

Wischerath v Church

2007 NY Slip Op 33661(U)

November 8, 2007

Supreme Court, Nassau County

Docket Number: 4609-06/

Judge: Daniel R. Palmieri

Republished from New York State Unified Court System's E-Courts Service.
Search E-Courts (<http://www.nycourts.gov/ecourts>) for any additional information on this case.

This opinion is uncorrected and not selected for official publication.

Scr

SHORT FORM ORDER

**SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU**

Present:

**HON. DANIEL PALMIERI
Acting Justice Supreme Court**

-----x
KARA WISCHERATH,

Plaintiff,

-against-

TRIAL PART: 50

INDEX NO.: 04609/06

**MOTION DATE: 8-15-07
SUBMIT DATE: 10-23-07
SEQ. NUMBER - 003**

**STANLEY W. CHURCH, PATRICIA CAHILL
and JAMES EASTMAN,**

Defendants

-----x

The following papers have been read on this motion:

- Notice of Motion, dated 7-19-07..... 1**
- Affirmation in Opposition, dated 9-18-07..... 2**
- Reply Affirmation, dated 10-2-07.....3**

This motion by defendant Stanley W. Church for an order pursuant to CPLR 3212 for summary judgment on the ground that the plaintiff did not sustain a "serious injury" as that term is defined by the Insurance Law is granted and the complaint is dismissed. ¹

This is an action to recover damages for personal injuries allegedly sustained by plaintiff in a motor vehicle accident on September 24, 2004.

Insurance Law § 5102(d) defines "serious injury" as a personal injury which results

¹ By order dated November 13, 2006 summary judgment was granted to the other two named defendants and the complaint and all cross claims against them were thereby dismissed.

in, among other things, "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 her bill of particulars, plaintiff alleges that she suffers from a permanent consequential limitation of use of a body organ or member, a significant limitation of use of a body function or system, and also sustained an injury satisfying the "90/180" category. This is based on her claims, among other things, of tenderness, spasms and loss of range of motion in her cervical and lumbar spines, disc herniations at C4-5 compressing the thecal sac in the mid-line; disc bulge at C6-7 C4-6, with compression of thecal sac; cervical radiculopathy; disc herniation at L5-S1 compressing the thecal sac at the midline; and traumatic myofascial pain syndrome.

On a motion for summary judgment where the issue is whether a plaintiff has sustained a serious injury under the no-fault law, the defendant bears the initial burden of presenting competent evidence that there is no cause of action. *Browdame v Candura*, 25 AD3d 747, 748 (2nd Dept. 2006). That has been accomplished here.

With regard to the "90/180" claim, the defendant submits the plaintiff's bill of particulars and the transcript of plaintiff's deposition, during which she stated that she was

confined to her home for a week after the accident. ² She indicated that she was able to continue her home-based fabric representative business, to see clients and to perform her work during the relevant period, albeit to a lesser extent. Further, although she testified that her business was affected by the accident, she also stated that she earned approximately the same income in 2004, 2005 and 2006. Under these circumstances, the defendant has satisfied his initial burden of establishing that the plaintiff has not sustained a serious injury satisfying the 90/180 category, as she was not prevented from performing substantially all of her normal activities during this period.

With respect to the other two categories claimed, the defendant has submitted affirmed medical reports of two physicians who conducted independent medical examinations of the plaintiff on behalf of the defendant.

On March 20, 2007, Erik J. Entin performed an independent neurological examination of plaintiff. After described testing of neurological functioning and a review of stated medical records, and while noting complaints of neck and low-back pain, Dr. Entin stated his impression that the plaintiff had an entirely normal neurological examination, with no evidence of right cervical or right lumbar radiculopathy.

Dr. John C. Killian performed an independent orthopedic examination of plaintiff on

² The Court notes that the deposition transcript submitted was not signed by the plaintiff, but the plaintiff herself submits and relies on the transcript as well in opposing the motion. Given this factor and the date of the deposition in February of 2007, service of this motion on July 20, 2007 and service of opposition on September 19, 2007, it is apparent that the plaintiff, through counsel, had the transcript for more than 60 days, and thus it may be used as if signed. CPLR 3116(a).

March 23, 2007. Range of motion testing was performed, in addition to other named testing. Range of motion results were compared to normal values, and showed no restrictions. Straight leg raising was negative from sitting and supine positions. Based on his examination and review of the plaintiff's medical records, he stated his opinion, which in part is as follows:

...She had subjective complaints of pain with the cervical motions and lumbar motions which were contradicted by complaints of pain with rotating the trunk as a unit which causes no spinal stress and were unaccompanied by objective findings including restricted motion or muscle spasm.... There were no positive objective findings in this examination to confirm this claimant's subjective complaints. Based on this examination I would conclude that she has fully recovered from any problems with her neck or back for which she was treated after this accident. She has no residual impairment of her neck and back and she has no disability... from this accident.

As indicated above, the examining physicians found no more than subjective reports of pain, which are insufficient as proof of serious injury within the meaning of Insurance Law § 5102(d). *See Toure v Avis Rent A Car Sys.*, 98 NY2d 345,350 (2002); *Scheer v Doubek*, 70 NY2d 678, 679 (1987); *Tuna v Babendererde*, 32 AD2d 574, 575 (3d Dept. 2006). Accordingly, the defendant has made his initial showing that he is entitled to judgment as a matter of law, shifting the burden to the plaintiff to provide objective proof of a serious injury such that an issue of fact is presented requiring a trial. *Gaddy v Eyler*, 79 NY2d 955, 957 (1992).

In opposition, the plaintiff presents two affirmed reports from a treating physician, Dr. Ali E. Guy, Board certified in physical medicine and rehabilitation. The first report presented is dated May 17, 2006, some eighteen months after the accident, and is based on

review of records and on an examination conducted on that day. The second is dated August 15, 2007, after this motion was made.

In his May, 2006 report he states at the outset that he first examined the plaintiff on September 29, 2004 (five days after the accident), and refers the reader to a detailed report of that date. That report, however, has not been submitted to the Court on this motion. In the May report, he states that EMG studies conducted in November of 2004 revealed evidence of cervical radiculopathy. He also avers that he personally reviewed the MRI films, and agrees with radiology reports that there were posterior central disc herniations at C4-C5 and C5-C6 compressing the thecal sac in the midline, a posterior central disc bulge at C6-C7 with minimal compression of the thecal sac in the midline, and a focal posterior disc herniation at L5-S1 compressing the thecal sac in the midline.

He also describes medications he prescribed and treatment he rendered, which began with physical therapy and later included drugs for pain and inflammation, and trigger point injections, the latter of which occurred in December of 2005 and January of 2006. Physical examination of the neck revealed "moderate tenderness, moderate spasm, and multiple trigger points present. Range of motion is normal except for lateral flexion, which is 0 to 20 degrees (normal is 0 to 40 to 45 degrees)...[back] revealed diffuse moderate tenderness, moderate spasm, and multiple trigger points present. Range of motion is normal except for extension which is 0 to 15 degrees (normal is 0 to 30 degrees)." He also refers to "SLR" which may mean supine leg raising, but this is not explained, and he states that the result was 75 degrees with bilateral low back pain. Normal values are not stated. He concludes his

description of the examination with a statement that “active range of motion testing and manual muscle power testing is within normal for all four extremities.”

In the opinion section Dr. Guy states that based upon the history, his examination and the results of the EMG studies and MRIs, he concludes that the plaintiff sustained a permanent partial disability causally related to the accident, which he later gives in the language of the statute as a “permanent consequential limitation and loss of use of the cervical and lumbar spine”. He states that the plaintiff will require medical services for the rest of her life, including physical therapy, seeing a physiatrist at least 12 times a year, and a neurosurgeon at least once a year for management of the disc herniations. He also states that she will ultimately require surgery in the form of an anterior cervical discectomy and lumbar laminectomy.

In the August, 2007 he again examined the plaintiff. His report refers to the September, 2004 and May, 2006 reports, and to an intervening examination of the plaintiff on June 26, 2006, at which time she received trigger point injections and a refill of Vicodin. Paraspinal injections followed in July, 2006 on two dates, and trigger point injections resumed and were given on two occasions in October, 2006. He also states that the “patient gets physical therapy and massage from a facility close to her house.”

Examination of the neck revealed diffuse moderate tenderness, moderate spasm and multiple trigger points. Lateral flexion was 0 to 20 degrees (normal 0 to 45), lateral rotation 0 to 20 degrees bilaterally (normal 0 to 60). With regard to the back, Dr. Guy states that examination revealed diffuse moderate tenderness, moderate spasm and multiple trigger

points. Extension was 0 to 15 degrees (normal 0 to 30) and flexion was 0 to 60 degrees. The “SLR” statement was the same as indicated above in the May, 2006 report. Finally, he states Dr. Guy refers back to that May, 2006 for the diagnosis and opinion, stating that they remain the same.

The plaintiff herself does not submit an affidavit.

The foregoing is insufficient to defeat the motion. The absence of the September, 2004 report or any other proof of the plaintiff’s claimed injuries close in time to the accident means that there is no proof supporting the conclusion that the currently claimed restrictions were the same ones found initially, and are therefore causally related to the accident, as claimed by Dr. Guy. This has been held fatal to the plaintiff’s attempt to demonstrate the existence of issues of fact as to the serious injuries claimed. *Rodriguez v Cesar*, 40 AD3d 731 (2d Dept. 2007); *Bell v Rameau*, 29 AD3d 839 (2d Dept. 2006); *Li v Woo Sung Yun*, 27 AD3d 624 (2d Dept. 2006); *Suk Ching Yeung v Rojas*, 18 AD3d 863 (2d Dept. 2005). Even accepting the presence of the disc herniations and bulges described (as Dr. Guy stated that he personally reviewed the films himself), the same is insufficient, standing alone, to establish a serious injury within the purview of the statute. *See Albano v Onolfo*, 36 AD3d 728 (2d Dept. 2007); *Yakubov v CG Trans Corp.*, 30 AD3d 509, 510 (2d Dept. 2006).

There also is a gap in treatment from the time of the last trigger point injection in October, 2006 until the preparation of Dr. Guy’s August, 2007 report, which is unexplained by the plaintiff in an affidavit, constituting an additional reason for dismissal. *Pommells v Perez*, 4 NY3d 566, 574 (2005). Although Dr. Guy makes reference to physical therapy and

massage in that report, he provides no dates, medical records or even a description of such treatment, rendering this statement without probative value.

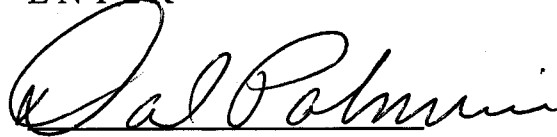
Finally, there is no medical proof rebutting the defendant's showing that she did not suffer an injury satisfying the "90/180" category under Insurance Law § 5102(d). *See, Duran v Sequino*, 17 AD3d 626 (2nd Dept. 2005); *Sainte-Aime v Ho*, 274 AD2d 569 (2nd Dept. 2000); *Albano v Onolfo, supra*.

Accordingly, the motion is granted.

This shall constitute the Decision and Order of this Court.

DATED: November 8, 2007

ENTER


HON. DANIEL PALMIERI
Acting Supreme Court Justice

**TO: Law Offices of Gary B. Pillersdorf, P.C.
Attorney for Plaintiff
225 Broadway, Suite 1000
New York, NY 10007**

**John P. Humphreys, Esq.
Attorney for Defendant Church
3 Huntington Quadrangle, Ste. 102S
P.O. Box 9028
Melville, NY 11747**

ENTERED
NOV 13 2007
NASSAU COUNTY
COUNTY CLERK'S OFFICE