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SUPREME COURT OF THE STATE OF NEW YORK — NEW YORK COUNTY

PRESENT: Hon Deborah Kaplan Justice

PART 20

Index Number : 103605/2003

GARCIA, JUANA

VS.

ARC XVI OF FORT WASHINGTON

SEQUENCE NUMBER : # 004

DISMISS COMPLAINT

INDEX NO. 103605-03

MOTION DATE

MOTION SEQ. NO. #004

MOTION CAL. NO.

read on this motion to/for

	PAPERS NUMBERED
Notice of Motion/ Order to Show Cause — Affidavits — Exhibits ...	1
Answering Affidavits — Exhibits	2
Replying Affidavits	3
Notice of Cross-motion - Affidavits	4

Cross-Motion: ☐ Yes ☐ No

Upon the foregoing papers, it is ordered that this motion and cross-motion are denied in accordance with the attached Opinion.

This constitutes the Decision and Order of the Court.

FILED
JUL 18 2008
COUNTY CLERK'S OFFICE
NEW YORK

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE FOR THE FOLLOWING REASON(S):

Dated: July 14, 2008

Deborah K

J.S.C.

DEBORAH A. KAPLAN

Check one: ☐ FINAL DISPOSITION ☑ NON-FINAL DISPOSITION

Check if appropriate: ☐ DO NOT POST ☐ REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 22

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JUANA GARCIA,

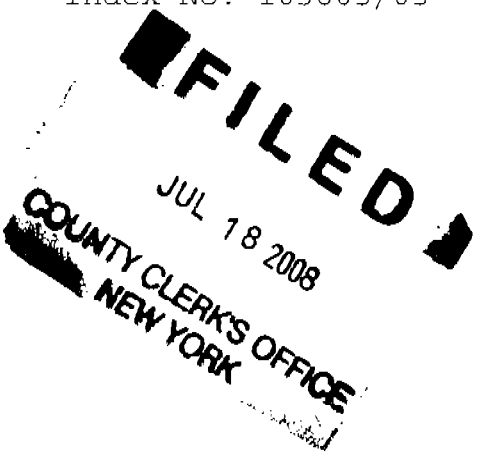
Plaintiff,

Index No. 103605/03

-against-

ARC XVI OF FORT WASHINGTON,
NELSON PEREZ and ANDREA SANTILLANA,

Defendants.



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DEBORAH A. KAPLAN, J.:

Defendants ARC XVI of Fort Washington (ARC) and Nelson Perez (Perez) move, pursuant to CPLR 3212, for an order dismissing the complaint on the ground that plaintiff failed to meet the "serious injury" threshold requirement of section 5102 (d) of the Insurance Law.

Defendant Andrea Santillana (Santillana) cross-moves, pursuant to CPLR 3212, for an order dismissing the complaint, and adopts the arguments and proof submitted by the co-defendants.

This is an action to recover for personal injuries allegedly sustained by plaintiff Juana Garcia as a result of a motor vehicle accident that occurred on July 2, 2001. At the time, plaintiff was a front-seat passenger in a vehicle operated by Santillana. The vehicle was stopped in front of 3827 Broadway, New York, New York, when it was struck by a vehicle owned by defendant ARC, and operated by defendant Perez.

Plaintiff was 52 years of age at the time of the accident, and employed as a hair stylist in a beauty salon. She contends that, as a result of the impact of the accident, her head and chest struck the dashboard, and she felt pain in her back, arm, head, chest, left shoulder, and neck.[1] Immediately after the accident, plaintiff took a taxi home and was taken to the emergency room at Columbia Presbyterian Hospital, where she was examined and released.[2]

The following day, plaintiff went to Ridgewood Medical & Diagnostic, P.C. (Ridgewood Medical) complaining of headaches, and pain in her left shoulder, neck and lower back. She was examined by Dr. Eddy Rodriguez, a physiatrist, who examined plaintiff; performed range of motion tests; and recommended that plaintiff consult with Dr. Deepika Bajai, a neurologist, and Dr. J. Mena, a chiropractor. On 8/30/01, and 10/18/01, plaintiff underwent MRI scans of her lumbosacral spine and cervical spine, respectively.[3] Plaintiff also underwent nerve studies,

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Plaintiff avers that, although she suffered a slip and fall two years prior to the subject accident, she did not injure the same parts of her body.

The papers are unclear as to whether plaintiff went to the emergency room on July 2, 2001, the day of the accident, or July 3, 2001. Neither party attaches a copy of the emergency room report.

The parties also submit an MRI report of the left shoulder of a patient named "Garcia, Juana," dated 6/16/01. However, Dr. Rodriquez affirms that this MRI report does not refer to the plaintiff herein, but refers to another patient with the same

approximately two years of physical therapy, and chiropractic treatments.

In her sworn affidavit, plaintiff avers that she stopped therapy and treatment because she did not have any health insurance and could not afford the transportation costs involved in going to the doctor's office. She states that, prior to the accident, she worked seven days a week, but that as a result of the injuries she sustained in the subject accident, on the advice of Dr. Rodriguez, she missed approximately five to six months of work, and then could work only part-time.

On January 3, 2006, plaintiff was examined by Dr. Jerry A. Lubiner, an orthopedist. On January 27, 2006, based on Dr. Lubiner's recommendation, plaintiff had arthroscopic surgery to her left shoulder at Cabrini Medical Center. Plaintiff claims that, despite the treatment and surgery, she still experiences pain in the left shoulder, head, neck, back, and knees, and that the pain and dizziness she still suffers interferes with her life on a daily basis. She cites as example that she cannot use her left arm to comb or style hair or cook. She also claims that she has difficulty sleeping and performing house cleaning.

In her verified bill of particulars and supplemental bill of particulars, plaintiff alleges that she sustained, inter alia,

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name who was previously treated by Dr. Rodriguez (Supplemental Affirmation in Opposition to Defendants' motions for Summary Judgment, Affirmation of Dr. Rodriguez, dated January 18, 2008).

cervical thoracic and lumbar sprain/strain; supraspinatus tendon partial tear of left shoulder; central herniation at L4-L5 and L5-S1 discs with compression of thecal sac; posterior herniation at the C5-C6 and C6-C7; posterior knee derangement; and radiculopathy in the cervical, thoracic and lumbosacral spine. She claims to have suffered non-permanent and permanent injuries.

THRESHOLD

Defendants seek to dismiss the complaint on the ground that plaintiff fails to satisfy the threshold requirement of suffering a "serious injury" under Insurance Law § 5102 (d). Pursuant to the Comprehensive Motor Vehicle Insurance Reparation Act of 1974 (now Insurance Law § 5101, et seq. - the "No-Fault" statute), a party seeking damages for pain and suffering arising out of a motor vehicle accident must establish that he or she has suffered a "serious injury" as contemplated by Insurance Law § 5102 (d).

In an automobile case, serious injury is a threshold issue, and thus, a necessary element of plaintiff's prima facie case (Licari v Elliott, 57 NY2d 230 [1982]; Toure v Harrison, 6 AD3d 270 [1st Dept 2004]; Insurance Law § 5104 [a]). This is in accord with the original intent of the "No-Fault" law, which was to "weed out frivolous claims and limit recovery to significant injuries" (Dufel v Green, 84 NY2d 795, 798 [1995]; see also Licari v Elliott, 57 NY2d at 235-37; Rubensccastro v Alfaro, 29 AD3d 436 [1st Dept 2006]).

In order to satisfy the statutory "serious injury" threshold, the plaintiff must submit objective proof of his or her injuries (Lopez v Senatore, 65 NY2d 1017, 1019 [1985]); subjective complaints of pain alone are insufficient to establish a prima facie case of a "serious injury" (Gaddy v Eyler, 79 NY2d 955, 957 [1992]; Scheer v Koubek, 70 NY2d 678, 679 [1987]). However, a CT scan or positive MRI may constitute objective evidence to support subjective complaints (see Arjona v Calcano, 7 AD3d 279 [1st Dept 2004]). Plaintiff must come forward with competent objective medical evidence based on the performance of objective tests in order to establish a prima facie case of "serious injury" (Grossman v Wright, 268 AD2d 79 [2d Dept 2000]).

The issue of whether the injuries allegedly sustained by plaintiff falls within the definition of a serious injury in the first instance, must be decided by the court (see Licari v Elliott, 57 NY2d 230, supra). On a motion for summary judgment based upon a failure to sustain a serious injury, the defendants bear the initial burden of establishing the absence of a serious injury by tendering evidentiary proof in admissible form eliminating any material issues of fact from the case (Toure v Avis Rent A Car Sys., 98 NY2d 345 [2002]; see also Gaddy v Eyler, 79 NY2d 955, supra; Pirrelli v Long Is. R.R., 226 AD2d 166 [1st Dept 1996]).

In support of defendants' claim that plaintiff failed to sustain a serious injury, defendants may rely either on the sworn statements of the defendants' examining physician, or plaintiff's deposition testimony and the unsworn reports of the plaintiff's examining physician (Fragale v Geiger, 288 AD2d 431 [2d Dept 2001]; Pagano v Kingsbury, 182 AD2d 268 [2d Dept 1992]). An affirmed physician's report demonstrating that plaintiff was not suffering from any disability or consequential injury resulting from the accident is sufficient to satisfy a defendant's burden of proof (see Gaddy v Eyler, 79 NY2d 955, supra).

Once defendant has made such a showing, the burden shifts to the plaintiff to come forward with prima facie evidence, in admissible form, to rebut the presumption that there is no issue of fact as to the threshold question (see Pommells v Perez, 4 NY3d 566 [2005]; Gaddy v Eyler, 79 NY2d 955, supra; Perez v Rodriguez, 25 AD3d 506 [1st Dept 2006]). A medical affirmation or affidavit based on a physician's personal examination and observations of plaintiff containing medical findings, based on the physician's own examination, tests and observations and review of the record, can support the existence and extent of a plaintiff's serious injury (O'Sullivan v Atrium Bus Co., 246 AD2d 418 [1st Dept 1998]).

The findings must demonstrate that plaintiff sustained at least one of the categories of "serious injury" as enumerated in

Insurance Law section 5102 (d) (Marquez v New York City Tr. Auth., 259 AD2d 261 [1st Dept 1999]; DiLeo v Blumberg, 250 Ad2d 364 [1st Dept 1998]).

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.

THE INSTANT MOTIONS

In support of their claim that plaintiff did not sustain a serious injury, defendants rely upon, inter alia, the affirmed medical reports of Dr. William J. Kulak, an orthopedic surgeon, and Dr. Jerome M. Block, a neurologist. On July 24, 2006, at defendants' request, plaintiff was examined by Dr. Kulak for an orthopedic evaluation. In his affirmed medical report, Dr. Kulak recites plaintiff's history and complaints, and details plaintiff's medical records. He notes that his review of the plaintiff's emergency room record, dated July 3, 2001, indicates that plaintiff complained only of nausea and vomiting; that the neurovascular examination of all four extremities was normal with

"no evidence of trauma"; that plaintiff's only complaint was that she had "nerves"; that she made no complaints of pain to the spine, shoulder, or pelvic girdle area; and that "[i]n the section for check-off in regard to the degree of pain, it is clearly written 'no pain'".

He further notes that the emergency room record indicates that the examination of the cervical spine was negative with no pain on range of motion, and "nontender" on palpation, and that the lower back, pelvis, and hip areas were also normal. There was no indication that x-rays were taken in the emergency room. Dr. Kulak opines that, based upon the emergency room record, plaintiff "sustained extremely minimal injuries, if any, in this occurrence."

Upon examining plaintiff, Dr. Kulak found that "[t]he cervical spine had a full range of motion in all planes at or beyond normal levels," i.e., flexion to 50-55 degrees, and extension to 55-60 degrees, left and right tilt to at least 40 degrees, and left and right rotation to 85-90, also normal (normal: 80 degrees). Dr. Kulak noted no spasm, trigger points or fullness on palpation.

Upon examination of the left shoulder, Dr. Kulak found no gross swelling or deformity, stability present on testing, and scars well healed. He examined the asymptomatic right shoulder, and used this for comparison as the normal for plaintiff. An

examination of the right shoulder revealed "[f]lexion was to 150 degrees without symptoms, internal rotation with flexion to 140 degrees without symptoms, abduction 145 degrees without asymmetry and combined internal rotation with extension without symptoms to only D12-L1." With regard to the left shoulder, Dr. Kulak found flexion negative at 155 to 160 degrees, abduction negative at 170 degrees and combined internal rotation with flexion negative at 160-165 degrees." He also noted that the Hawkins, supraspinatus and drop-arm tests were negative. Finally, the neurovascular examination of the upper extremities was within normal limits for motor and sensation.

Dr. Kulak concluded that there was evidence of pre-existing pathology, possible trauma to the left shoulder and left shoulder girdle area, and medical evidence of prior injury and prior treatment to the area. He opined that the minimal positive physical findings following the accident in the medical records were consistent with plaintiff's age, age-related osteoarthritis, and prior slip and fall accident. He further opined that the surgical procedure performed on plaintiff almost five years after the subject accident was completely unrelated to the accident. He did not find any indications of nerve, or disc injury caused by the subject accident, and found the MRI reports to be inconsistent with the subject injury and the medical records and findings.

On April 10, 2007, plaintiff was examined by Dr. Block, an independent neurologist, who concluded that there was "no indication of neurologic disability consequent to this accident." In his affirmed medical report of the same date, Dr. Block details plaintiff's history, and states that he reviewed plaintiff's verified bill of particulars, supplemental bill of particulars, and various medical reports. However, in reporting on his physical examination of plaintiff, he failed to set forth quantitative range of motion assessments and percentages for plaintiff's cervical and lumbar spines, and failed to provide an objective, numerical standard, i.e. "normal" range of motion, to which he compared plaintiff's cervical and lumbar ranges of motion. Further, although he makes a conclusory statement that "objective neurological testing revealed normal mental status, cranial nerves, reflexes, motor and sensory examinations," he fails to identify what objective tests he used. Accordingly, his medical report does not satisfy defendant's initial burden (Toure v Avis, 98 NY2d at 352).

However, contrary to plaintiff's contention, defendants' submission of Dr. Kulak's medical report is sufficient to make a prima facie showing that she did not suffer a serious injury as a matter of law, thus shifting the burden to her to raise a triable issue of fact (see e.g. Gaddy v Eyler, 79 NY2d at 956-957).

Plaintiff's opposition to defendants' motion includes, inter alia, Dr. Ginde's unsworn MRI reports of plaintiff's cervical and lumbar spines, and left shoulder[4]; Dr. Rodriguez's affirmation, reports, and records regarding plaintiff's medical treatment at Ridgewood Medical; Dr. Lubiner's affirmed report and operative record; and two of Dr. Aric Hausknecht's affirmed reports, along with a NCV/EMG report, dated January 10, 2006, which revealed bilateral L5-S1 radiculopathy.

The MRI report of the lumbosacral spine, dated 8/30/01, by Dr. Ravindra A. Ginde, shows that plaintiff sustained central herniation of discs at levels L4-L5 and L5-S1 with compression of thecal sac. The MRI report of the cervical spine, dated 10/18/01, by Dr. Ginde, shows that plaintiff sustained posterior herniation of discs at levels C5-C6 and C6-C7.

Although a diagnosis of disc herniations my constitute a serious injury within the meaning of the Insurance Law, the plaintiff is required to provide objective evidence of "the extent or degree of physical limitation" by means of "an expert's designation of a numeric percentage of a plaintiff's loss of range of motion .... [or] [a]n expert's qualitative assessment of a plaintiff's condition ...provided that the evaluation has an

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[4] These unsworn MRI reports are considered competent evidence since both sides are relying on these reports (Brown v Achy, 9 AD3d 30, 32 [1st Dept 2004]; Gonzalez v Vasquez, 301 AD2d 438 [1st Dept 2003]).

objective basis and compares the plaintiff's limitations to the normal function, purpose and use of the affected body organ ..." (Toure v Avis Rent A Car Sys., 98 NY2d at 350).

Plaintiff attaches the affirmation of Dr. Rodriguez, dated August 16, 2007, wherein he indicates that, on or about July 3, 2001, he examined plaintiff in connection with injuries that she sustained as a result of the subject accident. Thereafter, he supervised her physical therapy and treatment at Ridgewood Medical. He attaches copies of reports and records regarding plaintiff's treatment, and affirms their accuracy. He also affirms that plaintiff was disabled and unable to return to work from the first time he saw her on July 3, 2001 until December 17, 2001, as a result of the injuries she sustained in the subject accident.

On September 9, 2001, and September 22, 2001, Dr. Rodriguez performed nerve conduction studies of the upper and lower extremities, respectively. The impression of the upper extremities showed left median motor and sensory neuropathy, and that electrical studies of the lower extremities showed bilateral sensory motor neuropathy, and right S1 radiculopathy.

Attached to the records regarding plaintiff's treatment at Ridgewood Medical is a medical report, dated December 15, 2002,

by Dr. Mena, a chiropractor.[5] Dr. Mena noted that he first examined plaintiff on July 7, 2001, and reviewed her history and chief complaints of mid-back and lower-back pain and stiffness, shoulder pain/ weakness, neck and right hip pain, and headaches. He also noted that plaintiff had a slip/fall accident two years prior to the subject accident. He found existent limitations of the cervical spine and lumbrosacral spine after conducting range of motion tests[6]. He concluded that, based upon plaintiff's history, the physical and neurological findings, and the absence of symptoms prior to the accident, there was a causal relationship between the subject accident and plaintiff's injuries.

Plaintiff also submits the medical report of Dr. Hausknecht, dated January 11, 2006, in which he opines that, based on the objective tests performed during his examination of plaintiff on January 10, 2006, plaintiff suffers from limitations of her range of motion of both cervical spine and lumbar spine. He notes that the ranges of motion were objectively measured using an arthrodial protractor and goniometer with the cervical results as follows: L lateral flexion: 30 degrees (normal: 50 degrees), and

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In their motion, defendants rely on Dr. Mena's report, therefore, plaintiff may rely on said unsworn report (see Brown v Achy, supra).

Dr. Mena specifies the ranges of motion and compares them to the normal ranges of motion in his report.

R lateral flexion: 30 degrees (normal: 50 degrees). The remainder of the ranges of motion tested normal. The lumbosacral range of motion for forward flexion tested: 60 degrees (normal: 90 degrees), with the remainder ranges of motion testing normal.[7] He found cervical paravertebral tenderness and associated muscular spasm, and lumbosacral paravertebral tenderness and associated muscular spasm. The Spurling maneuver was positive bilaterally, and seated straight-leg testing was positive bilaterally at 45 degrees.

Dr. Hausknecht noted that plaintiff is still experiencing pain in her neck, back and left shoulder; that she has difficulty sitting, standing, bending, lifting and walking; and that she has been unable to return to her job in the beauty salon. After his examination of plaintiff, he concluded that plaintiff was disabled, and advised her to restrict her activities. He opined that "she may be an appropriate candidate for epidural steroid injection or surgical intervention."

Dr. Hausknecht performed a subsequent neurological physical examination on plaintiff on November 2, 2006. In his affirmation, he details plaintiff's medical history, and notes that plaintiff still complains of persistent neck and back pain, and that she has difficulty sitting, bending, lifting, and

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[7] It is noted that the normal ROM was based on the NYS Division of Disability Determination's and the American Medical Association's published guidelines.

walking. He notes that the Spurling maneuver tested positive on the left, and that the seated straight-leg raise tested positively bilaterally at 60 degrees.

The ranges of motion of the cervical spine and lumbrosacral spine were measured using an arthrodial protractor and goniometer. The cervical spine range of motion revealed: L lateral flexion: 35 degrees (normal: 50 degrees), and R lateral flexion: 30 degrees (normal: 50 degrees). The remainder ranges of motion tested normal. The lubrosacral range of motion tested Forward flexion: 60 degrees (normal: 90 degrees). The remainder ranges of motion tested normal. Based upon the findings of the physical examination, including the objective evidence of the range of motion tests, positive Spurling maneuver and positive straight-leg raise testing, the MRIs of the cervical and lumber region, and the NCV/EMG study, Dr. Hausknecht concluded that plaintiff's injuries have caused important limitations to her daily activities, and caused her to be permanently disabled.

Finally, plaintiff submits the medical report of Dr. Lubliner, dated December 12, 2006. Dr. Lubliner detailed plaintiff's history and medical records. He also detailed the results of the physical examinations he performed on January 3, 2006 and January 12, 2006. Based upon his review of plaintiff's history and medical records, and his examinations of plaintiff, Dr. Lubliner concluded that plaintiff suffers, and will continue

to suffer permanent disabilities, which interfere with her daily living, such as limiting her ability to work and to stand. He opined that there was a causal relationship between plaintiff's injuries and the subject accident, and recommended that she have surgery to her left shoulder. On January 27, 2006, plaintiff underwent surgery to her left shoulder at Cabrini Medical Center.

Evidence of range of motion limitations and positive straight-leg raising tests are sufficient to defeat summary judgment (see Toure v Avis Rent A Car Sys., 98 NY2d 345, supra), especially where, as here, they are coupled with positive MRI and nerve conduction test results (Brown v Achy, 9 AD3d 30, supra). The objective medical evidence submitted by plaintiff's experts include their assignment of quantitative measurements to plaintiff's loss of range of motion, and their averments that their opinions were based on MRIs (Toure v Avis Rent A Car, 98 NY2d 345, supra; Gonzalez v Vasquez, 301 AD2d 438, supra; Ramos v Dekhtyar, 301 AD2d 428 [1st Dept 2003]). This is sufficient to satisfy plaintiff's burden to demonstrate a disputed issue of fact on whether a serious injury has been sustained within the meaning of the Insurance Law.

Plaintiff's subjective complaints and her allegations that she was unable to perform her usual and customary activities following the accident for 90 out of the first 180 days following the accident, are corroborated by objective medical evidence, and

the affidavit of Dr. Rodriguez, dated August 16, 2007. Finally, the mere passage of time between the subject accident and the medical experts' opinions does not disqualify these experts' opinions, since plaintiff offers a reasonable explanation for the gap, i.e., economic factors (Pommells v Perez, 4 NY2d 566, supra).

Accordingly, it is

ORDERED that the motion and cross-motion for summary judgment dismissing the complaint are denied.

DATED: ~~July 7, 2008~~ July 14, 2008

ENTER:

Deborah Kaplan

Deborah Kaplan J.S.C.

FILED
JUL 18 2008
COUNTY CLERK'S OFFICE
NEW YORK