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SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK
COUNTY OF NASSAU - PART 17

PRESENT: HON. WILLIAM R. LaMARCA
Justice.

LINDA HARRIS,

Plaintiff,

-against-

RAYMOND BOUDART and ELIZABETH BOUDART,

Defendants.

Motion Sequence #1
Submitted March 27, 2008
XXX

INDEX NO: 20147/06

The following papers were read on this motion:

Notice of Motion.....1
Plaintiffs Affirmation in Opposition.....2
Plaintiffs Memorandum of Law.....3
Reply Affirmation.....4

Relief Requested

The defendants, RAYMOND BOUDART and ELIZABETH BOUDART, move for an order, pursuant to CPLR §3212, dismissing the plaintiff's complaint on the ground that the plaintiff has not sustained a serious injury within the meaning of Insurance Law §5102(d). Plaintiff, LINDA HARRIS, opposes the motion which is determined as follows:

Background

This action arises from an automobile accident which occurred on June 14th, 2006. The plaintiff alleges that the vehicle that she was driving was struck by the vehicle operated

by defendant, ELIZABETH BOUDART, and owned by defendant, RAYMOND BOUDART. The plaintiff alleges that as a consequence of said accident, she has sustained serious injuries as defined in Article 51 of the New York State Insurance Law.

In addressing the issue of the existence of a serious injury, the court initially looks to the pleadings. The plaintiff, LINDA HARRIS, who at the time of the subject accident was sixty-three (63) years of age, alleges that she sustained the following injuries which were proximately caused by the subject accident: broad based disc herniation at L5-S1 with foraminal extension; spondylitic ridge bulging disc complexes and uncovertebral joint hypertrophy with narrowing of the right left lateral recesses at C4-C5, C5-C6 and C6-C7; broad elevation of the epidural fat and impingement upon the thecal sac; crowding of the exiting right and left L5 roots, greater on the right than on the left; and L5-S1 narrowing and loss of disc signal (see, *Verified Bill of Particulars* annexed to the moving papers as Exhibit "D").

In support of the instant application to dismiss, the defendants contend that the injuries the plaintiff claims to have sustained do not fall within any of the categories of serious injury as defined in §5102(d) of the Insurance Law. The defendants additionally argue that the medical submissions proffered by the plaintiff to defeat the instant application are insufficient because they fail to properly account for a prior neck injury which the plaintiff had admittedly sustained as a result of a previous automobile accident in 1988.

As evidentiary support for the within application, the defendants provide three (3) affirmed independent medical reports of Michael J. Katz, M.D., Naunihal Singh, M. D. and Melissa Cohn, M.D. Additionally, the defendants rely upon the unsworn report of Charles

Bagley, M.D., dated August 14, 2006, who, at the request of the plaintiff's treating physician, conducted various electrodiagnostic studies of the plaintiff's upper and lower extremities.

Dr. Katz, a board certified orthopedic surgeon, conducted an examination of the plaintiff on November 16, 2007. Said examination included an evaluation of the plaintiff's cervical and lumbosacral spines. With regard to the cervical spine, range of motion testing was conducted by way of visual observation which revealed normal findings. Dr. Katz noted an absence of tenderness or spasm and stated that the Adson's test was negative. As to the lumbosacral spine, range of motion testing again revealed normal findings. Dr. Katz noted an absence of muscle spasm and that straight leg raising testing was negative.

Dr. Katz also reviewed various medical reports including two (2) post-accident MRI studies taken of the plaintiff's lumbar and cervical spines, performed on July 17, 2006 and August 14, 2006 respectively. The MRI of the lumbar spine revealed disc herniation at L5-S1 and the MRI to the cervical spine revealed "Multilevel spondylitic ridge bulging disc complexes and uncovertebral joint hypertrophy with narrowing of the right left lateral recesses at C4-C5, C5-C6 and C6-C7."

Dr. Katz ultimately diagnosed the plaintiff as having sustained a cervical and lumbosacral strain, both of which had resolved. He specifically commented the plaintiff was not disabled and ". . . shows no signs or symptoms of permanence relative to the musculoskeletal system. . ." as a result of the accident on June 14, 2006. He further stated that the plaintiff was ". . .capable of her activities of daily living" and has achieved her "pre-injury status."

Dr. Singh, a board certified neurologist and neuroradiologist, conducted an independent neurological examination of the plaintiff on December 11, 2007. This examination included a review of the plaintiff's medical records including the MRI studies. Dr. Singh conducted an evaluation of the plaintiff's cervical, thoracic, and lumbar spines, as well as her shoulder joints. Range of motion testing was accomplished by use of a goniometer and revealed normal ranges of motion in both the cervical and lumbar spines. Dr. Singh noted there was an absence of tenderness in both the cervical and lumbar spines. With particular regard to the lumbar spine, Dr. Singh noted that straight leg raising was possible bilaterally to 90 degrees, which he states is a normal finding. The examination of both the thoracic spine and the shoulders revealed normal findings. Dr. Singh concluded that the plaintiff sustained cervical and lumbar spine strain superimposed on pre-existing osteoarthritis. He further stated that the plaintiff suffered no "permanent neurological impairment" as a result of the subject accident and that she was capable of returning to "pre-loss activity levels including occupational duties."

Dr. Cohn, a board certified radiologist and neuroradiologist, conducted an independent radiologic review of the heretofore referenced MRI studies conducted relative to the plaintiff's cervical and lumbar spines. Dr. Cohn found that, as to the cervical spine, the plaintiff suffered from multilevel degenerative disc disease and with respect to the lumbar spine the plaintiff had degenerative disc disease at L5-S1. Dr. Cohn found no evidence of trauma related injury on either of the MRI studies.

Dr. Bagley, a board certified neurologist, upon referral by plaintiff's treating physician, conducted electrophysiological studies of the plaintiff's lower and upper extremities two (2) months post-accident, on August 14, 2006. Dr. Bagley stated that the

motor and sensory conduction studies of both the upper and lower extremities were within normal limits. He further opined that the EMG studies of both upper and lower extremities were normal and there was no evidence as to neuropathy or radiculopathy. The court notes at this juncture that, while the report of Dr. Bagley is not properly sworn, the defendant's may nonetheless rely upon same in support of their motion for summary judgment (*Pagano v Kingsbury*, 182 AD2d 268, 587 NYS2d 692 [2d Dept 1992]).

It is well settled that a motion for summary judgment is a drastic remedy that should not be granted where there is any doubt as the existence of a triable issue of fact (*Sillman v Twentieth Century Fox*, 3 NY2d 395, 165 NYS2d 498, 144 NE2d 387 [C.A. 1957]; *Bhatti v Roche*, 140 AD2d 660, 528 NYS2d 1020 [2nd Dept 1998]). To obtain summary judgment, the moving party must establish its claim or defense by tendering sufficient evidentiary proof in admissible form sufficient to warrant the Court, as a matter of law, to direct judgment in the movant's favor. Such evidence may include deposition transcripts as well as other proof annexed to an attorney's affirmation (CPLR §3212 [b]; *Olan v Farrell Lines*, 64 NY2d 1092, 489 NYS2d 884, 479 NE2d 229 [C.A.1985]).

If a sufficient *prima facie* showing is demonstrated, the burden then shifts to the non-moving party to come forward with competent evidence to demonstrate the existence of a material issue of fact, the existence of which necessarily precludes the granting of summary judgment and necessitates a trial. It is incumbent upon the non-moving party to lay bare all of the facts which bear on the issues raised in the motion (*Mgrditchian v Donato*, 141 AD2d 513, 529 NYS2d 134 [2d Dept 1998]). Conclusory allegations are insufficient and to defeat the application and the opposing party must provide more than

a mere reiteration of those facts contained in the pleadings (*Doran v Mutual Benefit Life Insurance Co.*, 106 AD2d 540, 483 NYS2d 66 [2nd Dept. 1984]; *Bethlehem Steel Corp. v Solow*, 70 AD2d 850, 418 NYS2d 40 [1st Dept. 1979]). When considering a motion for summary judgment, the function of the court is not to resolve issues but rather to determine if any such material issues of fact exist (*Barr v County of Albany*, 50 NY2d 247, 428 NYS2d 665, 406 NE2d 481 [C.A. 1980]; *Daliendo v Johnson*, 147 AD2d 312, 543 NYS2d 987 [2nd Dept. 1989]).

Within the particular context of a threshold motion which seeks dismissal of a personal injury complaint, the movant bears a specific burden of establishing that the plaintiff did not sustain a "serious injury" as enumerated in Article 51 of the Insurance Law §5102(d) (*Gaddy v Eyler*, 79 NY2d 955, 582 NYS2d 990, 591 NE2d 1176 [C.A.1992]). Upon such a showing, it becomes incumbent upon the nonmoving party to come forth with sufficient evidence in admissible form to raise an issue of fact as to the existence of a "serious injury"(*Licari v Elliott*, 57 NY2d 230, 455 NYS2d 570, 441 NE2d 1088 [C.A.1982]).

Within the scope of the defendant's burden, a defendant's medical expert must specify the objective tests upon which the stated medical opinions are based and when rendering an opinion with respect to the plaintiff's range of motion, must compare any findings to those ranges of motion considered normal for the particular body part (*Qu v Doshna*, 12 AD3d 578, 785 NYS2d 112 [2d Dept 2004]; *Browdame v Candura*, 25 AD3d 747, 807 NYS2d 658 [2d Dept 2006]; *Mondi v Keahan*, 32 AD3d 506, 820 NYS2d 625 [2d Dept 2006]).

Applying the aforesaid criteria particularly to the reports of Dr. Katz and Dr. Singh, the Court finds that the defendants have established a *prima facie* case that the plaintiff failed to sustain a serious injury (*Gaddy v Eyler, supra; see also, Kearse v New York City Transit Authority,* 16 AD3d 45, 789 NYS2d 281 [2d Dept 2005]). As set forth above, both Dr. Katz and Dr. Singh found the plaintiff to have normal and complete ranges of motion with regard to the both the cervical and lumbo-sacral spines notwithstanding the MRI reports which indicated disc bugles and herniations (*Diaz v Turner*, 306 AD2d 241, 761 NYS2d 193 [2nd Dept. 2003]; *see also, Meely v 4 G's Truck Renting Co.,* 16 AD3d 26, 789 NYS2d 277 [2d Dept 2005]). Moreover, both Dr. Katz and Dr. Singh stated the specific tests upon which their respective medical conclusions were based and compared the plaintiffs ranges of motion to those ranges of motion considered normal. (*Qu v Doshna*, *supra; Browdame v Candura*, *supra*). Thus, the burden now shifts to the plaintiffs to demonstrate a triable issue of fact with respect to the existence of a "serious injury" (*Licari v Elliott*, *supra*).

In opposition to the defendants' motion, counsel for the plaintiff submits a sworn affidavit of James W. Rogers, D.C., and the affirmations of Philip Rafiy, M. D. and Dennis Rossi, M. D.

As articulated in the verified bill of particulars, the plaintiff is claiming that the injuries she sustained fall within the following statutorily enumerated categories of injury as are articulated in §5102(d) of the Insurance Law: a permanent consequential limitation of use of a body organ or member; a significant limitation of use of a body function or system; and a medically determined injury or impairment 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 establish either a permanent consequential limitation of use of a body organ or member or a significant limitation of use of a body function or system the Court of Appeals has stated that "[w]hether a limitation of use or function is 'significant' or 'consequential' relates to medical significance and involves a comparative determination of the degree or qualitative nature of an injury based on the normal function, purpose and use of the body part" (*Toure v Avis Rent A Car Systems, Inc.*, 98 NY2d 345, 746 NYS2d 865, 774 NE2d 1197 [C.A.2002] quoting *Dufel v Green*, 84 NY2d 795, 622 NYS2d 900, 647 NE2d 105 [C.A. 1995]).

Dr. Rogers, a chiropractor, examined the plaintiff on June 16, 2006, immediately after the subject accident and treated the plaintiff during the six (6) weeks subsequent thereto. During the initial visit, he conducted a complete orthopedic and neurologic examination which included range of motion testing, as well as an array of orthopedic tests including, Soto Hall, Cervical foraminal compression test, straight leg raising and Goldthwaite's test, all of which produced positive findings. Based upon this examination, Dr. Rogers states that there was a 54% decrease in the range of motion in cervical spine and 50% decrease in the range of motion in the lumbar spine. Dr. Rogers concluded that these range of motion deficits were "chiropractically significant" and were "sufficient to prevent, or interfere with, the activities of daily living." Dr. Roger's diagnosis, after the initial evaluation, was as follows : Lumbar IVD; Lumbar Radiculitis; Multiple Lumbar subluxation

complexes; Cervical sprain/strain; Cervical Radiculitis; and Multiple Cervical subluxation.

As set forth above, after the initial examination, the plaintiff underwent chiropractic care with Dr. Rogers for a period of six (6) weeks following this initial evaluation. There is no indication in the record that the plaintiff was seen by Dr. Rogers again until February 1, 2008. On said date, Dr. Rogers reexamined the plaintiff, at which time he again conducted both range of motion testing and a panoply of orthopedic tests. Predicated upon this most recent examination, Dr. Rogers concluded that the plaintiff had sustained a 47% decrease in the range of motion in the cervical spine and a 36% decrease in the range of motion in the lumbar spine. Dr. Rogers ultimately concluded that the plaintiff had sustained cervical and lumbar IVD disorder, cervical and lumbar radiculopathy, multiple cervical and lumbar and lumbar subluxations and left knee derangement. He opined that these injuries left Ms. Harris partially disable as a result of the automobile accident of June 14, 2006.

Dr. Rafiy examined the plaintiff on July 31, 2006, May 3, 2007 and June 7, 2007. On the initial visit, Dr. Rafiy conducted a physical examination which included straight leg raising which yielded positive results. Dr. Rafiy also noted lumbar tenderness. Based upon his examination and upon a review of the plaintiff's MRI of the lumbar spine, Dr. Rafiy concluded that the plaintiff suffered from lumbar disc herniation. Dr. Rafiy did not, however, offer an opinion as to the impact said injury had on the plaintiff's ability to engage in her daily and customary activities.

On the first of two follow up visits, Dr. Rafiy again conducted straight leg raising testing which again was positive, at which time Dr. Rafiy diagnosed the plaintiff as having sustained lumbar disc herniations. On the plaintiff's final visit, on June 7, 2007, Dr. Rafiy

performed a nerve conduction study of the lower extremities and thereafter diagnosed the plaintiff as having left peroneal nerve neuritis. He concluded that, based upon the plaintiff's history which included a prior neck injury, taken together with the results of both the straight leg raising testing and the nerve conduction study, the injuries sustained were the "natural sequelae" of the subject accident and causally related thereto.

The affirmation of Dr. Rossi, plaintiff's radiologist, dated February 8, 2008 merely reiterates those findings as they were set forth in the reports he originally issued in connection with the MRI studies the plaintiff had undergone. He stated that the MRI of the cervical spine revealed "[m]ultilevel spondylitic ridge bulging disk complexes and uncovertebral joint hypertrophy with narrowing of the right left lateral recesses at C4-C5, C5-C6 and C6-C7. Slight anterolisthesis C3 on C4." Dr. Rossi stated that the MRI on the lumbar spine revealed "[b]road based disc herniation at L5-S1 with bilateral foraminal extension".

The Law

While a herniated or bulging disc or the presence of a radiculopathy may constitute a serious injury within the ambit of Insurance Law §5102(d), a plaintiff is required to provide, *inter alia*, objective medical evidence contemporaneous with the subject accident, which demonstrates the extent and degree of the alleged physical limitation resulting from the disc injury and its duration (*Ifrach v Neiman,* 306 AD2d 380, 760 NYS2d 866 [2nd Dept 2003]; *Jason v Danar,* 1 AD3d 398, 767 NYS2d 779 [2nd Dept 2003]; *Felix v New York City Tr. Auth.*, 32 AD3d 529, 819 NYS2d 835 [2nd Dept 2006];*Garcia v Sobles*, 41 AD3d 426 , 838 NYS2d 146[2nd Dept 2007]; *Bestman v Seymour*, 41 AD3d 629, 838 NYS2d

645 [2nd Dept 2007]; *Marrache v Akron Taxi Corp.*, __ AD3d __, 856 NYS2d 239 [2d Dept 2008]).

When examining medical evidence offered by a plaintiff on a threshold motion, the court must insure that the evidence is objective in nature and that a plaintiff's subjective claims as to pain or limitation of motion are supported by verified objective medical findings (*Grossman v Wright*, 268 AD2d 79, 707 NYS2d 233 [2nd Dept.2000]). Further, in addition to providing medical proof contemporaneous with the subject accident, the plaintiff must also provide competent medical evidence containing verified objective findings based upon a recent examination wherein the expert must provide an opinion as to the significance of the injury (*Kauderer v Penta*, 261 AD2d 365, 689 NYS2d 190 [2nd Dept 1999]; *Constantinou v Surinder*, 8 AD3d 323, 777 NYS2d 708 [2nd Dept 2004]; *Brown v Tairi Hacking Corp.*, 23 AD3d 325, 804 NYS2d 756 [2nd Dept 2005]).

Applying the foregoing principles to the medical evidence submitted by the plaintiff, the Court finds that the plaintiff has failed to raise a triable issue of fact. Initially, with respect to Dr. Rogers, the Court notes that he personally conducted the physical examination of the plaintiff and accordingly it can be properly deemed objective medical evidence (*Grossman v Wright*, *supra*). Moreover, certain of the medical conclusions reached by Dr. Rogers were properly predicated upon a recent examination (*Kauderer v Penta*, *supra*; *Brown v Tairi Hacking Corp.*, *supra*). However, what deprives the report of its probative value, is that the report does not take into account the prior accident, in which the plaintiff was admittedly involved and in which she sustained injury to her neck (*Vidor v Davila,* 37 AD3d 826, 830 NYS2d 772 [2nd Dept 2007]; *see also Wright v Rodriguez*, 49

AD3d 532, 855 NYS2d 147[2nd Dept. 2008]). In fact, the report of Dr. Rogers is devoid of any mention that he was even aware of this prior automobile accident in which the plaintiff complained of injuries to her neck. Absent an acknowledgment with respect to the plaintiff's prior accident and the effect of same upon her physical condition, if any, Dr. Rogers report and the conclusions contained therein are speculative and not probative as to the proximate causality as between the subject accident of June 14, 2006 and the injuries claimed by the plaintiff (*Freese v Maffetone*, 302 AD2d 490, 756 NYS2d 70 [2nd Dept. 2003]; *Kallicaharan v Sooknanan*, 282 AD2d 573, 723 NYS2d 376 [2nd Dept 2001].

Other than the report of Dr. Rogers, the only other medical evidence contemporaneous with the subject accident is the examination conducted by Dr. Rafiy on July 31, 2006. While such an exam could be considered temporally relevant, the substance of the report renders it insufficient to raise a triable issue of fact. On the initial examination, Dr. Rafiy's only comment was that the plaintiff had sustained herniations in the lumbar spine. However, nowhere with respect to this initial evaluation does Dr. Rafiy opine as to any observed initial range of motion restrictions as a consequence thereof (*Ifrach v Neiman, supra*; *Jason v Danar, supra*; *Felix v New York City Tr. Auth., supra*; *Garcia v Sobles, supra*; *Bestman v Seymour, supra; Marrache v Akron Taxi Corp., supra*). Morever, while Dr. Rafiy does mention in his report that the plaintiff suffered a prior neck injury, he does little more than afford it a glancing reference and ultimately states that any symptoms relative thereto have resolved. However, the only basis upon which Dr. Raify supports his conclusion appears to be the medical history as provided to him by the plaintiff. There is no indication in his affirmation that he reviewed any medical records

relative to that prior accident and thus has failed to sufficiently account for the prior neck injury and how, if at all, said injury impacted the plaintiff's physical condition (*Vidor v Davila, supra*).

Even assuming *arguendo* that the reports of Dr. Rogers and Dr. Rafiy were free from infirmity, neither of these health care professionals explain the gap in treatment which presents itself in the case at bar. While the court is cognizant that a gap in treatment, in and of itself, is not determinative of a particular case, an injured plaintiff who is claiming to have suffered a serious injury bears the burden of providing to the motion court a reasonable explanation for having stopped therapeutic treatments (*Pommells v Perez*, 4 NY3d 566, 797 NYS2d 380, 830 NE2d 278 [C.A. 2005]). Here, as stated in Dr. Rogers affidavit, after the plaintiff's initial visit on June 16, 2006, she underwent chiropractic care for the six (6) weeks immediately thereafter. Subsequent thereto, the plaintiff did not again see Dr. Rogers until approximately 18 months later on February 8, 2008[1]. With regard to Dr. Rafiy's affirmation, upon a close reading thereof, the totality of the plaintiff's three visits, the last of which was in June of 2007, appear to have been for diagnostic as opposed to therapeutic purposes. Additionally, Dr. Rafiy does not comment at all about why the plaintiff ceased presenting to his office.

As a final matter, neither of the plaintiff's three (3) medical experts refuted or even addressed the findings of the defendants examining radiologist, Dr. Cohn, who stated that

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[1] In her deposition, taken on August 30, 2007, the plaintiff testified that at that time she still was still treating with Dr. Rogers every few weeks. However, this assertion is not corroborated by the affidavit of Dr. Rogers who indicates only that the plaintiff underwent chiropractic treatment for the six weeks following her initial evaluation on June 16, 2006.

the plaintiff suffered from degenerative disc disease in both the cervical and lumbar spines (*Larkin v Goldstar*, 46 AD3d 631, 848 NYS2d 254 [2nd Dept. 2007]).

In the case at bar, given the plaintiff's failure to offer competent evidence that was contemporaneous with the subject accident, the absence of an explanation for the gap in treatment, together with the plaintiff's medical experts failure to address the findings of Dr. Cohn, the plaintiff has failed to demonstrate that she has sustained a permanent consequential limitation of use of a body organ or member or a significant limitation of use of a body function or system (*Bestman v Seymour*, *supra*; *Marrache v Akron Taxi Corp.*, *supra*; *Pommells v Perez*, *supra; Larkin v Goldstar*, *supra*). Additionally, the plaintiff has failed to provide competent evidence that she suffered a medically determined injury, the existence of which prevented her from performing substantially all of her customary activities for 90 out of the first 180 days immediately following the subject accident (*Sainte-Aime v Ho*, 274 AD2d 569, 712 NYS2d 133 [2nd Dept. 2000]). The affidavit from Dr. Rogers is the only medical report to offer an opinion as to the claimed impact the plaintiff's injuries had upon her ability to engage her in day to day activities. However, for reasons stated herein above, the report is speculative and not probative on that issue. Moreover, the record reveals that the plaintiff herself testified at her deposition that she lost only one day from work as a result of the automobile accident (*see generally, Hernandez v Cerda*, 271 AD2d 569, 707 NYS2d 332 [2nd Dept. 2000]).

Based upon the foregoing, it is hereby

ORDERED, that defendants' motion, made pursuant to CPLR §3212, which seeks summary judgment dismissing the complaint is granted and the action is dismissed.

All further requested relief not specifically granted is denied.

This constitutes the decision and order of the Court.

Dated: June 18, 2008

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