Oliver v Town of Huntington
2007 NY Slip Op 32174(U)
July 16, 2007
Supreme Court, Suffolk County
Docket Number: 0002501/2005
Judge: Robert W. Doyle
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SHORT FORM ORDER

INDEX No. 05-2501
CAL. No. 06-02598-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 1-17-07
ADJ. DATE 3-13-07
Mot. Seq. # 003 - MG; CASEDISP

---X
TIFFANY L. OLIVER,

Plaintiff,

- against -

THE TOWN OF HUNTINGTON and QUINCY NELSON, JR.,

Defendants.
---X

JONATHAN BELL, ESQ.
Attorney for Plaintiff
247 West 35th Street, 5th Floor
New York, New York 10001

JOHN J. LEO, ESQ., Town Attorney
By: Valerie E. Smith, Esq.
Town of Huntington
Town Hall
100 Main Street
Huntington, New York 11743

Upon the following papers numbered 1 to 9 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1 - 4 ; Notice of Cross Motion and supporting papers ___; Answering Affidavits and supporting papers 5 - 7 ; Replying Affidavits and supporting papers 8 - 9 ; Other ___; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that the motion by defendants for summary judgment dismissing the plaintiff's complaint for failure to satisfy the serious injury threshold set forth in Insurance Law § 5102(d) is granted.

Plaintiff seeks to recover damages for injuries allegedly sustained in a motor vehicle accident which occurred on the morning of March 24, 2004 on Jericho Turnpike in Plainview, New York. Plaintiff was transported from the accident scene to the emergency room of Huntington Hospital where x-rays revealed that she did not sustain a fracture or dislocation in her spine, pelvis or left knee. Two days after the accident, plaintiff started treating with John Kelly, M.D. an orthopedist who referred her for an MRI and physical therapy.

In support of their motion for summary judgment, defendants have submitted, *inter alia*, the pleadings, the Huntington Hospital records, transcripts of plaintiff's 50-h hearing and examination before trial, office notes of Dr. Kelley's initial evaluation of plaintiff and follow up visits on July 8, 2004, September 8, 2004, November 3, 2004 and March 30, 2005, an MRI report dated June 29, 2004, and the affirmation of Arthur M. Bernhang, M.D. In her complaint as amplified by her verified bill of particulars, plaintiff alleges that she sustained serious and permanent injuries which have resulted in a

loss of use and limited motion in her left knee. Plaintiff also alleges that her injuries have prevented her from enjoying a quality life and normal social activities.

In his initial evaluation of plaintiff, Dr. Kelley indicates that she complained of left knee pain. Upon physical examination, Dr. Kelley states that her left knee was tender to touch and that her degree of motion was limited mainly by the pain. Dr. Kelley's impression was that plaintiff "[m]ost likely had a dashboard injury with soft tissue and probably bony cartilaginous bruising." The plan was to have plaintiff receive initial therapy followed by a home program.

The radiologist who performed the June 29, 2004 MRI of the left knee which was ordered by Dr. Kelley to rule out a medial meniscal tear, reports that plaintiff had a small joint effusion and localized superficial soft tissue swelling. The radiologist also reports, "[n]o definite meniscal tear demonstrated."

Dr. Kelley's office notes from July 8, 2004, September 8, 2004 and November 3, 2004 indicate that plaintiff was receiving physical therapy, that she was still experiencing tenderness in her left knee, was making minimal progress with her knee pain, and that her range of motion was good. The office notes dated March 30, 2005 reveal that plaintiff returned to Dr. Kelley's office for a follow up visit at which time plaintiff was showing improvement, had no tenderness, had good range of motion, and no knee joint effusion although she complained of "some vague, achy type tenderness."

Dr. Bernhang, defendants' physician, examined plaintiff on July 17, 2006 and reports that she complained of pain in her knee with activities such as walking up the stairs while carrying an infant, hiking and ice skating. She also indicated that she rides a commuter train to work every day and that trying to balance on the train causes soreness in her left knee as does the rocking motion when on a boat.

Dr. Bernhang reports he measured plaintiff's ranges of motion using a goniometer, quantifies the results which he compares to average ranges, and concludes that the physical examination of plaintiff revealed only subjective symptoms of tenderness medial to the patellar tendon without any objective findings. Dr. Bernhang's impression is that plaintiff sustained a "[s]oft tissue injury to the medial aspect of the tibial tubercle of the left knee (a dashboard injury of the knee) without residual loss of function, without residual atrophy, without residual patellar tendinitis, without intrarticular damage to the knee." According to Dr. Bernhang, there is no objective orthopaedic evidence of any residual injuries to plaintiff's left knee and no apparent disability as plaintiff is working full time without restriction and is not under any active medical care.

Based on this evidence, defendants have satisfied their initial burden of establishing as a matter of law that plaintiff's knee injury does not constitute a serious injury within the meaning of Insurance Law § 5102(d) (***Oberly v Bangs Ambulance Inc.***, 96 NY2d 295, 727 NYS2d 278 [2001]; ***Toure v Avis Rent A Car Sys.***, 98 NY2d 345, 746 NYS2d 865 [2000]; ***Gaddy v Eyler*** , 79 NY2d 955, 582 NYS2d 990 [1992]; ***Nannarone v Ott***, ___AD3d___, ___NYS2d___, 2007 WL 1631406, 2007 NY Slip Op 04800). Thus, in order to survive summary dismissal, the burden shifts to plaintiff to present competent evidence based upon objective medical findings and diagnostic tests of a serious injury causally related to the accident (*see*, ***Gaddy v Eyler***, *supra*). Plaintiff has failed to satisfy this burden.

In opposition, plaintiff has submitted the affidavit of her treating orthopedist, Dr. Kelley, wherein he asserts, that the office notes attached thereto are true and accurate copies of records maintained in the regular course of business (*see,* CPLR 4518; ***Osowicki v Young*** 140 AD2d 898, 528 NYS2d 716 [1988] [office notes authored by a patient's treating physician the veracity of which are sworn to in an affidavit constitute business records pursuant to 8 NYCRR 29.2(a)(3) and may be considered on a motion for summary judgment]). In addition to the same office notes produced by defendants, annexed to Dr. Kelley's affidavit are office notes for follow-up visits on August 24, 2005 and January 24, 2007, as well as a letter to plaintiff's attorney dated February 19, 2007. Dr. Kelley's August 24th examination of plaintiff revealed no effusion, 0 to 130 degrees of motion, no atrophy of the left thigh compared to the right, some localized atrophy of the skin where plaintiff received a cortisone injection, and resisted patellofemoral compression pain and crepitation. Dr. Kelley's impression was that plaintiff was showing improvement but still had some pain with certain activities.

Dr. Kelley indicates that his January 24, 2007 examination of plaintiff's knee showed no erythema, atrophy, effusion or swelling and that she had "resisted patellofemoral compression pain and crepitation." Dr. Kelley also indicates that plaintiff had "no ligamentous instability," "no point tenderness along the joint lines" but that "she has medial more than lateral patella facet tenderness." Plaintiff's meniscal tests were negative as was her calf exam, and the "distal neurovascular exam is in tact." Dr. Kelley's impression was that plaintiff had reached maximum medical improvement and that she had a 5% permanent partial impairment of the left lower extremely which he opines is causally related to the accident. Dr. Kelley also notes that plaintiff denies any history of knee pain prior to the accident and that she is not likely to need surgery in the future. Significantly, in his letter dated February 19, 2007, Dr. Kelley writes, "the objective test that documents the patient's impairment would be her complaints of pain, with a history of a direct blow, to the patellofemoral compartment, with crepitation and pain on physical exam, and without any x-ray evidence of joint space narrowing."

Dr. Kelley's initial impression that plaintiff suffered a soft tissue injury and bruising does not satisfy the "serious injury" threshold under Insurance Law § 5102(d) (*see,* ***Moore v County of Suffolk***, 6 AD3d 408, 774 NYS2d 375 [2004]; *see also,* ***Gaddy v Eyler****, supra;* ***Maenza v Letkajornsook***, 172 AD2d 500, 567 NYS2d 850 [1991]). Additionally, Dr. Kelley has not set forth the objective tests or diagnostic studies performed to support his conclusion that plaintiff has a 5% permanent disability (*see,* ***Bushman v Di Carlo***, 268 AD2d 920, 702 NYS2d 426, *lv denied* 94 NY2d 764, 708 NYS2d 53 [2000]). Indeed, it is clear that Dr. Kelley's medical opinions were based upon the plaintiff's subject complaints of pain which are insufficient, on their own, to raise a triable issue of fact as to whether she sustained a serious injury (*see,* ***Scheer v Koubek***, 70 NY2d 678, 518 NYS2d 788 [1987]; ***Kivlan v Acevedo***, 17 AD3d 321, 792 NYS2d 573 [2005]).

Moreover, plaintiff has failed to proffer competent medical evidence showing that she was unable to perform substantially all of her daily activities for not less than 90 of the first 180 days subsequent to the subject accident. Plaintiff's self-serving testimony regarding the usual and customary activities she was unable to perform for the statutory time frame, without any medical evidence which connects this purported inability with the alleged accident-related injuries, or an order by a doctor to curtail such activities, is insufficient to raise an issue of fact (*see,* ***Kivlan v Acevedo****, supra;* ***Pierre v Nanton***, 279 AD2d 621, 719 NYS2d 706 [2001]; ***Sainte-Aime v Ho***, 274 AD2d 569, 712 NYS2d 133 [2000]).

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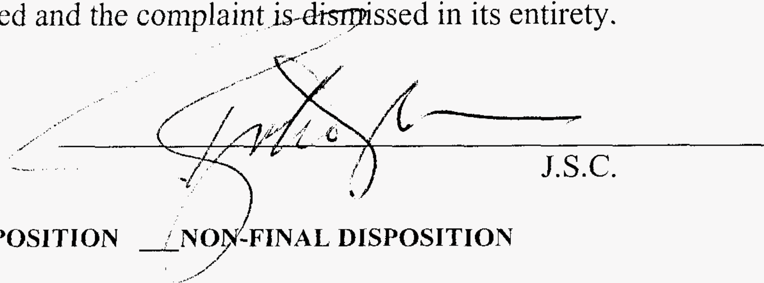
Furthermore, it appears that plaintiff was last treated on August 24, 2005. No explanation is provided by the plaintiff or Dr. Kelly for the seventeen month gap in treatment (*see, **Holder v Brown***, 18 AD3d 815, 796 NYS2d 641 [2005]). Thus, the medical opinions set forth by Dr. Kelley on January 24, 2007, after the defendants made the instant motion for summary judgment, appear to have been tailored to meet the statutory requirements, and are insufficient to defeat defendants' prima facie showing (*see, **Lopez v Senatore***. 65 NY2d 1017, 494 NYS2d 101 [1985]).

Finally, the office notes regarding the physical therapy treatments plaintiff received at Altman Physical Therapy Center and at Star Sports Therapy & Rehabilitation are not properly sworn, and thus, without probative value (*see, **Grasso v Angerami***, 79 NY2d 813, 580 NYS2d 178 [1991]; ***Holder v Brown***, *supra*). The office notes are certified by an agent, and thus are admissible as business records of the physical therapy having been performed but inadmissible for the purpose of verifying the contents thereof (*see*, CPLR 4518; ***Hefte v Bellin***, 137 AD2d 406, 524 NYS2d 42 [1988]).

Accordingly, the motion is granted and the complaint is dismissed in its entirety.

Dated: JUL 16 2007



J.S.C.

X FINAL DISPOSITION ___ NON-FINAL DISPOSITION