Salehi v Walter
2007 NY Slip Op 33423(U)
October 16, 2007
Supreme Court, Suffolk County
Docket Number: 0017771/2005
Judge: Robert W. Doyle
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[* 1]

SHORT FORM ORDER

INDEX No. 05-17771
CAL. No. 07-00503-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 7-6-07
ADJ. DATE 8-17-07
Mot. Seq. # 001 - MG; CASEDISP

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DESIREE SALEHI,

Plaintiff,

- against -

KRISTIE R. WALTER,

Defendant.

---X

SCHOEN & STRASSMAN, LLP
Attorneys for Plaintiff
52 Elm Street
Huntington, New York 11743

DeSENA & SWEENEY, LLP
Attorneys for Defendant
1383 Veterans Memorial Highway, Suite 32
Hauppauge, New York 11788

Upon the following papers numbered 1 to 23 read on this motion for summary judgment ; Notice of Motion/ Order to Show Cause and supporting papers 1 - 12 ; Notice of Cross Motion and supporting papers ____; Answering Affidavits and supporting papers 13 - 21 ; Replying Affidavits and supporting papers 22 - 23 ; Other__; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion by defendant for an order pursuant to CPLR 3212 granting summary judgment in her favor 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 injuries allegedly sustained by the then 18 year old plaintiff on August 14, 2002 at approximately 2:40 p.m. when her vehicle was struck by defendant's vehicle on Route 25 A at its intersection with Broadway, in Rocky Point, New York. By her amended and supplemental verified bill of particulars, plaintiff alleges that as a result of the subject accident she sustained pain and limitation of use and function resulting from aggravation and exacerbation of a prior herniated disc at C3-4 with encroachment upon the ventral aspect of the thecal sac; disc herniation at C4-5 with encroachment upon the ventral aspect of the thecal sac; straightening of the curvature of the cervical spine with loss of the normal lordosis; cervical radiculopathy; resultant headaches, neck pain and dizziness: cervical sprain; entrapment of the bilateral median nerves about both wrists, with numbness and paresthesia; herniated disc at L4-5 with effacement in neural foramen; lumbosacral sprain; myofascial pain syndrome; spinal intersegmental joint dysfunction; decreased disc space; and lumbar degenerative disc disease.

By her verified bill of particulars, plaintiff alleges that she sustained serious injuries under the threshold categories of Insurance Law § 5102 (d) "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."

Defendant now moves for summary judgment in her favor on the grounds that plaintiff did not sustain a "serious injury" as defined in Insurance Law § 5102 (d). In support of her motion, defendant submits the summons and verified complaint; her answer; plaintiff's verified bill of particulars; plaintiff's verified amended and supplemental bill of particulars; the affirmed report dated October 17, 2006 of defendant's examining orthopedist, Joseph P. Stubel, M.D. (Dr. Stubel), based on an examination of plaintiff one day prior thereto; the affirmed report dated October 13, 2006 of Beatrice C. Engstrand, M.D. (Dr. Engstrand) based on an examination of plaintiff on said date; the affirmed reports of defendant's examining radiologist, Steven L. Mendelsohn, M.D. (Dr. Mendelsohn) based on his review of two MRI's of plaintiff's cervical spine and an MRI of plaintiff's lumbar spine; and plaintiff's deposition transcript.

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 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."

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 NY2d 295, 727 NYS2d 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 "significant limitation of use of a body function or system" categories, either objective evidence of the extent, percentage or degree of the limitation or loss of range of motion and its duration based on a recent examination of the plaintiff must be provided or there must be a sufficient description of the "qualitative nature" of plaintiff's limitations, with an objective basis, correlating plaintiff's limitations to the normal function, purpose and use of the body part (*see*, ***Toure v Avis Rent A Car Systems, Inc.***, 98 NY2d 345, 746 NYS2d 865 [2000]; ***Mejia v DeRose***, 35 AD3d 407, 825 NYS2d 722 [2d Dept 2006]).

It is for the court to determine in the first instance whether a prima facie showing of "serious injury" has been made out (*see*, ***Tipping-Cestari v Kilhenny***, 174 AD2d 663, 571 NYS2d 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 AD2d 396, 582 NYS2d 395, 396 [1st Dept 1992]). Once defendant has met the burden, plaintiff must then, by competent proof, establish a prima facie case that such serious injury exists (***Gaddy v Eyler***, 79 NY2d 955, 582 NYS2d 990 [1992]). 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 [2d Dept 1992]). The proof must be viewed in a light most favorable to the nonmoving party, here, the plaintiff (***Cammarere v Villanova,*** 166 AD2d 760, 562 NYS2d 808 [3d Dept 1990]).

Here, defendant made a prima facie showing that plaintiff did not sustain a "serious injury" within the meaning of Insurance Law § 5102 (d) by submitting affirmed medical reports demonstrating that plaintiff's injuries were not permanent and were of a degenerative nature, predating the subject accident (*see*, ***Bartley v Trans Car & Limo, Inc.***, 41 AD3d 624, 836 NYS2d 892 [2d Dept 2007]). Defendant's examining orthopedist, Dr. Stubel, indicated in his affirmed report dated October 17, 2006 that plaintiff related her past history of having been involved in prior accidents in 1996 and 2001 and that plaintiff's current complaints were neck and back pain with the neck pain radiating toward both shoulders. In addition, Dr. Stubel provided the results of his examination of plaintiff's cervical spine, lumbar spine and both shoulders. With respect to plaintiff's cervical spine, Dr. Stubel's findings included, no reported tenderness on palpation and no palpable trigger points or muscle spasm and the following range of motion testing results, extension to 45 degrees (normal 45 degrees); flexion to 45 degrees (normal 45 degrees); rotation to 80 degrees bilaterally (normal 80 degrees); and lateral flexion to 45 degrees bilaterally (normal 45 degrees). He added that Tinel's sign was negative at both carpal tunnels and both cubital tunnels and pinprick sensation and motor strength were grossly normal in the upper extremities. Regarding plaintiff's lumbar spine, Dr. Stubel found that there was no reported tenderness or palpable muscle spasm and recorded range of motion measurements of forward bending to 90 degrees (normal 90 degrees); lateral flexion to 30 degrees (normal 30 degrees) bilaterally; and lateral rotation to 60 degrees (normal 60 degrees) bilaterally. He also recorded that plaintiff's straight leg raising was to 80 degrees (normal 80 degrees) bilaterally with no complaints of pain; that reflexes at the Achilles and patella tendons were bilaterally symmetrical and 2+; and that motor strength and sensation in the lower extremities were grossly normal. For the cervical spine and lumbar spine, Dr. Stubel noted that the vascular examination of the upper extremities and lower extremities were grossly normal. As for the examination of both shoulders, Dr. Stubel indicated that there was no reported tenderness or muscle spasm noted on palpation and that range of motion testing revealed that plaintiff's forward flexion was to 150 degrees (normal 150 degrees); internal rotation was to 80 degrees (normal 80 degrees); external rotation was to 80 degrees (normal 80 degrees); abduction was to 150 degrees (normal 150 degrees); and extension was to 30 degrees (normal 30 degrees). Dr. Stubel also found a normal sulcus sign; negative rotator cuff signs; negative apprehension test and negative impingement sign. Defendant's examining orthopedist diagnosed sprain of the neck, back and shoulders and concluded that based on the information provided, medical records reviewed and his examination findings, the subject accident exacerbated pre-existing injuries from plaintiff's prior accident in 2001. He opined that there were no specific objective findings of disability concerning the subject accident and injuries. He also opined that plaintiff could perform her usual activities of daily living and her usual work.

Defendant's examining neurologist, Dr. Engstrand, indicated in her affirmed report dated October 13, 2006 that plaintiff related to her that she suffered neck pain and low back pain in the prior accident of 2001and that the subject accident added shoulder pain; that she works as a waitress but does not do any lifting and that she has a two year old child. Among Dr. Engstrand's findings were that the motor examination revealed normal tone, bulk and power; no atrophy or fasciculation; supple neck; rapid movements were symmetrical; straight leg raising was negative bilaterally; and Tinel's and Phalen's signs

were negative bilaterally. Dr. Engstrand provided range of motion testing results as follows, cervical flexion 45 degrees (normal 45 degrees); cervical extension 45 degrees (normal 45 degrees); cervical rotation 80 degrees (normal 80 degrees); and cervical lateral flexion 40 degrees (normal 40 degrees). In addition, Dr. Engstrand recorded lumbar ranges of motion of flexion 90 degrees (normal 90 degrees); extension 30 degrees (normal 30 degrees); rotation 30 degrees (normal 30 degrees); and lateral flexion 30 degrees (normal 30 degrees). She also indicated that sensory testing was normal to common and cortical modalities throughout and that cerebellar testing showed no dysmetria or intention tremor. Dr. Engstrand added that plaintiff's deep tendon reflexes were 2 and equal bilaterally in the biceps, brachioradialis, triceps, patellar jerks, Achilles jerks and that station and gait were normal. In conclusion, Dr. Engstrand diagnosed resolved cervical and lumbar sprain and opined that maximum benefit from neurological treatment had been achieved and that plaintiff may continue gainful employment and normal activities of daily living.

By affirmed report, Dr. Mendelsohn, defendant's examining radiologist, reviewed an MRI of plaintiff's cervical spine performed on December 10, 2001 after the previous accident and concluded that the MRI showed very mild age related cervical degenerative changes but that there was no evidence of focal disc herniation or any trauma related abnormality. In another affirmed report, he reviewed a subsequent MRI of the cervical spine taken on October 16, 2006 after the subject accident and concluded that there were mild degenerative changes at the C3-4 and C4-5 levels which had minimally progressed when compared with the prior MRI of December 10, 2001. Also, Dr. Mendelsohn reviewed the MRI of plaintiff's lumbar spine performed on October 18, 2001 and concluded that plaintiff had mild multilevel lower thoracic and upper lumbar age related degenerative changes but no evidence of focal disc herniation or any trauma related abnormality.

At her deposition on October 13, 2006, four years after the subject accident, plaintiff testified that following the subject accident in August 2002 she went to the hospital emergency room with complaints concerning her lower back, neck, shoulders and chest, x-rays were taken and then she was released. In addition, plaintiff testified that she was told at the emergency room to take Advil and follow up with her chiropractor. According to plaintiff, she had been involved in prior motor vehicle accidents in 1996 injuring her head and in July 2001injuring her neck and lower back. Plaintiff could not remember when she went to see her chiropractor, Dr. Skurka, after the subject August 2002 accident. According to plaintiff, she saw Dr. Skurka a couple of times a week and received treatment to her neck and back in the form of electrical stimulation and adjustments. When asked whether she had any employment in New York from the time of the subject accident in August 2002 until she moved to Florida in May 2003, plaintiff responded that she could not remember at which place she was working. Plaintiff did remember that she worked at Suffolk Diner after the 2001 accident but was not sure if it was also after the subject accident in 2002 and testified that she never carried trays but could do everything else that was required. Plaintiff added that she could not carry trays due to pain and also because she "didn't really like to carry the trays." Plaintiff also testified that after moving to Florida she began seeing a chiropractor, Dr. Mancusi, whom she had been seeing regularly up until a couple of months before. Plaintiff further testified that she was never referred to a neurologist's office. With respect to current restrictions in addition to carrying trays, plaintiff testified that she could no longer bowl or do daily household chores such as sweeping, mopping, standing and washing dishes and had difficulty with driving too long without moving around and sleeping. Plaintiff added anything that requires lifting and that she had more difficulty performing chores after the 2002 accident as compared

to after the 2001 accident. Plaintiff clarified that she did not remember ever going bowling after the July 2001 accident but before the August 2002 accident. As for current complaints, plaintiff testified that she suffered from headaches every day, pain in her shoulder areas some days, numbness in her fingers and hands, and cramps in her toes.

In opposition to the subject motion, plaintiff contends that she did sustain a serious injury as defined in Insurance Law § 5102 (d). In support of her opposition to the subject motion, plaintiff submits her own affidavit dated August 3, 2007; the affidavit dated August 3, 2007 of plaintiff's initial treating chiropractor, Jamie P. Skurka, D.C. (Dr. Skurka); the affidavit dated August 7, 2007 of plaintiff's examining orthopedic surgeon, David Weissberg, M.D. (Dr. Weissberg); the affidavit dated August 1, 2007 of plaintiff's treating chiropractor in Florida, Joseph M. Mancusi, D.C. (Dr. Mancusi); an unsworn page entitled "Pain Drawing" from Dr. Skurka's office; and plaintiff's uncertified hospital emergency room records from 2001 and August 14, 2002.

Initially the Court notes that contrary to plaintiff's attorney's contentions, defendant's examining radiologist did provide an opinion as to why the new disc bulge at the C3-4 level seen in the MRI film of plaintiff's cervical spine of October 16, 2006 was not causally related to the accident. He opined that the C3-4 discs showed progressed degenerative changes as compared to the 2001 MRI, specifically, "C3-4 and C4-5 discs demonstrate mild dessication with minimal circumferential degenerative bulging with mild marginal osteophyte formation, minimally progressed compared with prior MRI of 12-10-01." The other contention that the findings of defendant's examining orthopedist and neurologist are suspect inasmuch as neither reviewed the relevant x-rays or MRI films is disingenuous since defendant's examining orthopedist expressly stated in his report that "no x-rays were brought by the claimant" and the list of medical records reviewed by defendant's examining neurologist indicates that plaintiff did not provide any x-rays or MRI films for Dr. Engstrand to review either.

In opposition, plaintiff failed to raise a triable issue of fact as to whether plaintiff sustained a serious injury or an aggravation of any pre-existing injuries (*see*, ***Nociforo v Penna***, 42 AD3d 514, 840 NYS2d 396 [2d Dept 2007]). The mere existence of a herniated or bulging disc, or even of radiculopathy, is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the disc injury and its duration (*see*, ***Furrs v Griffith***, 43 AD3d 389, ___ NYS2d ___, 2007 WL 2247295, 2007 NY Slip Op 06346 [NYAD 2 Dept Aug 07, 2007]; ***Mejia v DeRose***, 35 AD3d 407, 825 NYS2d 722 [2d Dept 2006]). The findings in the affidavit of plaintiff's initial treating chiropractor, Dr. Skurka, that plaintiff sustained a severe aggravation and exacerbation of all of the injuries that she had sustained in her prior July 2001 accident fail to raise an issue of fact. For initial examination results after the subject accident, Dr. Skurka provides percentage losses based on a comparison with his initial examination results three months after the July 2001 accident, even though he last saw plaintiff on August 12, 2002 and he stated that he regularly treated plaintiff through April 1, 2002. Plaintiff's treating chiropractor also states in his affidavit that during plaintiff's visit on August 12, 2002 two days prior to the subject accident plaintiff reported to him that she still had some low back pain, mild neck pain and mild left arm pain. Nowhere does Dr. Skurka state that plaintiff's initial examination results three months after the July 2001 accident reflect her condition just before the subject August 14, 2002 accident nor does he provide medical evidence, generated at or near the date of the August 14, 2002 accident, documenting her alleged injuries (*see*, ***King v Islam***, ___ NYS2d ___, 2007 WL 2729663, 2007 NY Slip Op 06836 [NYAD 2 Dept Sep 18, 2007]). Thus, Dr.

Skurka's cursory finding that in comparison with plaintiff's initial examination three months after the July 2001 accident, there was a loss of cervical flexion and lateral flexion of approximately 20 and 30 percent respectively as measured by goniometer, lacks probative value. His other positive orthopedic testing findings initially after the subject accident also have the same deficiency since all are in comparison to results recorded almost one year prior thereto.

Dr. Skurka further states in his affidavit that he treated plaintiff regularly until April 2003 when she moved to Florida but provides no objective examination results for the period after the subject accident up to April 2003 other than the above mentioned findings. Thus, although Dr. Skurka later sets forth in his affidavit quantified limitations in the plaintiff's cervical and lumbar spine ranges of motion in comparison to normal measurements based on recent re-examinations on February 4, 2005 and October 13, 2006, neither he nor the plaintiff proffered competent medical evidence showing range of motion limitations in plaintiff's spine that were contemporaneous with the subject accident (*see*, ***Iusmen v Konopka***, 38 AD3d 608, 831 NYS2d 530 [2d Dept 2007]; *see also*, ***Umanzor v Pineda***, 39 AD3d 539, 834 NYS2d 218 [2d Dept 2007]). The affidavit of plaintiff's examining orthopedic surgeon, Dr. Weissberg, is also insufficient for the same reason inasmuch as he provides range of motion measurements in terms of percentage loss for plaintiff's cervical and lumbar spine based on a one time examination of plaintiff on October 17, 2006 (*see*, *id.*; *see also*, ***Bestman v Seymour***, 41 AD3d 629, 838 NYS2d 645 [2d Dept 2007]). The affidavit plaintiff's treating chiropractor in Florida, Dr. Mancusi, is similarly deficient inasmuch as he had been treating plaintiff from February 6, 2004 up to and including July 20, 2007 (*see*, *id.*; *see also*, ***Bestman v Seymour***, *supra*). In addition, Dr. Mancusi's finding was that on November 3, 2006 when he examined plaintiff, she had bilateral trapezius spasm as well as spasm in the cervical and lumbar regions which was consistent with his findings in visits prior to and subsequent to that date. In any event, a mere finding of spasms without quantified limitations based on objective testing or qualitative restrictions is insufficient to raise issues of fact (*see e.g.*, ***Negrete v Hernandez***, 2 AD3d 511, 768 NYS2d 231 [2d Dept 2003]).

Moreover, plaintiff's treating medical providers failed to address the finding of defendant's expert radiologist attributing the condition of plaintiff's cervical and lumbar spine to degenerative changes thereby rendering speculative the opinions of plaintiff's treating medical providers that plaintiff's lumbar and cervical conditions were caused by the subject motor vehicle accident (*see*, ***Abreu v Bushwick Bldg. Products & Supplies, LLC***, ___ NYS2d ___, 2007 WL 2783111, 2007 NY Slip Op 06938 [NYAD 2 Dept Sep 25, 2007]). Furthermore, plaintiff's treating medical providers failed to indicate in their affidavits what treatment, if any, plaintiff received for her alleged injuries (*see*, ***Kivelowitz v Calia***, ___ NYS2d ___, 2007 WL 2782979, 2007 NY Slip Op 06955 [NYAD 2 Dept Sep 25, 2007]; ***Smith v Askew***, 264 AD2d 834, 695 NYS2d 405 [2d Dept 1999]).

Plaintiff also relied on her own hospital records concerning her prior accident in 2001 and the subject accident in 2002 which submissions are without probative value since they were uncertified (*see*, ***Nociforo v Penna***, 42 AD3d 514, 840 NYS2d 396 [2d Dept 2007]).

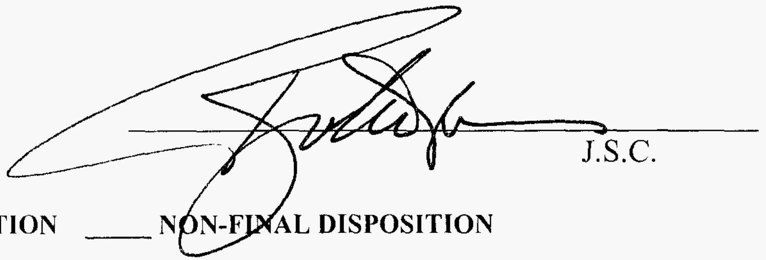
In the absence of such admissible objective evidence of injury, plaintiff's self-serving affidavit is insufficient to raise a triable issue of fact as to whether she sustained a serious injury as a result of the subject accident (*see*, ***Whitfield-Forbes v Pazmino***, 36 AD3d 901, 829 NYS2d 583 [2d Dept 2007]).

[* 7]

Furthermore, plaintiff failed to proffer competent medical evidence 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 accident (*see*, ***D'Alba v Yong-Ae Choi***, 33 AD3d 650, 823 NYS2d 423 [2d Dept 2006]; ***Hernandez v DIVA Cab Corp.***, 22 AD3d 722, 804 NYS2d 396 [2d Dept 2005]; ***Sainte-Aime v Ho***, 274 AD2d 569, 712 NYS2d 133 [2d Dept 2000]).

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

Dated: OCT 16 2007



J.S.C.

X **FINAL DISPOSITION** ____ **NON-FINAL DISPOSITION**