Hein v Bulut
2007 NY Slip Op 31216(U)
May 14, 2007
Supreme Court, Suffolk County
Docket Number: 0010434/2005
Judge: Robert W. Doyle
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SHORT FORM ORDER

INDEX No. 05-10434
CAL. No. 06-02191-MV

SUPREME COURT - STATE OF NEW YORK
POST-NOTE MOTION PART - SUFFOLK COUNTY

PRESENT:

Hon. ROBERT W. DOYLE
Justice of the Supreme Court

MOTION DATE 12-14-06
ADJ. DATE 2-14-07
Mot. Seq. # 001 - MD

DAWN E. HEIN,	:	JOSEPH C. STROBLE, ESQ.
	:	Attorney for Plaintiff
Plaintiff,	:	40 Main Street, P.O. Box 596
	:	Sayville, New York 11782
- against -	:	
	:	
BAYRAM BULUT and JOAN MARIE RHATIGAN,	:	ROBERT P. TUSA, ESQ.
	:	Attorneys for Defendants
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Defendants.	:	Hauppauge, New York 11788

Upon the following papers numbered 1 to 27 read on this motion for summary judgment dismissing the complaint; Notice of Motion/ Order to Show Cause and supporting papers 1 - 11; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 12 - 25; Replying Affidavits and supporting papers 26 - 27; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion for summary judgment dismissing the complaint is denied.

This action arose from a vehicular accident, occurring on August 25, 2004 in which the plaintiff allegedly sustained serious personal injuries. The defendants move for summary judgment dismissing the complaint pursuant to Insurance Law §5102(d). The plaintiff opposes the motion and defendants have submitted a reply affirmation in rebuttal to that opposition.

Under the Insurance Law "'[s]erious injury' means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use 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" (Insurance Law §5102[d]).

In the context of the plaintiff's claims, the term "significant," as it appears in the statute, has been defined as "something more than a minor limitation of use" (***Licari v Elliott,*** 57 NY2d 230, 455 NYS2d 570 [1982]). For this purpose, the plaintiff must demonstrate not only the extent or degree of the limitation but also its duration (***Beckett v Conte,*** 176 AD2d 774, 575 NYS2d 102 [1991], app. den. 79

NY2d 753, 581 NYS2d 281). The duration of the injury must be more than "fleeting" (***Partlow v Meehan,*** 155 AD2d 647, 548 NYS2d 239 [1989]). The term "consequential" means important or significant (***Kordana v Pomellito,*** 121 AD2d 783, 503 NYS2d 198 [1986], app. dis. 68 NY2d 848, 508 NYS2d 425). A "permanent loss" of use of a body organ, member, function or system must be total (***Oberly v Bangs Ambulance, Inc.,*** 96 NY2d 295, 727 NYS2d 378 [2001]). In order to prove the extent or degree of physical limitation, an expert can designate a numeric percentage of a plaintiff's loss of range of motion or give a "qualitative assessment of a plaintiff's condition...provided that the evaluation has an objective basis and compares the plaintiff's limitations to the normal function, purpose and use of the affected body organ, member, function or system" (***Toure v Avis Rent A Car Sys.,*** 98 NY2d 345, 746 NYS2d 865, 868 [2002]; rearg. den. ***Manzano v O'Neil,*** 98 NY2d 728, 749 NYS2d 478).

On a motion for summary judgment to dismiss a complaint for failure to set forth a prima facie case of serious injury as defined by Insurance Law §5102(d), 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 AD2d 396, 582 NYS2d 395, 396 [1992]). Once the defendant has met the burden, the plaintiff must then, by competent proof, establish a *prima facie* case that such serious injury exists (***DeAngelo v Fidel Corp. Services, Inc.,*** 171 AD2d 588, 567 NYS2d 454, 455 [1991]). Such proof, in order to be in a competent or admissible form, shall consist of affidavits or affirmations (***Pagano v Kingsbury,*** 182 AD2d 268, 587 NYS2d 692 [1992]). The proof must be viewed in a light most favorable to the non-moving party, here the plaintiff (***Cammarere v Villanova,*** 166 AD2d 760, 562 NYS2d 808, 810 [1990]).

The defendants submit in support of their motion, inter alia, the affirmation of their attorney, the verified complaint and answer, the verified bill of particulars, the plaintiff's deposition testimony of March 17, 2006, an application for motor vehicle No- Fault benefits and the plaintiff's records for emergency care treatment at Mather Memorial Hospital. The defendants also submit the reports, notes and records of the plaintiff's treating physicians and other treating health care providers which include the reports of Dr. David M. Heckler (Dr. Heckler), concerning the plaintiff's visits of August 27, 2004, September 1, 2004, *September 13, 2004 and September 27, 2004*, a report of the plaintiff's treating dentist, Richard N.Cohen (Dr. Cohen), dated January 18, 2005, the reports of the plaintiff's treating physicians at South Shore Medical Care & Diagnostics, P.C., doctors Andrea Coladner (Dr. Coladner) and Maria Herrera (Dr. Herrera), dated September 16, 2004, October 27, 2004, December 6, 2004, January 4, 2005, May 3, 2005 and July 22, 2005, the reports of the plaintiff's chiropractor at South Shore Medical Care & Diagnostics, P.C., Dr. Paul Priolo (Dr. Priolo), dated January 11, 2005 and February 23, 2005, records of the plaintiff's physical therapy and acupuncture treatments and the handwritten notes of the plaintiff's acupuncture treatment. Defendants further submitted the MRI reports of the plaintiff's lumbar and cervical spines dated November 29, 2004 and the sworn reports of defendants' experts, doctors Michael J. Katz (Dr. Katz) and E. Kojo Essuman (Dr. Essuman), dated May 24, 2006 and June 15, 2006, respectively.

The plaintiff's emergency treatment hospital records, except those documents or portions of documents which are illegible and/or irrelevant (*see,* ***Tornatore v Haggerty***,307 AD2d 522, 763 NYS2d 344 [2003]; ***Huron Group, Inc. v Pataki,*** 5 Misc3d 648, 785 NYS2d 827 [2004], aff. 23 AD3d 1051, 803 NYS2d 465, lv. app. granted 6 NY3d 803, 812 NYS2d 440), were considered by the court (***Winkler v Lombardi,*** 205 AD2d 757, 613 NYS2d 430 [1994]). The Court did consider the aforementioned unsworn reports of the plaintiff's treating physicians and health care providers (***Pagano v Kingsbury,*** supra), but not the physical therapy and acupuncture records which cannot be considered as competent evidence on the motion (***Tornatore v Haggerty,*** supra; ***Scott v Basdeo,*** 6 Misc3d 1020[A], 800 NYS2d 357 [2004]).

The Court did not consider any of the other reports, notes and records of the plaintiff's treating physicians and health care providers as they were illegible and/or irrelevant and/or undated and/or unsigned (***Tornatore v Haggerty***, supra; ***Wadi v Tepedino,*** 242 AD2d 327, 661 NYS2d 260 [1997]; ***Pagan v Gondola Cab Corp.,*** 235 AD2d 251, 652 NYS2d 277 [1997]) nor did it consider the application for No-Fault benefits as it was unsigned (***Pagan v Gondola Cab Corp.,*** supra). The Court also considered the MRI reports of November 29, 2004 and defendants' experts' reports.

The plaintiff alleges in his complaint that the subject accident occurred on August 25, 2004 and that he sustained serious injuries and economic loss greater than basic economic loss as a result of the accident. As a procedural matter the Court notes that the plaintiff's attorney in his opposing affirmation states that a supplemental verified bill of particulars was "filed". The defendants have submitted in support of their motion only the original verified bill of particulars. Since the defendants'attorney has neither contended in her reply affirmation that the supplemental bill was not served on them nor objected to the Court's consideration of it, the Court will refer to this as the dispositive document.

The plaintiff avers in her supplemental bill of particulars that she sustained as a result of the accident, inter alia, torn ligaments of the left and right knee, "Chipped teeth 4 with confirmed TMJ [1] Syndrome", scars on the left knee, aggravation of durasic disc herniation, tendinitis of the left elbow, right knee post traumatic arthritis and muscle atrophy, labral tear in the left shoulder, left lateral and lateral epicondylitis, bilateral "wrist sprain/carpal tunnel syndrome/ulnar neuropathy" left shoulder impingement, bilateral "anterior disc displacement with reduction", bilateral muscle spasm, bilateral "musculoskeletal disorders of neck, postural kyphosis, and bilateral temporal tendinitis", fractured upper ribs on the right side, disc bulges at C4-C5 and C5-C6 with a narrowing of the ventral CSF space, multiple lacerations and scarring on both legs, knee contusions, lumbago, "closed dislocation, multiple cervical and lumbar vertebrae", and a permanent partial disability to the effected areas as a result of the accident.

The plaintiff further avers in the supplemental bill that she was confined to Mather Memorial Hospital (Mather) for one day and that information regarding her confinement to her bed and home and regarding her incapacitation from employment and household duties would be provided in her deposition. The plaintiff stated that her expenses were approximately $6000 for the hospital, $10,000 for physicians, $2000 for x-rays and MRI's and $1000 for miscellaneous expenses. Finally, the plaintiff avers that she is claiming the serious injury categories of fracture, dismemberment, permanent loss, permanent consequential limitation, significant limitation and non-permanent injury.

The plaintiff testified at her deposition that after the accident she was pulled from her car, strapped to "the board" and given a cervical collar. She was then placed in the ambulance, given oxygen and taken to Mather. She was not admitted at Mather. While being treated at Mather she complained that "everything hurt" but particularly her ribs, chest, knee elbow, jaw, neck and back. She told the nurse that she also had chipped teeth. The nurse was aware of the lacerations on her left knee and foot. While at Mather she was given a painkiller medication and was given a prescription upon leaving Mather. After leaving Mather there were no further MRIs or x-rays taken of her knees or mid-back since she had no major medical insurance and could not afford having the tests done. She could not afford to see a TMJ specialist either.

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[1] The Court takes judicial notice that TMJ is a colloquial abbreviation for temporomandibular joint dysfunction (Stedman's Medical Dictionary, 27th Edition, page 1839)

One day after the accident she was treated at Dr. Heckler's office by Emily, the physician's assistant. Emily gave her a sling for her right arm because she was walking around holding her ribs. She wore the sling for approximately seven to eight weeks. She was treated at Dr. Heckler's office five times. On one of those visits Dr. Heckler gave her a brace for her knees which she wore on a daily basis for four months and then wore it intermittently after that. Dr. Heckler confirmed that the x-rays taken of the plaintiff's ribs at Mather showed the existence of fissure fractures in two ribs on the right. Dr. Heckler's office prescribed Cyclobenzaprine, Vicodin and Ibuprofen. She continued to take the Vicodin for approximately four and one half months and still takes it occasionally when she has pain. She took Vicodin the night before the deposition because she had pain in her neck and back and recently took Cyclobenzaprine for cramping in her back and right leg. She also took 600 milligrams of Ibuprofen on a daily basis for approximately five months and took it recently for pain in the jaw.

She was treated at South Shore Medical (SSM), a physical therapy facility where she received physical therapy for her knees and right shoulder. At SSM she was treated by Dr. Coladner and Dr. Herrara, who were doctors of osteopathy. The first time she was seen by Dr. Coladner she complained of pain in ribs, neck, back, knees, jaw, elbow, wrists and shoulders and shooting pains in her legs. She was informed by Dr. Coladner that an MRI of her neck taken after the subject accident showed two bulging discs and was informed by Dr. Priolo that an MRI of her lower back taken after the accident showed four pre-existing disc bulges. One of the four disc bulges was in the sacral spine and had occurred in another incident when she broke her tailbone. Dr. Herrera told her that because of her effort to compensate for pain, the bone under the right knee was changing shape.

A couple of weeks after the accident she saw Dr. Cohen, a dentist, about her jaw. She complained to him that her jaw joints hurt a lot and that anytime she opened her mouth more than an inch she could feel her jaw popping. Dr. Cohen informed her that she would have to be seen by a TMJ specialist, but would have to wait because there was still swelling and bruising in her jaw. She saw Dr. Cohen three times and he advised her to not eat hard or big foods.

She currently has numbness in both legs as well as pain in her lower and middle back. She also gets stabbing pain in her lower back to the right of the spine if she sits in a hard chair, stands in one spot or bends over to pick something up. In the latter case she has to bend at her knees. She also has pain to the left of the right shoulder blade and weakness in the whole right arm. Generally, she is not as strong as she used to be. She had difficulty walking up and down stairs because her knees "pop". Although her ribs healed after four months she still has pain where the spine meets the lower rib if she twists her body or tries to pick something up. Her jaw still "pops out of place" and she had difficulty eating things that are large, hard or chewy. The plaintiff was not able to drive after the accident until the second week in December.

Finally, the plaintiff testified that in 1998 she was injured when a car in which she was a passenger ran into a snowbank. As a result of this accident she sustained only neck sprain. Chiropractic treatment ended after three months and she is no longer troubled by this injury. Prior to this injury she had never injured her back and, in between this accident and the incident in 2001, there were no other incidents affecting her spine. In 2001 she fell on ice and broke her tailbone and herniated two discs. The day following this incident she went to Middle Island Pain and Rehabilitation (Middle Island). She was treated there by Doctors Braunbach and Studo, who were chiropractors, and by Dr. Mosamillo, who was a doctor of osteopathy. Following an x-ray she was informed that she had fractured her coccyx tailbone. She had pain in her middle and lower back which continued up to the time of the subject accident. She

had no pain in the upper back between the base of the neck and the shoulder blades and the neck pain continued only intermittently. In relation to the 2001 incident she had MRIs of her neck, middle back and lower back. The MRI of the neck was negative, but the MRI of the middle back showed two herniated discs and the MRI of the lower back showed the same four pre-existing bulging discs. Although she continues to see Dr. Braunbach, she sought treatment at Middle Island only two to three times in the two months preceding the subject accident. After the subject accident she was not involved in any other accident or incident where she re-injured the same parts of her body that she injured in the subject accident. She did not injure her knees or suffer a head injury in the 2001 incident.

The emergency room records of Mather indicate that the plaintiff's chief complaints upon arriving at the hospital were that she had pains in her neck, back, left knee and elbow. The Mather Emergency Physician Record (EPR) indicated that the plaintiff had reported pain in her head, face, mouth, neck, chest, abdomen, her entire back, right shoulder and left foot. It also indicated that the plaintiff had trouble breathing. The "CLINICAL IMPRESSION" section of the EPR showed strains or sprains of the plaintiff's neck and lumbar region and contusions of the chest and left knee. A report of x-rays taken of the plaintiff's right ribs indicates no evidence of fracture or dislocation and that there was a negative examination. However, the same report also states "Fissure fractures of the ribs in excellent position and alignment are frequently not demonstrated for some time until callous formation appears. If clinically indicated, suggest re-examination in 2 weeks time." (Motion, Exhibit E). Reports of x-rays of the plaintiff's mandible, sternum, cervical spine, left knee including the patella, pelvis, lumbosacral spine and left foot were negative. The report of the x-ray of the plaintiff's lungs indicated that there was no "acute process" (Motion, Exhibit E).

Dr. Heckler's stated in his report of August 27, 2004 that the plaintiff suffered from chest and rib pain. Dr. Heckler stated in his report of September 1, 2004 that the plaintiff had sustained multiple contusions. Dr. Heckler stated in his report of September 13, 2004 that the plaintiff had sustained muscle spasms. Dr. Heckler stated in his report of September 27, 2004 that the plaintiff had sustained knee sprains and contusions. In each of these reports Dr. Heckler stated that the observed injuries were caused solely by the accident. Dr. Cohen noted in his report of January 18, 2005 that the plaintiff had chipped several teeth as a result of the subject accident. He also noted that there was TMJ tenderness on right and left.

Dr. Coladner noted in her report dated September 16, 2004 that the plaintiff complained, among other things, of being unable to lay down and sleep properly because of sternal pain, daily headaches, difficulty moving her neck because of pain and soreness, bilateral upper trapezius pain, intermittent numbness in the right arm, right and left shoulder pain, pain and swelling in the left elbow, left wrist pain, pain in the mid-back, pain in between the shoulder blades, low back pain, radiating bilateral leg pain, bilateral leg weakness and numbness, left knee pain and swelling, bilateral knee popping, clicking and snapping and left foot pain and numbness. Dr. Coladner noted pre-existing herniated discs in the thoracic spine from a work related injury in 2001. Dr. Coladner also noted that as a result of this accident the plaintiff sustained a fractured coccyx and two disc bulges in the lumbar spine. The plaintiff reported to her that she was 60% healed from this incident and that she was on Worker's Compensation Disability when the subject motor vehicle accident occurred and was currently not working. Dr. Coladner performed a range of motion examination on the plaintiff's neck and trapezius. After a comparing her findings with the normal ranges for these tests, she noted significant deficiencies in extension, right and left rotation as well as right and left lateral flexion. She also noted that there was tenderness, muscle spasm, and trigger points in the left cervical paraspinal muscles. Her range of motion findings for the left

shoulder were all within normal limits, but Dr. Coladner noted that the right side was not tested because of pain incidental to fractured rib pain. Similarly, although range of motion findings for the left elbow and wrist were within normal limits, testing was not done on the right side because of the fractured rib pain. Dr. Coladner's range of motion findings for the lumbar spine, upon comparison with normal ranges, showed significant deficiencies in flexion, extension, right and left rotation, and right and left lateral flexion. Dr. Coladner's range of motion testing for the knees, upon comparison with normal findings, showed a significant deficiency of range in the left knee for flexion. Her "IMPRESSION" indicated "multiple trauma", cervical and lumbar spine nerve root injury and knee laceration. Dr Coladner recommended an MRI examination of the cervical and lumbar spines and the shoulder and knee as well as other objective testing of the cervical and lumbar spines and upper and lower extremities.

Dr. Coladner stated in her report of October 27, 2004 that she saw the plaintiff for re-evaluation. The plaintiff continued to complain of pain in her jaw, neck, right shoulder, left elbow, mid and lower back and in both knees. The plaintiff also complained of continued but diminished rib pain. She also stated that she could sleep for 4 to 5 hour periods. Dr. Coladner again performed a range of motion examination on the plaintiff's neck and trapezius. After comparing her findings with the normal ranges for these tests, she noted significant deficiencies in extension as well as right and left lateral flexion. She again noted that there was tenderness, muscle spasm, and trigger points in the left cervical paraspinal muscles. Dr. Coladner's range of motion findings for the left shoulder were all within normal limits, but the right shoulder showed serious deficiencies for external and internal rotation. Range of motion testing for the wrists and elbows was shown to be within normal limits. Dr. Coladner's range of motion findings for the lumbar spine continued to show significant deficiencies in flexion, extension, right and left rotation, and right and left lateral flexion. Dr. Coladner's range of motion testing for the knees again showed a significant deficiency of range in the left knee for flexion. Her "IMPRESSION" again indicated "multiple trauma", cervical and lumbar spine nerve root injury and knee laceration and also lateral epicondylitis. Dr Coladner again recommended an MRI examination of the cervical and lumbar spines to "rule out HNP or other pathology" (Motion, Exhibit F).

Dr. Coladner stated in her report of December 6, 2004 that she again saw the plaintiff for re-evaluation. The plaintiff informed her that, while she still had a "host of complaints", overall she was feeling better. Dr. Coladner noted that the plaintiff was also continuing to take medications. Dr. Coladner stated that she reviewed an MRI of the plaintiff's cervical spine with her which showed bulging discs at C4-C5 and C5-C6. Dr. Coladner again performed a range of motion examination on the plaintiff's neck and trapezius. After comparing her findings with the normal ranges for these tests, Dr. Coladner noted significant deficiencies in extension and right rotation. Dr. Coladner's range of motion findings for the left shoulder were all within normal limits, but the right shoulder showed a serious deficiency for internal rotation. Range of motion testing for the elbows was shown to be within normal limits. Dr. Coladner's range of motion findings for the lumbar spine continued to show significant deficiencies in flexion, extension, right and left rotation, and right and left lateral flexion. Dr. Coladner's range of motion testing for the knees again showed a significant deficiency of range in the left knee for flexion. Her "IMPRESSION" indicated "Cervical Disc Bulge, Low Back Pain, Rule Out Knee Derangement, Status Post Rib Fracture" (Motion, Exhibit F). Dr. Coladner noted that the plaintiff was still not working and was partially disabled. Dr. Coladner recommended that the plaintiff continue to take her present medications and that an MRI be taken of her left knee.

Doctors Coladner and Herrara stated in their report of January 4, 2005 that they saw the plaintiff for re-evaluation. The plaintiff informed them that she had pain in her neck, both shoulders and between the

shoulder blades, in the mid and lower back, right buttock, and knees. She also complained that anterior knee pain was worsened by walking. Doctors Coladner and Herrara noted that the plaintiff was continuing to take medications. The doctors stated that an MRI of the plaintiff's cervical spine which showed bulging discs at C4-5 and C5-6 was again reviewed with her and that an MRI of the plaintiff's lumbar spine revealed disc bulges at L2-3, L3-4, L4-5 and L5-S1. Range of motion testing was again done on the plaintiff's neck and trapezius. After comparing the findings with the normal ranges for these tests, the doctors noted significant deficiencies in extension and right and left rotation and 10 degrees deficiencies in flexion, and right and left lateral flexion. Range of motion findings for the lumbar spine, upon comparison, showed a significant deficiency only in flexion. Range of motion testing for the knees, upon comparison, showed findings to be within normal limits. The doctors' "IMPRESSION" indicated "Cervical Pain, Cervical Disc Disp without Myelopathy, Low Back Pain, Knee Derangement, Patella Tendinitis, Myofascial Pain Syndrome" (Motion, Exhibit F). It was again noted that the plaintiff was not working and was partially disabled. Doctors Coladner and Herrara recommended that the plaintiff continue to take her present medications.

Dr. Priolo, a chiropractor, stated in his report of January 11, 2005 that the plaintiff complained that she had difficulty sleeping, that she had headaches, that she had pain in her jaw, mid and lower back, lower ribs and right leg. She also complained that neck and back pain was worsened by activity. He reviewed MRI examinations which showed bulging discs in the cervical spine at C4-5 and C5-6 and in the lumbar spine at L2-3, L3-4, L4-5 and L5-S1. Dr. Priolo also noted that the plaintiff's medical history indicated that as a result of a work-related injury in 2001 she sustained two herniated discs in the thoracic spine, bulging discs in the lumbar spine and a fractured coccyx. The patient told him that she was 60% healed from that incident. It was again noted that the plaintiff was on Worker's Compensation disability when the subject accident occurred. Range of motion testing was again done on the plaintiff's neck and trapezius. After comparing the findings with the normal ranges for these tests, Dr. Priolo noted significant deficiencies in extension, right rotation and right lateral flexion,10 degree deficiencies in left rotation and left lateral flexion and a 5 degree deficiency in flexion. Range of motion findings for the lumbar spine, upon comparison, showed significant deficiencies in flexion, extension, left rotation, and left lateral flexion. Orthopedic findings for the thoracic spine were all negative. Dr. Priolo's "IMPRESSION" was that the plaintiff was suffering from cervical, thoracic and lumbar subluxation. Dr. Priolo recommended that the plaintiff receive chiropractic treatment for two to three times per week for six weeks and referred the plaintiff to a TMJ specialist.

Dr. Priolo stated in his re-evaluation report of February 23, 2005 that although the plaintiff reported that her symptoms were less intense, she did complain that she had still had pain in her neck, jaw, mid and lower back and knees. She also complained that her knees locked and that she had increased pain with prolonged standing. Range of motion testing was again done on the plaintiff's neck and trapezius. After comparing the findings with the normal ranges for these tests, Dr. Priolo again noted significant deficiencies in extension, right rotation and right lateral flexion,10 degree deficiencies in left rotation and left lateral flexion and a 5 degree deficiency in flexion. Range of motion findings for the lumbar spine, upon comparison, again showed significant deficiencies in flexion, extension, left rotation, and left lateral flexion. Orthopedic findings for the thoracic spine were again all negative. Dr. Priolo repeated his recommendation that the plaintiff receive chiropractic treatment for two to three times per week for six weeks.

Doctors Coladner and Herrara stated in their report of May 3, 2005 that they saw the plaintiff for re-evaluation. The plaintiff informed them that she had pain in her neck which radiated to the right shoulder

but which was also less intense. She again complained of pain in the mid and lower back, right buttock, and knees which was exacerbated by walking. The plaintiff also complained that she had a lump in her left elbow since the accident and that it was tender to palpation. Doctors Coladner and Herrara noted that the plaintiff was continuing to take medications. Range of motion testing was again done on the plaintiff's neck and trapezius. After comparing the findings with the normal ranges for these tests, the doctors noted significant deficiencies in extension and right and left rotation and 10 degrees deficiencies in flexion, and right and left lateral flexion. Range of motion findings for the lumbar spine, upon comparison, showed a significant deficiency only in flexion. Range of motion testing for the knees and left elbow, upon comparison, showed findings to be within normal limits. With regard to the thoracic and upper trunk area, the doctors noted that there was tenderness in the right rhomboid and bilateral paraspinal muscles. The doctors'"IMPRESSION" indicated "Cervical Pain, Cervical Disc Disp without Myelopathy", thoracic and low back pain and myofascial pain syndrome (Motion, Exhibit F). Doctors Coladner and Herrara recommended that the plaintiff continue to take her present medications and that she should be treated with acupuncture.

Doctors Coladner and Herrara stated in their report of July 22, 2005 that they saw the plaintiff for re-evaluation. The plaintiff informed them that she had persistent pain in her neck which radiated to the shoulder, numbness in her hands and pain in her knees, mid and lower back with the mid-back pain radiating to the ribs. She also informed them that the pain was worsened by sitting or standing for prolonged periods. Range of motion testing was again done on the plaintiff's neck and trapezius. After comparing the findings with the normal ranges for these tests, the doctors noted significant deficiencies in extension and right and left rotation and 10 degrees deficiencies in flexion, and right and left lateral flexion. Range of motion findings for the lumbar spine, upon comparison, showed a significant deficiency only in flexion. Range of motion testing for the knees, upon comparison, showed findings to be within normal limits. With regard to the thoracic and upper trunk area, the doctors noted that there were trigger points in the bilateral thoracic paraspinal muscles. The doctors'"IMPRESSION" indicated "Cervical Pain, Cervical Disc Disp without Myelopathy", thoracic and low back pain and cervical, thoracic and lumbar myofascial pain syndrome (Motion, Exhibit F). Doctors Coladner and Herrara recommended that the plaintiff continue to take her present medications and that she should consider trigger point injections.

All of the reports of Doctors Coladner, Herrara, and Priolo (Doctors) state that an x-ray examination of the ribs revealed right fissure fractures. Beginning with Dr. Coladner's report of December 6, 2004, the Doctors refer in their subsequent reports to an MRI of the plaintiff's cervical spine which indicated disc bulges at C4-5 and C5-6. Starting with Doctors Coladner and Herrara's report of January 4, 2005, the Doctors also refer to an MRI of the plaintiff's lumbar spine which indicated disc bulges at L2-3, L3-4, L4-5 and L5-S1.

A report of an MRI taken of the plaintiff's lumbar spine on November 29, 2004 indicated that there were no bulging or herniated discs, that there was no central or foraminal stenosis, that the discs were normally hydrated and that there was no spondylolisthesis or compression fracture. The "IMPRESSION" section of the report indicated that this was a normal exam (Motion, Exhibit F). A report of an MRI taken of the plaintiff's cervical spine on November 29, 2004 indicated that there were bulging discs at C4-5 and C5-6 resulting in a mild narrowing of the ventral CSF space without cord compression.

Dr. Katz, an orthopedist, averred in his report dated May 24, 2006 that he examined the plaintiff the same date. She informed him that as a result of the subject accident she sustained injuries to her neck,

back and left knee, came under the outpatient care of Dr. Coladner and had physical therapy treatment for four months and that she was not currently working nor had worked at the time of the subject accident because of a work related injury which occurred in 2001. Dr. Katz noted that the plaintiff's medical history showed that the work related injury in 2001 was to the plaintiff's back and that she had numerous herniated lumbar and thoracic discs prior to the subject accident. The history also reflected that she had injured her neck in an automobile accident in 1988. Her present complaint was that she had pain in her left knee depending on the weather. Dr. Katz, performed range of motion testing of the plaintiff's cervical spine for flexion, extension, right and left-sided lateral flexion and right and left-sided rotation and, after comparison, found the results to be within the normal range for those findings. Dr. Katz, performed range of motion testing of the plaintiff's lumbosacral spine for forward flexion, full extension and full lateral and side bending and, after comparison, found the results to be within the normal range for those findings. He noted the absence of paravertebral muscle spasm. Other objective orthopedic tests were negative. He noted that although the plaintiff walked in and out of the examining room slowly, the plaintiff changed positions normally and did not use a cane, walker or crutch. On his examination of the plaintiff's left knee he observed that there was no effusion or swelling, that range of motion in the flexion/extension arc was 0 to 135 degrees with normal at 135 degrees and that there was no medial or lateral joint line tenderness. The patellar apprehension test, the posterior drawer sign, the posterior sag sign were all negative. Dr. Katz further observed that there was no demonstrable crepitus, that the prepatellar bursa was supple and lacked swelling, erythema, or induration and that there was a well healed laceration along the medial compartment of the knee.

Dr. Katz's diagnosis was that the plaintiff had resolved cervical and lumbosacral strain and a healed abrasion on the left knee. Dr. Katz concluded "The claimant is a 40-year-old female who alleged an injury of 08/25/04 as a seat-belted driver. It is clear that she had a significant pre-existing injury that rendered her disabled prior to the alleged date of 08/25/04 and was totally unrelated. The claimant is currently not disabled based on the events of 08/25/04. She shows no signs or symptoms of permanence referable to the neck or back. She had some healed abrasions medially along the left knee, which have healed since the date of the accident. Currently, she is not disabled based on the events of 08/25/04. She is capable of her activities of daily living. With regard to causal relationship, it is clear that her disability status is related to her prior accident of 2001 and not to any event of 08/25/04" (Motion, Exhibit H).

Dr. Essuman, a neurologist, averred in his report dated June 15, 2006 that he examined the plaintiff on that date. In the "HISTORY" portion of his report he noted that on August 25, 2004 the plaintiff had been taken to Mather after an accident to be treated for injuries which included a dental fracture. The plaintiff complained of headaches extending into the left jaw, neck pain extending into the trapezii and shoulders and pain in the lower back, hips and buttocks with more pain in the right hip and buttock. Dr. Essuman performed range of motion studies of the plaintiff's cervical and lumbosacral spines and, upon comparison, found his testing results to be within the normal ranges. Other objective studies indicated that there were no neurological deficits. Dr. Essuman's diagnosis was that the plaintiff's neurological examination was normal and negative. He indicated that the plaintiff had sustained soft tissue injury which was minor, resolved and "without sequelae" (Motion, Exhibit H). Dr. Essuman found no evidence of radiculopathy and no clinical correlation between the plaintiff's subjective symptoms and his objective findings on examination. He concluded that the plaintiff could continue all occupational duties and, based on his examination findings, that there were no factors precluding the plaintiff from engaging in full time employment and the activities of daily living. Dr. Essuman also noted that the injuries sustained and the subject accident were causally related

Initially the defendants contend that evidence the plaintiff was on Worker's Compensation disability insurance at the time of the subject accident demonstrates, prima facie, that the plaintiff did not sustain a non-permanent injury. In this regard Doctors Priolo and Coladner stated that the plaintiff informed them that she was on Worker's Compensation disability insurance and was not working either at the time of the subject accident or at the time of treatment. However, turning to the defendants' other proof, the supplemental bill of particulars is silent with regard to the plaintiff's confinement to bed and home and incapacitation from household duties following the accident. The plaintiff testified in her deposition that she could not drive until the second week of December and had difficulty eating, going up and down stairs, walking, standing, sitting and bending over. She further testified that she wore a sling brace on her right arm for seven to eight weeks, wore a knee brace on a daily basis for four months and continued to take prescription medications for four to five months. The plaintiff also complained to Doctors Coladner and Priolo that she had difficulty sleeping. These complaints were clinically supported by the Mather emergency room records which indicated the possibility of fissure fractures in the ribs, by the significant range of motion deficiencies noted in the reports of Doctors Coladner, Herrera and Priolo dated September 16, October 27, December 6, 2004, January 4, January 11 and February 23, 2005, by the reports of Dr. Heckler who observed muscle spasms and attributed the plaintiff's injuries solely to the subject accident and by the report of Dr. Cohen who noted TMJ tenderness. Since this proof raises triable issues of fact as to whether the plaintiff sustained a non-permanent injury, defendants have failed to meet their prima facie burden (***O'Neal v Cancilla,*** 294 AD2d 921, 741 NYS2d 815 [2002]; ***Frier v Teague,*** 288 AD2d 177, 732 NYS2d 428 [2001]).

With regard to the fracture category of serious injury, the Mather emergency room x-ray report of the plaintiff's right ribs indicated that the plaintiff did not sustain a fracture and that it was a negative examination. However, the same report indicated that fissure fractures of the ribs could not be ruled out at that time. The emergency room records also indicate that the plaintiff on admission complained of pain in her chest and had trouble breathing. The plaintiff also testified that Dr. Heckler confirmed that the x-rays taken of her ribs at Mather showed fissure fractures in two ribs on the right side and that she was given a sling for her right arm by Dr. Heckler's physician assistant because she was observed holding her ribs. Doctors, Coladner, Herrara and Priolo all note in their reports that an x-ray examination of the plaintiff's ribs revealed fissure fractures on the right hand side and Dr. Coladner noted in her initial reports that the plaintiff complained of pain in her ribs. Since this evidence raises a triable issue of fact as to the possibility of rib fractures, defendants have failed to meet their prima facie burden (***Kaplan v Septama,*** 38 AD3d 847, NYS2d , 2007 N.Y. Slip Op. 02712).

The defendants contend that Dr. Coladner's opinion that an x-ray report had shown fissure fractures of the plaintiff's ribs should not be considered because there is no record of further x-rays being taken in her office and because Dr. Coladner may have relied on the x-rays of the plaintiff's ribs taken at Mather which state, in part, that there was no fracture. The Court rejects this contention in that defendants will not be permitted to omit from the evidence they have tendered for the Court's consideration only those portions unfavorable to their position. In any event, this contention merely raises a triable issue of fact as to credibility (***Parker v Defontaine-Stratton,*** 231 AD2d 412, 647 NYS2d 189 [1996]; ***Francis v Basic Metal, Inc.,*** 144 AD2d 634, 534 NYS2d 697 [1988]).

With regard to the categories of permanent consequential limitation and significant limitation, the plaintiff has alleged in her supplemental bill of particulars, inter alia, that she has sustained as a result of

the accident disc bulges at C4-C5 and C5-C6 and TMJ[2]. The plaintiff testified that prior to being transported in the ambulance she was given a cervical collar and that while being treated at Mather, although she had pain all over her body, the pain was more intense in her ribs, chest, knee, elbow, jaw, neck and back. She also testified that Doctors Coladner and Priolo had informed her that MRIs taken after the accident showed two cervical bulging discs and four pre-existing disc bulges in the lower back and that Dr. Cohen treated her for the pain in her jaw and advised her that she should see a TMJ specialist. The plaintiff further testified that she could not afford to see a TMJ specialist. The Mather emergency room records reflect that although the plaintiff did express complaints of pain in her neck, face and mouth, x-rays of her mandible and cervical spine were negative. While Dr. Heckler summarized in his reports that the plaintiff had sustained muscle spasms, sprains and contusions, Dr. Cohen noted in his report of January 18, 2005 that there was TMJ tenderness on both sides. An MRI of the plaintiff's cervical spine taken on November 29, 2004 showed bulging discs at C4-5 and C5-6 and did not state the cause of that condition. Dr. Priolo stated in his report of January 11, 2005 that he referred the plaintiff to a TMJ specialist and stated in his report of February 23, 2005 that the plaintiff still complained of pain in her jaw and neck and that his cervical spine range of motion testing showed significant deficiencies. Doctors Coladner and Herrrara stated in their reports of May 3rd and July 22nd 2005 that the plaintiff continued to complain of persistent pain in her neck, that their range of motion testing for the cervical spine showed significant deficiencies and that an MRI of the plaintiff's cervical spine showed disc bulges at C4-5 and C5-6.

Although Dr Katz, the defendants' expert, found in his report of May 24, 2006 that all of the plaintiff's range of motion tests for the cervical spine were within normal limits, he failed to distinguish Doctors Coladner and Herrara's report dated nearly a year after the accident and only ten months prior to his own report, which indicated significant range of motion deficiencies for the cervical spine (***Kovalenko v General Electric Capital,*** 37 AD3d 664, 831 NYS2d 438 [2007]. His report is also unclear as to whether the plaintiff did or did not sustain a permanent disability and fails to provide the basis for his conclusion that any disability was totally unrelated to the subject accident. Although Dr. Katz did note that the plaintiff's medical history showed that she had sustained a neck injury in an automobile accident in 1998 and had sustained injury to her thoracic and lumbar spines in a work related accident in 2001, the plaintiff has testified that the neck injury sustained in 1998 was merely a sprain and that after three months of chiropractic treatment it was healed. As Dr. Katz noted, and as the plaintiff has testified, the accident of 2001 did not result in injuries to the plaintiff's cervical spine or to her jaw. In any event, Dr Heckler's and Dr. Essuman's opinions that the plaintiff's injuries were caused by the subject accident are sufficient to raise a triable issue of fact with respect to causation. Dr. Essuman in his report of June 15, 2006, although finding normal cervical ranges of motion, also fails to address the contrary cervical range of motion findings in Dr. Coladner and Herrera's reports of May 3rd and July 22nd 2005. Moreover, although the plaintiff complained to Dr. Essuman of headaches extending into the left jaw and noted that the plaintiff's injuries following the accident included a dental fracture, Dr. Essuman failed to address the plaintiff's claim in the supplemental bill of particulars of TMJ syndrome (***Rodriguez v J & K Taxi, Inc.,*** 12 AD3d 434, 783 NYS2d 843 [2004]. Since the defendants' evidence raises a triable issue of fact with respect to the serious injury categories of significant limitation and permanent consequential limitation, defendants have failed to meet their prima facie burden (***Seymour v Roe,*** 301 AD2d 991, 755 NYS2d 452 [2003]; ***Coppotelli v Jacobowitz,*** NYLJ, August 18, 1998, page 24, Col. 5 [App. Term, Second and

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[2] The TMJ syndrome is considered a serious injury pursuant to Insurance Law Section 5102[d] (***Mancusi v Miller Brewing Co.,*** 251 AD2d 265, 675 NYS2d 56 [1998])

Eleventh Judicial Districts]).

Since the defendants have failed to meet their prima facie burden as to the serious injury categories of fracture, permanent consequential limitation, significant limitation and non-permanent injury, the Court need not consider the defendants' contentions with respect to the remaining serious injury categories asserted by the plaintiff, dismemberment and permanent loss (***Cesar v Felix,*** 181 AD2d 852, 581 NYS2d 411 [1992]), or the evidence tendered by the plaintiff in opposition to the defendants' motion (***D'Onofrio v Arsenault,*** 35 AD3d 646, 828 NYS2d 117 [2006]). Accordingly, the defendants' motion for summary judgment dismissing the complaint is denied.

Dated: MAY 14 2007

J.S.C.

____ **FINAL DISPOSITION** __X__ **NON-FINAL DISPOSITION**