicability to this Claim.

CONCLUSION

Mr. [REDACTED] has shown by clear and convincing evidence that the Claims Administrator erred in adopting a Qualifying Diagnosis of Level 1.5 Neurocognitive Impairment, rather than Level 2 Neurocognitive Impairment. His date of Diagnosis, however, is tied to that new Diagnosis and cannot be backdated to 2016. I therefore grant Mr. [REDACTED] Appeal in part and deny it in part.

Date: September 15, 2025



David A. Hoffman, Special Master

¹⁴ *Frequently Asked Questions: FAQ #101* (How is the date of a Qualifying Diagnosis determined?), NFL CONCUSSION SETTLEMENT, <https://www.nflconcussionsettlement.com> (emphasis added).