

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION

SUSAN HENNEN)	
)	Case No. 1:15-cv-09452
<i>Plaintiff</i>)	
)	Judge Thomas M. Durkin
<i>v.</i>)	
)	
METROPOLITAN LIFE INSURANCE)	
COMPANY)	
)	
<i>Defendant</i>)	

METROPOLITAN LIFE INSURANCE COMPANY'S
RESPONSE TO PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

When this case first came before the Court, Susan Hennen acknowledged that for a diagnosis of radiculopathy to be objective, the radiculopathy must be “corroborated” by EMG, MRI, or similar objective study. (Opinion, R. 46 at 16, citing R. 26 at 11). MetLife demonstrated that it reasonably determined that the objective medical evidence was negative for radiculopathy, and that the ERISA Plan’s 24-month benefit cap for neuromusculoskeletal conditions applied to Hennen’s claim.

To vacate the Court’s judgment on appeal, Hennen postured that radiculopathies cannot be reliably objectively verified by EMG, may elude detection by MRI, and that the objective tests offered by modern medical science are inconclusive. She relied solely on medical journals gleaned from the internet, without any support from her physicians. The Seventh Circuit acknowledged that it is reasonable for MetLife to require objective evidence to support for a diagnosis of radiculopathy, as the Plan expressly requires. But the Seventh Circuit panel majority found it would be unreasonable to discount first-hand clinical observations by physicians if the tests were inconclusive and unreliable. Without weighing in definitively on the reliability of objective tests, the Seventh Circuit remanded the matter for further evaluation by MetLife.

On remand, MetLife obtained an independent medical examination by Dr. Nicholas Schlageter, a board-certified neurologist and Fellow of the American Academy of Neurology. Dr. Schlageter performed needle electrode EMG and nerve conduction studies, highly sensitive H-reflex studies, physically examined Hennen, observed her pain behaviors, and concluded to a reasonable degree of medical certainty that she does not have radiculopathy. She has a

lumbosacral plexopathy, as documented by Dr. Schlageter's tests and her own medical records. Dr. Schlageter opined that his testing of Hennen was objective and reliable.

Hennen now admits that the electrodiagnostic tests are objective and persuasive. She simply disagrees with Dr. Schlageter's medical interpretation of the objective tests. She retained Dr. Julian Freeman, an internist who is not board certified in neurology, is not licensed in neurology by the Illinois Department of Financial and Professional Regulation, and did not receive the specialized training required to obtain board certification in neurology.¹ Dr. Freeman reviewed the medical records and declared that the EMGs and MRIs beyond doubt objectively prove that Hennen has radiculopathy. That transforms this case into a contest between competing medical opinions. In a contest of medical opinions, the arbitrary and capricious standard mandates that the ERISA administrator's reasonable choice prevails.

MetLife reasonably determined that Dr. Schlageter's medical opinions made the most sense. Dr. Schlageter comprehensively explained that the objective findings support that Hennen has a lumbosacral plexopathy, which is a condition of the peripheral nervous system and surrounding tissue of the lumbar plexus, and not diseased nerve roots as required to support a diagnosis of radiculopathy under the ERISA Plan's terms.

Neurology is an exceedingly complex medical science, and MetLife acted reasonably by relying on neurologist Dr. Schlageter's expert findings. Under the arbitrary and capricious

¹ The licensure and education of Dr. Schlageter and Dr. Freeman are published by the Illinois Department of Financial and Professional Regulation at <https://www.idfpr.com>. Board certification in neurology requires a 4-year neurology residency and 2-year fellowship in neurology. *See* <https://www.aan.com/tools-and-resources/medical-students/careers-in-neurology/how-to-become-a-neurologist/> (viewed 5/19/21).

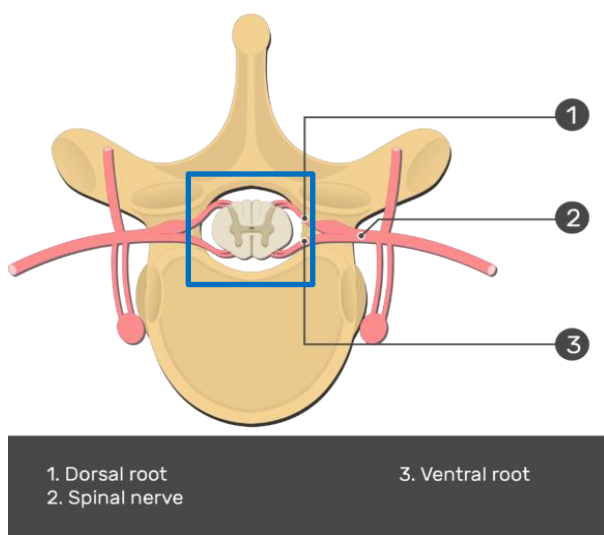
standard, MetLife's reasonable choice warrants judicial deference and should be upheld by the Court.

ARGUMENT

I. MetLife Reasonably Determined that Hennen's Claimed Disability was due to a Plexopathy, and Lacked Objective Evidence of Radiculopathy.

A. Dr. Schlageter's electrodiagnostic and neurologic findings are reliable objective evidence that Hennen is negative for radiculopathy.

MetLife, in its Memorandum, describes the electrodiagnostic progression of nerve root disease associated with lumbar radiculopathy. The peripheral *nerve root* consists of the ventral root and dorsal root as depicted in the blue square in the following cross section of the spinal column:²



Damaged nerve roots are detected on EMG by abnormal insertional activity (when the needle electrode is inserted into the muscle fiber) and spontaneous nerve activity (when the needle is at rest and normal nerves are electrically silent). See Bryan Tsao, M.D., *Electrodiagnosis of*

² See <https://www.getbodysmart.com/spinal-cord/spinal-nerve-roots>; <http://www.neuroanatomy.wisc.edu/SCLinic/Radiculo/Radiculopathy.htm> (viewed 5/19/21).

Cervical & Lumbosacral Radiculopathy, 25 NEUROL. CLIN. 473, at 480 (2007).³ Over time damaged nerve roots repair themselves and form new connections by reinnervation.

Reinnervated nerve roots appear on EMG testing as “broad, large, and polyphasic MUAPs.” *Id.* These MUAPs “usually persist indefinitely after radiculopathy” and are common electrodiagnostic findings “years after patients had their initial symptoms.” *Id.*

Dr. Neil McPhee’s broken bone analogy cogently describes the electrodiagnostic features of active nerve root damage characteristic of radiculopathy and subsequent nerve root reinnervation: “At the time of a bone fracture, there are associated symptoms including pain, as well as evidence of the fracture on x-ray. With time the bone fracture heals, but there is still evidence on the x-ray of a prior fracture with changes reflecting the healing.” (LR56.1 ¶ 54).⁴ Similarly, diseased nerve roots fire spontaneously and uncontrollably, emitting fibrillations, positive sharp waves, and fasciculations. With time damaged nerve roots repair themselves through reinnervation. Radiculopathy is no longer “active,” but MUAPs may appear as an electrodiagnostic vestige of past radiculopathy. (LR56.1 ¶ 54).

Hennen’s 2015 EMG showed no electrodiagnostic evidence of active nerve root damage. Insertional activity was normal and spontaneous activity was absent. But the 2015 EMG, as interpreted by Dr. Joseph Kipta and his instructor Dr. Rabia Malik, detected abnormal MUAPs in all eight muscle groups tested, which they thought was electrodiagnostic evidence of four separate damaged nerve roots throughout the L3-S1 level of the spine. By contrast, Dr. McPhee opined that the MUAPs “could possibly be consistent with a past history of radiculopathy” but

³ See https://www.researchgate.net/publication/6382551_The_Electrodiagnosis_of_Cervical_and_Lumbosacral_Radiculopathy/link/5a85afe8aca272017e560ff2/download (viewed 5/19/21).

⁴ Citations to “LR56.1 ¶ _” are to MetLife’s Local Rule 56.1 Statement of Material Facts. (Doc. #104). Citations to “Add’l ¶ _” are to MetLife’s Statement of Additional Material Facts.

past radiculopathy was unlikely “given the diffuse distribution of such findings,” “the unlikeliness of so many nerve roots being affected,” and the “clear cut examination findings” and “imaging” studies. (LR56.1 ¶ 52).

On remand, neurologist Dr. Schlageter performed a needle EMG and nerve conduction velocity testing of the same muscle groups tested by the 2015 EMG. Dr. Schlageter’s EMG of Hennen was normal with no electrodiagnostic evidence of lumbar radiculopathy. Dr. Schlageter’s EMG recorded normal insertional activity, no spontaneous activity, no polyphasic MUAPs, and normal MUAP amplitude, duration, configuration, and pattern. (LR56.1 ¶¶ 86-88). Dr. Schlageter noted that the recruitment activity was mildly decreased in four muscle groups, which he opined was secondary to pain based on his observation of Hennen’s pain behaviors, the fact that all other electrodiagnostic parameters were normal, and his expertise as a board-certified neurologist. (LR56.1 ¶¶ 87, 90, 109, 110).

The normal MUAPs detected by Dr. Schlageter’s EMG are crucial findings that Hennen never had radiculopathy. When MUAPs appear due to reinnervation of the damaged nerve roots, the MUAPs typically are permanent. As reinnervation progresses, MUAPs become more pronounced, not less pronounced: “In early stages of reinnervation, these MUAPs show a moment-to-moment variation in configuration as immature motor unit junctions are established; with time, this instability is replaced with broad, large, and polyphasic MUAPs.” Bryan Tsao, M.D., *Electrodiagnosis of Cervical & Lumbosacral Radiculopathy*, 25 NEUROL. CLIN. 473, at 480 (2007).⁵ See also Tsao, *supra* (explaining that abnormal MUAP duration, amplitude, and polyphasic wave activity “usually persist indefinitely after radiculopathy, and it is common to

⁵ See https://www.researchgate.net/publication/6382551_The_Electrodiagnosis_of_Cervical_and_Lumbosacral_Radiculopathy/link/5a85afe8aca272017e560ff2/download (viewed 5/19/21).

find such abnormalities on a NEE [needle EMG] years after patients had their initial symptoms”).

The complete absence of abnormal MUAP amplitude, duration, and polyphasic waves in all eight muscle groups tested by Dr. Schlageter constitutes objective evidence that Hennen never had four separate radiculopathies at the L3-S1 level as hypothesized by Drs. Kipta and Malik. Dr. Schlageter concluded that Hennen’s EMG was completely normal.

Dr. Schlageter further tested his findings by performing bilateral H-reflex testing, which is a sensitive objective test for S1 radiculopathy. Dr. Schlageter opined, “The absence of H-reflex would provide objective evidence for possible S1 radiculopathy.” (LR56.1 ¶¶ 86, 89). Hennen’s H-reflex was normal in both legs and provides objective evidence that Hennen never had a radiculopathy of the S1 nerve root, refuting the assessment of Drs. Kipta and Malik.

Dr. Schlageter concluded, to a reasonable degree of medical certainty, that Hennen’s diagnosis is lumbosacral plexopathy, which is a neuromusculoskeletal disorder, and not lumbar radiculopathy, based on his 2019 EMG and physical examination including H-reflex testing, the 2015 EMG, the MRI scans, and the clinical findings. (LR56.1 ¶¶ 87, 104-105, 111).

B. MetLife reasonably relied on the medical opinions of neurologist Dr. Schlageter over the file review criticisms of Dr. Freeman and Hennen’s treating physicians.

To obtain a remand from the Seventh Circuit and vacate this Court’s judgment, Hennen postured that radiculopathies cannot be reliably objectively verified by electrodiagnostic tests or imaging studies. She bemoaned that radiculopathies may exist without electrodiagnostic findings, and that rare non-compressive radiculopathies may elude detection by MRI. She relied exclusively on generalizations from a selection of academic journal articles procured through Google.

Yet Hennen, in her current brief, now proclaims that her electrodiagnostic tests and MRI images are reliable objective evidence of radiculopathy. She retained Dr. Freeman who proclaimed, “Objective data from MRI imaging, operative findings, and EMG/NCV studies confirm the presence of lumbar sacral radiculopathy, that has not resolved and continues to the present.” (LR56.1 ¶ 95). Dr. Freeman espoused peculiar views, such as his theory that each “datum” must be classified as normal or abnormal in isolation without any medical interpretation, and his insistence that Dr. Schlageter’s opinions are unreliable because he should have performed painful unnecessary tests even though Hennen was crying in pain. Dr. Freeman was more interested in conjuring a tempest of medical disagreement for disagreement’s sake, than rendering medically valid neurologic opinions.

Under the arbitrary and capricious standard, “reaching a decision amid such conflicting medical evidence is a question of judgment that should be left to [the administrator].” *Davis v. Unum Life Ins. Co. of Am.*, 444 F.3d 569, 578 (7th Cir. 2006). “[Q]uestions of judgment are left to the plan administrator,’ and ‘it is not our function to decide whether we would reach the same conclusion’ as the administrator.” *Sisto v. Ameritech Sickness & Acc. Disability Plan*, 429 F.3d 698, 701 (7th Cir. 2005) (quoting *Trombetta v. Cragin Fed. Bank for Savs. Emp. Stock Ownership Plan*, 102 F.3d 1435, 1438 (7th Cir. 1996), and *Tegtmeier v. Midwest Operating Eng’rs Pension Trust Fund*, 390 F.3d 1040, 1045 (7th Cir. 2004)).

MetLife reasonably determined that Dr. Schlageter’s medical opinions were more compelling than the opinions of Dr. Freeman or Hennen’s treating physicians. As a board-certified neurologist, Dr. Schlageter practices exclusively in the field of neurology and has performed needle EMGs for 20 years. (LR56.1 ¶ 108). Dr. Schlageter physically examined Hennen, performed thorough electrodiagnostic tests, and analyzed her medical records. Dr. Schlageter

concluded to a reasonable degree of medical certainty that Hennen does not have radiculopathy, she has a lumbosacral plexopathy, and his electrodiagnostic tests of Hennen are reliable. It was reasonable for MetLife to rely on his expert medical opinions.

1. Dr. Schlageter's EMG of Hennen was normal, making testing of the unaffected opposite leg unnecessary.

Hennen argues that Dr. Schlageter's EMG testing contains "critical inconsistencies and omissions that render his conclusions unreliable, implausible, and equivocal." (Pl. Br. pg. 13). She laments that Dr. Schlageter declined to perform EMG testing of her unaffected right leg "allegedly" due to her complaints of pain from the nerve conduction study. According to Hennen, MetLife should have rejected Dr. Schlageter's medical opinions outright, because he disobeyed MetLife's request to perform EMG testing on her unaffected leg. (Pl. Br. pg. 13). Dr. Freeman, in furtherance of his pattern of criticizing everything, weighed in by stating, "The reason for not performing a right leg EMG exam for comparative values, as instructed by the insurer, is not evident." (LR56.1 ¶ 99).

Dr. Schlageter, however, *personally observed* Hennen's pain behaviors and properly exercised his medical judgment to refrain from performing painful EMG testing of her unaffected right leg: "It was my judgment that I would not perform an EMG on the right leg because of [Hennen's] complaint of increased pain from the nerve conduction studies." (LR56.1 ¶ 86). Dr. Schlageter's first-hand observations are confirmed by Hennen's disability advocate Nurse Ouding, who noted that Hennen was "crying" during the nerve conduction study and "remains tearful" after the test. (LR56.1 ¶ 94).

Moreover, Dr. Schlageter explained that bilateral leg EMG testing was unnecessary given his normal EMG of Hennen's left leg. MetLife had requested bilateral EMG testing only because the 2015 EMG showed abnormal MUAP duration, amplitude, and polyphasic waves in all eight

muscle groups (as interpreted by Dr. Kipta). Dr. McPhee advised that Dr. Kipta should have tested the opposite leg “if he thought motor unit potentials were of long duration in all left lower extremity muscles before coming to a conclusion of polyradiculopathies involving four nerve roots....” (LR56.1 ¶ 43).

Dr. Schlageter’s EMG, by contrast, found no electrodiagnostic evidence of radiculopathy in Hennen’s left leg, obviating the need for control testing of the right leg. (LR56.1 ¶¶ 86-88, 90). Because Dr. Schlageter’s EMG of the left leg was normal, EMG testing of Hennen’s unaffected right leg was unnecessary.

Dr. Freeman posits that pain from nerve conduction studies is “very different” than pain from needle EMGs. He argues that the needle EMG should have proceeded on the right leg despite Hennen’s cries of pain, with the courtesy of offering her “small gauge” needles. (Pl. Br. pgs. 13-14). It is well established that a needle EMG, in which a needle electrode is inserted into the muscle fiber and stimulated with an electrical current, is far more painful than nerve conduction studies, which uses stick-on patches to measure surface nerve activity. *See Yalinay Dikmen, et al., Expected & Experienced Pain Levels in Electromyography*, ARCHIVES OF NEUROPSYCHIATRY, 364-367 (2013) (“As expected, needle EMG is more painful than NCS.”).⁶

Hennen illogically suggests, without any medical support, that her “ability to tolerate” testing in her left leg, while complaining of pain in the right leg, “reinforces the existence of a left leg pathology.” (Pl. Br. pg. 14). But the issue is not whether Hennen has “left leg pathology” or nerve pain generally. All pain is nerve pain. Rather, the crucial issue is whether she has objective evidence of a disease of the *nerve roots* within the spinal column as required by the

⁶ *See* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5363430/> (viewed 5/19/21).

Plan. Hennen's complaints of pain in her right leg during the nerve conduction study provides no evidence, much less objective evidence, that she has diseased nerve roots in her lumbar spine.

2. Dr. Schlageter concluded that the electrodiagnostic evidence was negative for radiculopathy.

Hennen accuses Dr. Schlageter of "dismissing" electrodiagnostic abnormalities based on a "warped interpretation" of what constitutes "normal" and "objective." (Pl. Br. pgs. 18-19). She endorses the approach advocated by Dr. Freeman in which every finding must be categorized in isolation as either a "normal" or "abnormal" datum, devoid of medical interpretation. She declares that the slightly decreased recruitment pattern detected by Dr. Schlageter's EMG, the latency detected by Dr. Schlageter's H-reflex study, and the 2015 EMG's long duration MUAPs, all must be categorized as "abnormal." Having transformed normal medical findings into abnormal findings, she proceeds to criticize Dr. Schlageter for dismissing these "abnormalities."

But Hennen contradicts herself. She also argues that the Plan does not require proof "by objective evidence *devoid of any human interpretation* that she suffers from lumbar radiculopathy." (Pl. Br. pg. 19). Medical data is meaningless without expert medical interpretation of the data, as Hennen admits.

Dr. Schlageter's medical interpretation of the electrodiagnostic evidence was negative for radiculopathy. Dr. Schlageter explained that the slightly decreased recruitment detected by his EMG of Hennen was secondary to pain, and therefore was not evidence of radiculopathy. (LR56.1 ¶¶ 87, 109). "A clinical judgment must be made by the electromyographer on the significance of reduced recruitment." Kerry Mills, M.D., *Basics of Electromyography*, 76 J. NEUROL. NEUROSURG. PSYCHIATRY 32, 32 (2005).⁷ "A fluctuating voluntary effort is

⁷ See https://jnnp.bmj.com/content/76/suppl_2/ii32 (viewed 5/19/21).

accompanied by sporadic recruitment of motor units and is easily recognized by an experienced electromyographer.” *Id.* at 33. Dr. Schlageter further explained that the H-reflex study, which is a sensitive objective test for S1 radiculopathy, was well within published values for H wave latency and, therefore, “does not support the presence of an S1 radiculopathy.” (LR56.1 ¶ 109).

Similarly, Hennen argues that Dr. Schlageter “conceded” that the 2015 EMG findings “were consistent with radiculopathy,” but he “dismissed” those findings because a lumbosacral plexopathy “cannot be ruled out.” (Pl. Br. pg. 2). She argues that Dr. Schlageter by his “own admission” found that “nothing in Hennen’s clinical history provided causal support” for lumbar plexopathy. (Pl. Br. pgs. 12-13).

But Hennen misstates Dr. Schlageter’s medical rationale and conclusions. Dr. Schlageter initially opined that the probability of a plexopathy was 50% based on the 2015 EMG because her medical history did not provide “potential causation of a plexopathy lesion.” (LR56.1 ¶ 101). Dr. Schlageter examined the medical evidence again and precisely identified the cause of the plexopathy lesion. Dr. Schlageter explained, “On further review” the MRI dated December 28, 2012 depicts “a small area of cystic change along the medial left psoas” measuring “1.5 cm” evidencing “trauma in the area of the lumbosacral plexus.” (LR56.1 ¶¶ 104, 105). Additionally, the January 2018 MRI depicted “posterior paraspinous scarring of the lower lumbar region,” which Dr. Schlageter explained “also indicated evidence of trauma to the lumbar area, which resulted in scarring.” (LR56.1 ¶ 105). Dr. Schlageter concluded to “a reasonable degree of medical certainty” that the 2015 EMG and nerve conduction study “does not show evidence of multiple lumbar radiculopathies.” (LR56.1 ¶ 105). Rather, the 2015 EMG and multiple MRIs provided objective evidence of lumbosacral plexopathy.

Hennen denounces Dr. Schlageter’s diagnosis of lumbosacral plexopathy as “highly improbable.” (Pl. Br. pg. 19). But the opposite is true. Hennen’s preferred diagnosis of lumbosacral polyradiculopathies presumes that five separate nerve root lesions exist to explain the 2015 EMG findings, without any evidence of such diffuse nerve root damage in any MRI, or in Dr. Schlageter’s EMG and H-reflex studies. As articulated by Dr. Schlageter,

On review of the EMG of 06/06/2015, the authors conclude that this study shows evidence of radiculopathies at the L3, L4, L5, and S1 levels. Additionally, there is a fifth lesion involving the superficial peroneal sensory nerve. Therefore, they postulate that there are five separate abnormalities to account for the findings reported in the study.

(LR56.1 ¶ 104). Dr. Schlageter opined that the diagnosis of lumbar polyradiculopathies fails to explain that 2015 peroneal sensory nerve abnormality: “The claimant’s attorney’s major argument appears to be that the EMG/NCV performed on 06/06/2015 shows evidence of a chronic lumbar radiculopathy. However, their diagnosis does not account for the sensory nerve findings, whereas the diagnoses of lumbosacral plexopathy does take that data into account.”

(LR56.1 ¶ 106).

Dr. Schlageter concluded that “the most reasonable explanation for all the data” is that Hennen has lumbosacral polyradiculopathy. (LR56.1 ¶ 105). “For these reasons it is my opinion that the EMG/NCV does not show evidence of multiple lumbar radiculopathies. My opinion is based on a reasonable degree of medical certainty.” (LR56.1 ¶ 105).

3. Hennen misrepresents that she has an undetectable *sensory* nerve root radiculopathy.

Hennen tries to explain the lack of electrodiagnostic evidence of radiculopathy by speculating that she has a unique type of radiculopathy—one that only affects the sensory nerve roots—that cannot be detected by EMG. She quotes from a medical journal that “[t]he EMG only evaluates motor axonal loss or motor axon conduction block, and for these reasons, a

radiculopathy affecting the sensory root will not yield abnormalities by EMG.” (Pl. Br. pg. 9) (quoting Timothy R. Dillingham, *Electrodiagnostic approach to patients with suspected radiculopathy*, 13 PHYS. MED. REHABIL. CLIN. N. AM. 567 (2002)).

No physician opined that Hennen has a sensory nerve root radiculopathy. To the contrary, the impression of Drs. Kipta and Malik was that she had “left lumbar *motor* polyradiculopathies (L3-S1).” (LR56.1 ¶ 41). Hennen cannot impugn the reliability of Dr. Schlageter’s normal EMG findings by claiming to have a difficult to detect sensory nerve root radiculopathy.

During the remand, Hennen attempted to misdirect MetLife’s review and Dr. Schlageter’s independent medical exam with her sensory radiculopathy theory. She misrepresented to MetLife that “Ms. Hennen’s radiculopathy appears to be primarily sensory in origin,” even though her own physicians diagnosed her with motor nerve root radiculopathies. (LR56.1 ¶ 83). She requested that MetLife perform dermatomal somatosensory evoked potential (“DSEP” or “SSEP”) testing, and submitted an article about the utility of DSEP testing. But the article concluded that DSEP testing is not useful and requires “further study”:

At present, there is no evidence that DSEP findings provide any reliable information beyond the routine clinical examination and there is no evidence to suggest DSEPs are superior to already established neurophysiologic techniques.

(LR56.1 ¶ 83).

Given that Hennen was diagnosed by Drs. Kipta and Malik with multiple motor nerve root radiculopathies, and the unproven utility of DSEP testing, MetLife reasonably declined to perform the requested test. MetLife, however, informed Hennen that “[i]f you wish to make your own arrangements to have that testing performed, you can submit it for our review.” (LR56.1 ¶ 84). Hennen never obtained DSEP testing for MetLife’s review. Nor did she request

that any of her treating physicians consider such testing. Her goal was to criticize MetLife for not performing the test.

In furtherance of that goal, Hennen sent a questionnaire to Dr. Schlageter (without MetLife's knowledge) and quizzed him about DSEP and SSEP testing. Hennen asked, "Would data from a current somatosensory evoked potential study differentiate between radiculopathy and a plexus lesion?" (LR56.1 ¶ 101). Dr. Schlageter answered "I am not familiar enough with somatosensory evoked potential studies used in the diagnosis of radiculopathy or plexopathy to comment on this test." (LR56.1 ¶ 101).

Hennen proceeded to use Dr. Schlageter's answer as ammunition for internist Dr. Freeman to question his expertise and berate him. Dr. Freeman stated, "A generally accepted medical testing method (SSEP) is dismissed simply due to lack of familiarity with that method, without identification of relevant medical literature or citation of personal experience with SSEP studies" and "This is unexpected from a neurologist claiming expertise in neurodiagnostic testing, and inconsistent with usual methods of expert review and analysis." (LR56.1 ¶ 103).

The medical literature establishes that DSEPs and SSEPs are neither useful nor recommended tests for diagnosing radiculopathy. "SSEPs are used predominately in intraoperative monitoring during spinal surgery and instrumentation" and "most investigators have not found this to be of particular value" in detecting radiculopathy. Alexander Reeves, M.D., *et al.*, *Disorders of the Nervous System*, DARTMOUTH MEDICAL SCHOOL (2008).⁸ *See also* Dillingham, *supra* ("These tests [SSEPs and DSEPs] are not necessary for electrodiagnostic

⁸ *See* <https://vdoc.pub/documents/disorders-of-the-nervous-system-4t3hflt97ai0> (viewed 5/19/21).

testing for persons with suspected radiculopathies, and their usefulness is limited to special circumstances.”).

4. Dr. Schlageter’s neurologic exam and the clinical findings do not provide objective evidence of radiculopathy.

As an extension of the needle EMG and nerve conduction study, Dr. Schlageter performed a neurologic examination of Hennen and reviewed her medical records multiple times. Dr. Schlageter’s neurologic exam found no clinical evidence to support a diagnosis of lumbar radiculopathy. Hennen had normal muscle strength in both legs and arms, she walked with a normal gait, and her “[r]apid alternating movements are normal.” (LR56.1 ¶ 85). Her deep tendon reflexes were normal and symmetrical in both legs (“DTRs were 2/4”), which is further evidence that she does not have S1 nerve root radiculopathy. She exhibited decreased sensation “in her entire left leg” (rather than in a pattern that follows the nerve), muscle spasm, and “no tenderness in the sciatic notch.” (LR56.1 ¶ 85). Dr. Schlageter opined, “My examination and testing did not show evidence of a radiculopathy at that time.” (LR56.1 ¶ 110).

Hennen contends that Dr. Schlageter’s neurologic exam was incomplete because he did not perform straight leg testing. (Pl. Br. pg. 14). Notably, Drs. Kipta and Malik did not perform straight leg testing in conjunction with their 2015 EMG. Yet Hennen does not disparage the thoroughness of their medical examination.

Straight leg testing is a subjective test to determine whether the patient reports lower limb pain upon passive raising of the leg. It is a subjective screening test to help clinicians determine whether a referral for specialty testing is appropriate. *See Kaynoosh Hamayouni, M.D., et al., Sensitivity & Specificity of Modified Bragard Test in Patients with Lumbosacral Radiculopathy Using Electrodagnosis as a Reference Standard*, J. CHIROP. MED. 17(1): 36-38 (2018) (explaining that straight leg tests “are often used in making decisions about diagnosis imaging or

hospital referral” and have “poor diagnostic performance.”)⁹ *See also* Trond Iversen, M.D., *et al.*, *Accuracy of Physical Examination for Chronic Lumbar Radiculopathy*, *BMC MUSCULOSKELETAL DISORDERS* 14:206 (2013) (“The tests are not very helpful in clarifying the cause of radicular pain, and are therefore inaccurate for guidance in the diagnostic workup of the patients.”).¹⁰

Moreover, Hennen’s straight leg tests consistently were normal and negative for left lumbar radiculopathy. On March 11, 2015, Dr. Liana Palacci, an examining internist for the Social Security Administration, opined that Hennen’s straight leg raise was “negative.” (LR56.1 ¶ 60). Dr. Buvanendran opined that straight leg tests were negative and normal on June 19, 2015, September 11, 2015, December 21, 2015, March 4, 2016, and June 24, 2016. (LR56.1 ¶¶ 71, 72; Add’l ¶¶ 7, 8). Dr. Buvanendran only noted positive straight leg tests *in both legs* during three exams, on May 30, 2013, July 30, 2013, and July 11, 2014 (+ SLR B/L”). (Add’l ¶¶ 1-3). No physician has opined that Hennen has lumbar radiculopathy *bilaterally*. The straight leg screening test, therefore, not only is a subjective pain test, but the test results do not even provide subjective evidence of left lumbosacral radiculopathy in Hennen’s case.

Hennen declares that that the medical records from “November 2014 onwards” provide “abundant clinical and objective evidence” of radiculopathy. (Pl. Br. pg. 9). She argues that “clinical findings of reduced strength” in her left leg, “loss of sensation in her left leg in a radicular pattern,” and lumbar MRIs objectively confirm the presence of radiculopathy as defined by the Plan, and that Dr. Schlageter ignored the clinical evidence. (Pl. Br. pg. 10). The clinical findings, however, are equivocal and inconsistent, which is evidence that Hennen does

⁹ *See* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5883635/> (viewed 5/19/21).

¹⁰ *See* <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3716914/> (viewed 5/19/21).

not have lumbar radiculopathy. She had “5/5” bilateral leg strength and stable gait on July 11, 2014. (Add’l ¶ 3). She had “[n]o loss of sensation,” “[r]eflexes were present, equal, and symmetric,” and only mildly diminished left leg strength (“4+/5”) on March 11, 2015. (LR56.1 ¶ 60). She had “intermittent 5/5 strength” on June 8, 2015. (Add’l ¶ 5). She had “normal lumbar paraspinal strength,” “normal gait,” “age appropriate” range of motion of her spine, “no signs of instability,” and only subjective “decreased sensation” of the left leg during exams on September 11, 2015, December 21, 2015, March 4, 2016, and June 24, 2016. (Add’l ¶¶ 6-8). She had “intact touch sensations in all extremities” on July 7, 2017 and October 6, 2017. (Add’l ¶ 9). She had “normal” motor strength in both legs and “sensory exam intact” on March 9, 2018. (Add’l ¶ 11). She had normal “5/5” bilateral leg strength, “[n]ormal sensation” in both legs, and normal gait on March 23 and April 5, 2018. (Add’l ¶¶ 12, 13).¹¹

Hennen argues that Dr. Schlageter “dismissed” the clinical findings as “illegible” and “not time-concurrent.” As examples of medical records Dr. Schlageter purportedly dismissed as illegible, Hennen points to her clinical exams on January 18, 2013, May 30, 2013, July 30, 2013, and July 11, 2014. (Pl. Br. pg. 15). But Dr. Schlageter’s numerous reports specifically discuss the clinical findings on those dates. (Add’l ¶¶ 16, 19).

Hennen falsely contends that Dr. Schlageter “arbitrarily” confined “his consideration to medical records from 2018 and 2019, to the exclusion of all other medical evidence,” citing to Dr. Schlageter’s August 23, 2019 addendum. (Pl. Br. pgs. 16-17, citing MET03274-75). She neglects to mention that Dr. Schlageter was answering MetLife’s specific question to explain the basis for his assessment of her current functional restrictions contained in his initial March 18,

¹¹ Dr. McPhee opined that the “extreme” variations in Hennen’s symptoms of pain and motor strength were inconsistent with a “somatic physiologic” condition. (LR56.1 ¶¶ 43, 44, 55).

2019 independent medical examination report, in which he noted functional restrictions of “sitting for 15 minutes ... for a total of 4 hours in an 8-hour day” among other restrictions secondary to back pain. (Add’l ¶¶ 22, 17). Dr. Schlageter answered MetLife’s question by noting that his assessment of Hennen’s functional restrictions was based on “the MRI scan findings” and “my neurologic exam performed on 03/18/2019.” (LR56.1 ¶ 111). Hennen’s accusation that Dr. Schlageter refused to consider medical evidence that predates 2018 is definitively refuted by his four reports and addendum, in which he examined at length the medical findings from 2012 to 2019. (LR56.1 ¶¶ 86, 104-105, 111; Add’l ¶¶ 16, 19).

Hennen, in her brief, declares that all her treating physicians concurred that she has lumbar radiculopathy. But many of her treating physicians diagnosed her with “post laminectomy syndrome” or “failed back syndrome” (and not radiculopathy) from 2016 to 2018, including pain management physicians Dr. Adam Young, Dr. Timothy Lubenow, and Dr. William Landphair. (LR56.1 ¶ 73; Add’l ¶¶ 10, 12, 13).

Under the arbitrary and capricious standard, MetLife reasonably relied on Dr. Schlageter’s medical judgment over the opinions of Drs. Kipta, Malik, Buvanendran, and file reviewer Dr. Freeman. *Mote v. Aetna Life Ins. Co.*, 502 F.3d 601, 607 (7th Cir. 2007) (holding that the claim administrator reasonably relied on the medical opinions of a consulting physician who performed an independent medical examination of the plaintiff).

II. MetLife’s Determination was Not Influenced by a Structural Conflict of Interest.

A conflict of interest is “one factor among many” for a court to consider in determining whether an ERISA administrator abused its discretion. *Geiger v. Aetna Life Ins. Co.*, 845 F.3d 357, 365 (7th Cir. 2017) (quoting *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105, 108 (2008)). It is not the existence of a conflict—“which is a given in almost all ERISA cases”—but the

“gravity” of the conflict that is important. *Id.* Conflicts, however, “carry less weight when the insurer took active steps to reduce potential bias and to promote accuracy.” *Id.*

A financial conflict of interest played no role in MetLife’s determination. MetLife provided Hennen with a full and fair review on remand and reasonably addressed the issues identified by the Seventh Circuit’s panel majority. MetLife provided all of Dr. Schlageter’s findings to Hennen and actively solicited her comments. *See Geiger v. Aetna Life Ins. Co.*, No. 15-cv-3791, 2016 WL 3459712 (N.D. Ill. June 24, 2016), *aff’d*, 845 F.3d 357 (7th Cir. 2017) (holding that an administrator’s consultation with qualified physicians, performance of an independent medical exam, and providing the consulting physicians’ reports to the plaintiff for comment “all illustrate a reasonable procedure with sufficient safeguards to prevent a detrimental conflict of interest”) (citation omitted).

But that is not to say that a financial conflict of interest played no role in this case. That financial conflict belongs to Hennen. She tried to misdirect and derail MetLife’s review on remand by claiming to have a sensory nerve radiculopathy contrary to her own treating physician’s opinions. She disingenuously requested that MetLife perform unnecessary and irrelevant DSEP and SSEP testing. She retained Dr. Freeman who in exchange for pay engaged in a mission to criticize every opinion and finding made by Dr. Schlageter. MetLife demonstrated extraordinary care to ensure that its role during the administrative remand demonstrated impartiality and a commitment to reach a final determination that was not only reasonable, but compelling.

CONCLUSION

Under the arbitrary and capricious standard, MetLife's reasonable determination should be upheld, and summary judgment should be entered for MetLife, including an award of fees and costs under 29 U.S.C. §1132(g).

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CERTIFICATE OF SERVICE

I certify that on May 19, 2021, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to the attorney of record listed below:

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