Jordan v Garcia
2007 NY Slip Op 30969(U)
April 13, 2007
Supreme Court, Suffolk County
Docket Number: 0008493/2004
Judge: Emily Pines
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Short Form Order

Index Number: 8493-2004

Supreme Court - State of New York
I.A.S. Term, Part 23, Suffolk County

Present:

Hon. Emily Pines
Justice Supreme Court

Original Motion Date: 11-08-2006
Motion Submit Date: 02-15-2007
Motion Sequence No.: 002 MG CASEDISP

____X

JAVON S. JORDAN,

Plaintiff,

-against-

MANUEL A. GARCIA,

Defendant.

____X

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ORDERED, that this motion by Defendant for an order pursuant to **CPLR §3212** granting summary judgment dismissing the complaint against him on the grounds that Plaintiff did not sustain a "serious injury" as defined in **Insurance Law §5102(d)** is granted.

This is an action to recover damages for serious injuries allegedly sustained by Plaintiff as a result of a motor vehicle accident that occurred on August 30, 2003 on Wheeler Road at or near the intersection with Suffolk Avenue, in the Town of Islip, New York.

By bill of particulars dated October 19, 2004, Plaintiff claims that as a result of the subject accident she sustained the following serious and permanent injuries: herniated disc at C4-5 and C5-5 with ventral CSF effacement and cord abuttment; disc bulges C3-4 and C6-7; cervical spine sprain; cervical radiculopathy; disc bulges L2-3, L3-4, L4-5 and L5-S1; lumbar spine sprain; thoracic spine sprain; post-traumatic headaches; chest wall contusion.

Defendant now moves for summary judgment in his favor dismissing the complaint on the grounds that plaintiff did not sustain a "serious injury" as defined in Insurance Law §5102(d). In support of his motion, Defendant submits, among other things, the pleadings;

Plaintiff's bill of particulars dated October 19, 2004; hospital records, the affirmed report of defendant's neurologist, Matthew M. Chacko, M.D., dated September 16, 2005 based upon his examination of Plaintiff on that date; the affirmed report of Defendant's orthopedic surgeon, Vartkes Khachadurian, M.D. dated September 24, 2005 based upon his examination of Plaintiff on September 16, 2005; and the affirmed report of Defendant's radiologist, Sheldon P. Feit, M.D., dated May 18, 2005, based upon his independent radiology review of Plaintiff's records.

Insurance Law §5102(d) defines "serious injury" as "a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment."

In order to recover under the "permanent loss of use" category, Plaintiff must demonstrate a total loss of use of a body organ, member, function or system. ***Oberly v. Bangs Ambulance Inc.,*** 96 N.Y.2d 295, 727 N.Y.S.2d 378 (2001). To prove the extent or degree of physical limitation with respect to the "permanent consequential limitation of use of a body organ or member" or a "significant limitation of use of a body function or system" categories, either a specific percentage of the loss of range of motion must be ascribed or there must be a sufficient description of the 'qualitative nature" of Plaintiff's limitations, with an objection basis, correlating Plaintiff's limitations to the normal function, purpose and use of the body part. ***Toure v. Avis Rent A Car Systems, Inc.,*** 98 N.Y.2d 345, 746 N.Y.S.2d 865 (2000). A minor, mild or slight limitation of use is considered insignificant within the meaning of the statute. ***Licari v. Elliot,*** 57 N.Y.2d 430, 455 N.Y.S.2d 570 (1982).

It is for the Court to determine in the first instance whether a prima facie showing of "serious injury" has been made out. ***Tipping-Cestari v. Kilhenny,*** 174 A.D.2d 663, 571 N.Y.S.2d 525 (2d Dept. 1991). The initial burden is on the Defendant "to present evidence,

in competent form, showing that the Plaintiff has no cause of action." ***Rodriguez v. Goldstein,*** 182 A.D.2d 396, 582 N.Y.S.2d 395 (1st Dept. 1992). Once Defendant has met the burden, the burden shifts to Plaintiff to establish, by competent proof a *prima facie* case that such serious injury exists. ***Gaddy v. Eyler,*** 79 N.Y.2d 955, 582 N.Y.S.2d 990 (1992). Such proof, in order to be in a competent or admissible form, must consist of affidavits or affirmations. ***Pagano v. Kingsbury,*** 182 A.D.2d 268, 587 N.Y.S.2d 692 (2d Dept. 1992). The proof must be viewed in a light most favorable to the non-moving party, here, the Plaintiff. ***Cammarere v. Villanova,*** 166 A.D.2d 760, 562 N.Y.S.2d 808 (3d Dept. 1990).

Here, Defendant made a *prima face* showing that the Plaintiff did not sustain a serious injury within the meaning of **Insurance Law §5102(d)** through the submission of the affirmed medical reports of their examining orthopedic surgeon and neurologist. ***see, Mahabir v. Ally,*** 26 A.D.3d 314, 812 N.Y.S.2d 556 (2d Dept. 2006). Defendant's examining orthopedic surgeon, Dr. Khachadurian, indicated in his affirmed report that he has reviewed Plaintiff's medical records and provided the results of his examination of the Plaintiff. Dr. Khachadurian found that, as of the date of his examination on September 16, 2005, Plaintiff was not receiving any treatment or physical therapy. Dr. Khachadurian found that Plaintiff did not appear to be in acute distress, has normal lumbar lordosis, no shift in the lumbar spine, and no evidence of spasm of the paraspinal muscles. Dr. Khachadurian also provided specific measurements of Plaintiff's range of motion: flex forward to 80 degrees (normal), extend backward 30 degrees (normal), tilt 45 degrees side-to-side (normal) and twist 30 degrees side-to side (normal). He found the straight and well leg testing were negative for radicular or referred pain. Dr. Khachadurian also recorded specific measurements with regard to his examination of plaintiff's cervical spine: extend backwards 70 degrees (normal); side-to-side rotation 45 degrees (normal) and tilt 30 degrees side-to-side (normal). He found no evidence of radicular or referred pain to the upper extremities. As his final orthopedic diagnosis, Dr. Khachadurian listed post lumbar and cervical sprains, posttraumatic by history, resolved with no clinical evidence of herniated disc, radiculistis or radiculopathy to either upper or lower extremities. He found that Plaintiff was capable of performing usual work activities unrestricted, did not require further treatment and has no evidence of ongoing orthopedic disability.

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Defendant also submitted the affirmed medical report of Dr. Chacko, his examining neurologist. Dr. Chacko listed Plaintiff's medical records that he reviewed and related the results of his neurological examination indicating that Plaintiff's cognitive functions were intact, without evidence of aphasia or dysarthia. In addition, Dr. Chacko reported that Plaintiff's neck showed normal range of motion in all directions and provided the specific results: flexion 50 (50 normal); extension 60 (60 normal); lateral flexion 45 (45 normal); and lateral rotation 80 (80 normal). He noted sensory examination was normal to touch and pinprick sensation bilaterally, straight leg raising is negative bilaterally. Furthermore, Dr. Chacko reported that Plaintiff walked with a normal gait, and that there was no ataxia and no sign of cerebellar dysfunction. He stated that Plaintiff complained of tenderness on palpation of the cervical and lumbar areas, but no muscles spasm was felt. Dr. Chacko reported that his impression was a history of cervical and lumbar strain and that the neurological examination did not reveal any clear focal neurological deficits. He concluded there were no findings consistent with the presence of any cervical or lumbar radiculopathy, no muscle weakness, reflex asymmetry or sensory changes. Finally, he reported that plaintiff was capable of performing normal activities of daily living.

Defendant also submitted the affirmed report of Dr. Feit, radiologist. Dr. Feit reviewed the MRI of plaintiff's cervical spine that was performed on October 15, 2003, six weeks after the accident. Dr. Feit reported that there were no abnormal areas of T2 brightening and desicatory changes were identified at all the visualized cervical discs. He reported that the evaluation of the sagittal images demonstrated ventral epidural defects at the C3-4, C4-5 and C5-6 levels, corresponding to mild disc bulges which encroach on the subarachnoid space and slightly indent on the cervical cord. He reported no other bulges or herniations, no signal abnormalities within the cervical cord, the craniocervical junction was intact, no evidence of spondylolisthesis or paraspinal soft tissue mass lesions. Thus, Dr. Feit concluded there were mild disc bulges at the C3-4, C4-5 and C5-6 levels with no evidence of focal herniation. He reported that his review of the MRI revealed "pre-existing degenerative change" and that the disc bulges were not posttraumatic but were "degenerative secondary to annular degeneration and/or ligamentous laxity."

Based upon the foregoing affirmed medical reports, Defendant argues that Plaintiff is

unable to prove that she sustained a serious injury within the meaning of **Insurance Law §5102(d).** Specifically, Defendant argues that all the objective tests performed by these examining doctors were negative and thus there has been no findings of any permanent injury to any body area specified in the statute, that nothing significant, or consequential was noted by the doctors and there has been no demonstration that Plaintiff was prevented from performing substantially all of the material acts which constitute her usual and customary daily activities for not less than ninety (90) days during the one hundred eighty (180) days immediately following the accident.

In opposition to the motion, Plaintiff submits an affidavit, affirmation of counsel, a copy of her deposition transcript and the following affirmed medical reports: Robert Diamond, M.D., who prepared a report dated October 23, 2003 of the MRI scan of Plaintiff's cervical spine on October 15, 2003; Poonam S. Dulai, M.D., a neurologist who prepared a report dated November 15, 2003 based upon a neurological evaluation conducted on Plaintiff on November 10, 2003; Mike Pappas, D.O., who prepared a report dated March 21, 2005 based upon an examination performed on that date; and Josephine Brawner, M.D., who prepared reports dated May 3, 2004 and October 9, 2003 based upon her evaluation of the Plaintiff on those dates.

At her deposition on August 4, 2005, Plaintiff testified that about a week after the accident she went to Southside Hospital with complaints about pain in her back and neck, that x-rays were taken but that she was released with only a prescription for Motrin. Thereafter, she testified that in either September or October of 2003 she sough medical attention from Deer Park Medical where she received treatment for more than a year. She stated that she stopped in or about February of 2005 because she could no longer afford the treatment. Plaintiff testified that the treatment consisted of acupuncture, stretching, heat therapy, electronic stimulation and massage treatment. Plaintiff testified that at the time of the accident she was not employed but that she was currently employed as a direct care counselor. In her affidavit in opposition to the motion, Plaintiff states that since the accident, normal daily activities such as housework and laundry are accompanied by pain and that although she trained formally for dance for a period of thirteen (13) years prior to the accident, she can no longer dance without extreme pain and limitation. Furthermore, Plaintiff alleges that although she has a degree as a certified nursing

assistant, she cannot work in that field because of her physical limitations as a result of the injuries sustained in the accident. She claims that doctors advised her that the injuries are permanent and that she has reached maximum improvement.

Dr. Brawner evaluated plaintiff on October 9, 2003, and her affirmed report is annexed to the opposition papers. In the report, Dr. Brawner finds that Plaintiff shows tenderness of lumbar paravertabrals but no tenderness in the sacroiliac notches. Straight leg raise was negative. A sensory examination revealed hypoesthesia in the left C5 and C6 dermatomes and motor testing revealed weakness of the left biceps. Dr. Brawner's reported impression was post traumatic cervical, thoracic and lumbar strain and sprain and referred plaintiff for an MRI, range of motion testing, physical therapy and a neurological evaluation. In the affirmed report of Dr. Diamond, radiologist, he states his interpretation of the MRI scan of the Plaintiff's cervical spine. In that report dated October 15, 2003, he states his interpretation and impression that cervical kyphosis is noted compatible with reflex muscle spasm; C3/4 and C6/7 posterior suliamentous disc bulges are present; C4/5 and C5/6 posterior disc herniations are present and right maxillary sinusitic change is present. In an additional report, also on October 15, 2003, Dr. Diamond sets forth his interpretation and impression of dextroconvex scoliosis and upper lumbar kyphotic curvature compatible with reflex muscle spasm; transitional lower intervertebral disc termed L5/S1. L2/3 through L5/S1 posterior subligamentous disc bulges. In an affirmed report of Dr. Dulai, neurologist, dated November 15, 2003, he reports that he examined Plaintiff on November 10, 2003, and that she was alert and well oriented with no signs of aphasia. He noted tenderness in the cervical and lumbar spine but no atrophy was noted and all primary and cortical sensory modalities were intact. His impression was post traumatic mixed headaches, vascular with cervical symptoms contributing.

Plaintiff also submits a affirmed report of Dr. Pappas, who evaluated her on March 21, 2005, one year and seven months post-accident. Dr. Pappas performed computerized range of motion testing using digital inclinometry on plaintiff on that date. He reported that Plaintiff had cervical range of motion losses as follows: cervical flexion - 18%; extension - 47%; left lateral range - 22%; right lateral range - 31%; left cervical rotation - 21%; right cervical rotation - 51%. Dr. Pappas further reported lumbar range of motion losses as follows: left lumbar lateral range -

12%; right lumbar lateral range - 12%; lumbar flexion - 27%; and extension - 40%. Dr. Pappas reported his assessment as post-traumatic cervical, thoracic and lumbar myofascial derangement; post-traumatic disc herniations C4-5, C5-6; left C6 cervical radiculopathy; post-traumatic disc bulges L2-L3 through L5-S1. He then concluded that these injuries were "significant" and "partially permanent" and that the prognosis for full recovery to the cervical and lumbar spine was "poor".

Plaintiff argues that the MRI findings on October 23, 2003 which revealed a herniated disc at C3-4 and C5-6 combined with the losses in range of motion as set forth in the March 21, 2005 report of Dr. Pappas demonstrates a serious injury and thus prevents the Court from granting the motion for summary judgment.

In reply, Defendant argues that there is no recent examination of Plaintiff (the most recent being March 21, 2005) and that her reliance on these stale reports is insufficient to defeat the motion for summary judgment. Further Defendant argues that the range of motion testing performed on Plaintiff was normal when she presented for treatment at the emergency room on September 23, 2003 (twenty-four days after the accident). Moreover, Defendant notes that when Plaintiff sought treatment on October 9, 2003, forty days after the accident, November 10, 2003 and May 3, 2004, no restrictions in Plaintiff's range of motion were found. Thus, Defendant's argument is two-fold. First, that Plaintiff's range of motion was not quantified within a reasonable time after the accident; that is, there are no restrictions or limitations contemporaneous with the accident on August 30, 2003. Second, there is no objective medical proof that Plaintiff currently has decreased range of motion. Given these deficiencies in proof, Defendant argues that, while Plaintiff may have sustained disc bulges, such are insufficient to establish sustain a finding of serious injury especially where, as here, Plaintiff has failed to explain the cessation or gap in treatment from July, 2004.

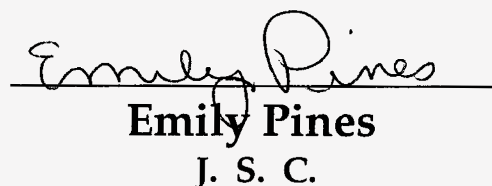
Here, the Court agrees that Plaintiff has failed to raise a triable issue of fact that she sustained a "serious injury" under **Insurance Law §5102(d)** as a result of the subject accident. ***Puerto v. Omholt,*** 17 A.D.3d 650, 794 N.Y.S.2d 117 (2d Dept. 2005). ***See also, Brown v. Tairi Hacking Corp.,*** 23 A.D.3d 325, 804 N.Y.S.2d 756 (2d Dept. 2005). Neither the reports from the emergency room on September 23, 2003, nor the initial examination

of Plaintiff on October 9, 2003 demonstrated any objective range of motion losses contemporaneous with the subject accident. ***See, Umanzor v. Pineda***, __A.D.3d __, __N.Y.S.2d __, 2007 WL 1016894 (2d Dept. 2007). The range of motion testing performed on March 21, 2005 was two years ago; thus, the findings were insufficient to demonstrate the extent of Plaintiff's current physical limitations. ***Whitfield-Forbes v. Pazmino***, 36 A.D.3d 901, 829 N.Y.S.2d 583 (2d Dept. 2007). Moreover, the mere existence of a bulging disc is not evidence of a serious injury absent objective evidence of the extent of the alleged physical limitations resulting from the injury and its duration. ***Mejia v. DeRose***, 35 A.D.3d 407, 825 N.Y.S.2d 722 (2d Dept. 2006). Finally, Plaintiff failed to demonstrate by competent medical evidence that she was unable to perform her usual and customary daily activities for a period of not less than 90 days during the 180-day period immediately following the accident. ***See, Faulkner v. Steinman,*** 28 A.D.3d 604, 813 N.Y.S.2d 529 (2d Dept. 2006); ***Lewis v. City of New York,*** 2 A.D.3d 597, 768 N.Y.S.2d 356 (2d Dept. 2003). The affidavit of plaintiff detailing her complaints of pain are insufficient to establish a serious injury. ***Doyaga v. Teleeba,*** 35 A.D.3d 798, 828 N.Y.S.2d 443 (2d Dept. 2006).

Based upon the foregoing, the motion by Defendant for summary judgment in his favor dismissing the complaint on the ground that Plaintiff did not sustain a "serious injury" as defined in **Insurance Law §5102(d)** is granted and this action is dismissed.

The foregoing constitutes the ***DECISION*** and ***ORDER*** of the Court.

Dated: April 13, 2007
Riverhead, New York



Emily Pines
J. S. C.