Haas v Wiseberg
2008 NY Slip Op 32655(U)
September 22, 2008
Supreme Court, Nassau County
Docket Number: 7452/06
Judge: Roy S. Mahon
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SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. ROY S. MAHON
Justice

STEVEN A. HAAS,

Plaintiff(s),

- against -

DONNA J. WISEBERG,

Defendant(s).

TRIAL/IAS PART 9

INDEX NO. 7452/06

MOTION SEQUENCE NO. 2

MOTION SUBMISSION DATE: July 10, 2008

The following papers read on this motion:

Notice of Motion	X
Affirmation in Opposition	X
Reply Affirmation	X

Upon the foregoing papers, the motion by defendant for an Order granting the defendant(s), Donna J. Wiseberg, summary judgment pursuant to CPLR 3212 dismissing the complaint on the basis that the plaintiff, Steven A. Haas did not sustain a "serious injury" under §5102(d) of the Insurance Law, is determined as hereinafter provided:

This personal injury action arises out of a rear end collision that occurred on April 11, 2005 at approximately 6:00 pm on Merrick Avenue at or near its intersection with Arbor Road, Town of Hempstead, Nassau County, New York.

The plaintiff in the plaintiff's Verified Bill of Particulars sets forth:

> "6. As a result of the occurrence, the plaintiff, Steven A. Haas, sustained the following personal injuries, all of which are alleged to be of a permanent nature:
>
> Right shoulder impingement syndrome;
> Partial rotator cuff tear of the right shoulder;
> Arthritis acromioclavicular joint of the right shoulder;
> Frozen right shoulder;
>
> On October 11, 2006 Plaintiff underwent the following procedures;

Manipulation of the right shoulder under anesthesia;
Arthroscopy of the right shoulder with subacrominal decompression;
Acromioplasty of the right shoulder;
Coracoacromial ligament release of the right shoulder;
Debridement of the right partial thickness rotator cuff tear;
Bursal sided rotator cuff tear and arthroscopic mumford procedure/resection of distal clavicle of the right shoulder;

<u>Plaintiff also sustained the following:</u>

Internal derangement of the right shoulder;
Loss of range of motion of the right shoulder;
Permanent scarring of the right shoulder;
Central disc herniation at C3-C4;
C4-C5 disc/ridge favoring the left;
Disc herniation at C5-C6 favoring the left;
Left paracentral disc herniation at C6-C7;
Bilateral C5 through C7 radiculopathy;
Cervical radiculitis;
Cervical sprain/strain;
Loss of range of motion of the cervical spine;
Bulging discs at L3-L4 and L4-L5;
Foraminal narrowing at L3-L4, L4-L5 and L5-S1;
Left L5-S1 radiculopathy;
Lumbar radiculitis;
Lumbar sprain/strain;
Loss of range of motion of the lumbar spine;
Left ulnar entrapment at the elbow;
Sprain/strain of the left elbow;
Pain of the left elbow;
Loss of range of motion of the left elbow;
Pain in left hand;
Numbness in left hand;
Loss of range of motion of the left hand;
Numbness in left arm;
Loss of range of motion of the left arm;

All of the aforementioned injuries, resulting disabilities, aggravations, exacerbations and involvements are associated with further soft tissue injuries to the areas traumatically affected, including: fracture, tearing, derangement and damage to the associated muscle groups, ligaments, tendons, cartilage, blood, tissue, epithelial tissue, all concomitant to the specific injuries and related to the specific portions of the body mentioned hereinabove, with resultant scars, hemorrhage, pain, ecchymosis, deformity and disability; stiffness, tenderness, weakness and partial restriction and limitation of motion, pain on motion and loss of use of the abovementioned parts; atrophy, anxiety and mental anguish; all of which have substantially prevented the Plaintiff from enjoying the normal fruits of social activities.

The Plaintiff reserves the right to prove any and all further consequences and

any and all further medical expenses up to and at the time of trial.

7. Upon information and belief, all of the above injuries are permanent and continuing in nature, except for objective signs of contusions and abrasions.

All of the injuries and conditions caused and/or contributed to the Plaintiff living a lesser quality of life, including loss of enjoyment of life than the Plaintiff would otherwise have experienced, but for the injuries and conditions alleged herein.

The Plaintiff suffered, still suffers, and upon information and belief will continue to suffer pain, discomfort and limited movement of the injured portions of his body, including the adjacent and surrounding muscles, tendons, nerves, joints, fascia, vessels and soft tissues."

The defendant in support of the defendant's application, amongst other things, submits a copy of the plaintiff's treating orthopedists, Ross Orthopedic Group PC for the period October 18, 2005 to April 25, 2005; an affirmed letter report dated August 7, 2007 of Wayne Kerness MD, an orthopedist, of an orthopedic examination of the plaintiff performed on August 7, 2007; an affirmed letter report dated August 7, 2007 of Sarasavani Jayaram, MD, a neurologist of a neurological examination of the plaintiff conducted on August 7, 2007 and two affirmed letter reports both dated October 5, 2007 of Sondra J. Pfeffer, MD, a radiologist of a review of a cervical MRI of the plaintiff performed on August 9, 2005 and a lumbar MRI of the plaintiff also performed on August 9, 2005.

The rule in motions for summary judgment has been succinctly re-stated by the Appellate Division, Second Dept., in **Stewart Title Insurance Company, Inc. v. Equitable Land Services, Inc., 207 AD2d 880, 616 NYS2d 650, 651 (Second Dept., 1994):**

"It is well established that a party moving for summary judgment must make a prima facie showing of entitlement as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact (*Winegrad v. New York Univ. Med. Center*, 64 N.Y.2d 851, 853, 487 N.Y.S.2d 316, 476 N.E.2d 642; *Zuckerman v. City of New York*, 49 N.Y.2d 557, 562, 427 N.Y.S.2d 595, 404 N.E.2d 718). Of course, summary judgment is a drastic remedy and should not be granted where there is any doubt as to the existence of a triable issue (*State Bank of Albany v. McAuliffe*, 97 A.D.2d 607, 467 N.Y.S.2d 944), but once a prima facie showing has been made, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish material issues of fact which require a trial of the action (*Alvarez v. Prospect Hosp.*, 68 N.Y.2d 320, 324, 508 N.Y.S.2d 923, 501 N.E.2d 572; *Zuckerman v. City of New York, supra*, 49 N.Y.2d at 562, 427 N.Y.S.2d 595, 404 N.E.2d 718)."

It is noted that the question of whether the plaintiff has made a prima facie showing of a serious injury should be decided by the Court in the first instance as a matter of law **(see Licaro v. Elliot, 57 NY2d 230, 455 NYS2d 570, 441 NE2d 1088; Palmer v. Amaker, 141 AD2d 622, 529 NYS2d 536, Second Dept., 1988; Tipping-Cestari v. Kilhenny, 174 AD2d 663, 571 NS2d 525, Second Dept., 1991)**.

In making such a determination, summary judgment is an appropriate vehicle for determining

whether a plaintiff can establish prima facie a serious injury within the meaning of Insurance Law Section 5102(d) **(see, Zoldas v. Louise Cab Corp., 108 AD2d 378, 381, 489 NYS2d 468, First Dept., 1985; Wright v. Melendez, 140 AD2d 337, 528 NYS2d 84, Second Dept., 1988)**.

Serious injury is defined, in Section 5102(d) of the Insurance Law, wherein it is stated as follows:

> "(d) 'Serious injury' means a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, ember, 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 defendant properly offers the unsworn office records of the plaintiff's treating physicians, the Ross Orthopedic Group PC (see, **Pagano v Kingsbury**, 182 AD2d 268, 587 NYS2d 692 (Second Dept., 1992). In this regard, the defendant offers the entry for April 25, 2006 specifically as to the plaintiff's right shoulder:

> 04/25/06 -D/A/: 4/11/05
> Steve Haas returns to the office today for re-evaluation of his cervical lumbar radiculitis with herniated disc disease. He does still have tingling and numbness in his arms and legs, and is doing his own stretching and strengthening exercises. His new complaint is that of pain in the right shoulder with no clear history of trauma or recent injury. On exam, there is a positive impingement sign, and pain on abduction and external rotation as well as internal rotation. The patient is otherwise neurologically grossly intact with no clear dermatomal sensory or motor deficits. He is not interested in injection here today. He will continue on course with his own stretching and strengthening exercises, and return to the office in one month for re-evaluation. HR"

The report of Dr. Kerness in pertinent part provides:

> PHYSICAL EXAMINATION: Steven Haas presents as a 54 year old, right hand dominant male, standing 6'3" tall and weighing 250 lbs in no apparent distress. Steven Haas was not wearing any braces, or supports and ambulated without aid.
>
> OBSERVATIONS: Steven Haas was able to turn his head freely to speak with me in unguarded moments. He did not appear to walk or perform routine activities with difficulty when unguarded and was able to get on and off the examination table without difficulty.
>
> Cervical Tests:
> Tenderness Paraspinals: Negative

Tenderness Suprascapular	Negative
Spasm	Negative

Cervical Spine: Range of Motion in Degrees

	Claimant	Normal
Flexion	45°	45°
Extension	45°	45°
Lateral Flexion (R)	45°	30-45°
Lateral Flexion (L)	45°	30-45°
Rotation (R)	60°	60°
Rotation (L)	60°	60°

Shoulder Tests:
No tenderness was noted in the right shoulder.
Well healed portal scars were noted on the right shoulder.
Shoulder Abduction Test: Negative
Supraspinatus Test : Negative for rotator cuff tear

Shoulder: Range of Motion in Degrees

		Claimant	Normal
Forward Elevation	(R)	180°	180°
	(L)	180°	180°
Abduction	(R)	180°	180°
	(L)	180°	180°
Adduction	(R)	45°	45°
	(L)	45°	45°
Internal Rotation	(R)	55°	55°
	(L)	55°	55°
External Rotation	(R)	45°	45°
	(L)	45°	45°

Elbows: Range of Motion in Degrees
No tenderness was noted in the left elbow

	Claimant	Normal
Flexion (R)	135°	135°
Flexion (L)	135°	135°
Extension (R)	5°	5°
Extension (L)	5°	5°
Supination (R)	90°	90°
Supination (L)	90°	90°
Pronation (R)	90°	90°
Pronation (L)	90	90°

Pain on resisted extension: None noted on the left
Pain on resisted forearm Supination: None noted on the left

Thoracic Spine:

Tenderness	None noted
Triggers	None noted
Spasm	None noted

Lumbar Tests
No tenderness was noted in the lumbar spine
Laseque negative
Supine straight let raise: negative
Reverse seated straight leg raise: negative

Lumbar Spine: Range of Motion in Degrees

	Claimant	Normal
Flexion	90°	90°
Extension	30°	30°
Lateral Flexion (R)	30°	30°
Lateral Flexion (L)	30°	30°
Rotation (R)	30°	30°
Rotation (L)	30°	30°

The claimant walks with a normal gait and without a limp.
The claimant is able to walk on his heels and toes.

MUSCLE STRENGTH:

	Left	Right
Triceps	5	5
Biceps	5	5
Wrist extensor	5	5
Wrist flexor	5	5
Quadriceps	5	5
Hamstrings	5	5
Ankle Extensor	5	5
Ankle Flexors	5	5

SENSATION:
Sensation was intact

DEEP TENDON REFLEXES:
Deep tendon reflexes were tested and found to be normal/2+ bilaterally, ankle jerk, knee jerk, triceps and biceps.

DIAGNOSIS:
Resolved cervical, thoracic and lumbar sprain/strain
Status post, resolved, arthroscopic surgery to the right shoulder for internal derangement
Resolved left elbow sprain

IMPRESSION:
Steven Haas is not in need of any treatment from an Orthopedic perspective.
There are no clinical signs of ulnar nerve dysfunction.

. . .

CASUALTY: It appears that the shoulder onset is six months post accident. Within a reasonable degree of

> medical certainty this removes any causality as acute injuries do not take this long to appear and instead appears possibly related to underlying pre existing pathology."

Amongst other things, Dr. Jayaram in said physician's report of neurological examination sets forth:

"PHYSICAL EVALUATION INTRODUCTION:
The claimant presents in no apparent distress

GAIT: Normal

OBSERVATION DURING DISCUSSION: Steven Haas appears to move his head freely during conversation and does not appear to have any restrictions or pain. Claimant is able to dress and undress, boot and unboot as well as turn sides in the bed.

CERVICAL SPINE:
Cervical Tests

Foraminal Compression/Spurling Test:	Negative for radicular or localized pain
Jackson's Compression Test:	Negative for radicular or localized pain
Shoulder Depression Test:	Negative on the left, right deferred (S/P surgery)
Soto-Hall Test:	Negative
Cervical Distraction Test:	Negative
Valsalva maneuver:	Negative

There is no tenderness, spasm or triggers.

The claimant complains of subjective light lower cervical tightness on the left lateral movements.
The claimant's restrictions are self imposed as evident by the partial contraction of the antagonistic muscles. However, this is partially overcome on passive range of motion.

MOTION	Claimant A/P	Normal
Flexion	40/45°	45°
Extension	35/40°	45°
Lateral Right	40/40°	30-45°
Lateral Left	45/40°	30-45°
Rotation Right	55/60°	60°
Rotation Left	55/60°	60°

SHOULDERS:
Deferred to the appropriate specialty

Elbows: Range of Motion in Degrees:
Tinel's signs are absent over ulnar nerves bilaterally.

	Claimant	Normal
Flexion (R)	135°	135°

Flexion (L)	135°	135°
Extension (R)	5°	0-5°
Extension (L)	5°	0-5°
Supination (R)	90°	90°
Supination (L)	90°	90°
Pronation (R)	90°	90°
Pronation (L)	90°	90°

Wrist: Range of Motion in Degrees:
Tinel's signs are absent bilaterally over median nerves
Phalen's signs are absent bilaterally over median nerves

	Claimant	Normal
Flexion (R)	75°	75°
Flexion (L)	75°	75°
Extension (R)	60°	60°
Extension (L)	60°	60°
Ulnar Deviation (R)	30°	30°
Ulnar Deviation (L)	30°	30°
Radial Deviation (R)	20°	20°
Radial Deviation (L)	20°	20°

Thoracic Spine: Range of Motion:
(as evidenced during testing of the cervical and lumbar spine)
No tenderness, spasms or triggers are noted. Supple to touch.
The claimant was asymptomatic of thoracic spine pain at the time of the examination.

	Claimant Active/Passive	Normal
Forward Flexion	45°	20-45°
Extension	45°	25-45°
Right Lateral	40°	20-40°
Left Lateral	40°	20-40°
Right Rotation	50°	35-50°
Left Rotation	50°	35-50°

LUMBAR SPINE:

Forward Flexion:	Negative
Quick Test:	Not performed due to prior right knee surgery
Bechterw/Sitting Boot Test:	Negative-no radicular pain
Straight Leg Raising:	Negative-no radicular pain
Hoover's Test:	Negative
Kernig Test:	Negative

No tenderness, spasms or triggers are noted. Supple to touch
Decreased range of motion is due to decreased abdominal muscle tone and status post right knee surgery.
The claimant did not complain of lower back pain at the time of the examination.
The claimant's restrictions are self imposed as evident by the partial contraction of the antagonistic muscles. However, this is partially overcome

on passive range of motion.
NOTE: Flexion is 90 degrees when claimant is booting and unbooting

	Claimant A/P	Normal
Flexion	80/85°	90°
Extension	25/25°	30°
Lateral Flexion (R)	30/30°	30°
Lateral Flexion (L)	30/30°	30°
Rotation (R)	30/30°	30°
Rotation (L)	30/30°	30°

HEENT: Normocephalic, atraumatic, PERLA, EOMI, neck was supple without abnormality noted. Tympanic membranes clear, mucus membranes clear with no erythema noted. The neck is supple without JVD noted.

Cranial nerves II-XII grossly intact. Romberg's is absent. Normal peripheral pulses. Cerebellar and extrapyramidal functions are normal.

Higher Cortical Function:
The following were tested and found to be normal:
Oriented x 3
Recent/remote memory
Dysphasia/dysarthia
Apraxia/Agnosia
Calculation
Spell "WORLD" forwards and backwards
Delusions Illusions Hallucinations
Intellect/judgment/insight
Mood/affect

MUSCLE STRENGTH: The following were tested:
muscles of shoulder girdle-Flexors, extensors, adductors, abductors, int.rotators and ext.rotators, forearm muscles-flexors, extensors, supinators, pronators, wrist muscles-radial flexors, ulnar flexors, radial extensors, ulnar extensors and rotators, hand muscles-thenar muscles, hyopthenar muscles, dorsal interossei, palmar interossei, medial lumbricals, lateral lumbricals, long finger extensors, short finger extensors, short finger flexors and long finger flexors, hip flexors, extensors, abductors, adductors, internal/external rotators, knee flexors/extensors, ankle dorsi-flexors/plantar flexors, Peronei, flexors and extensors of toes and intrinsic foot muscles.

Strength was 5/5 throughout with the exception of 4/5 in the right deltoid and levator scapula due to status post right shoulder surgery (deferred). Normal muscle tone. There is no atrophy, fasciculation's or tremors or other involuntary movements.

REFLEXES: Deep Tendon: Biceps Triceps Supinator Knee Ankle
Right within normal limits through out
Left within normal limits throughout
(Normal is 2+/2+)

SUPERFICIAL: Right and Left
Abdominal decreased secondary to decreased abdominal muscle

	tone
Plantars	within normal limits throughout

SENSATION: The following were tested and found to be normal
Pain, touch, joint/position, 2 point discrimination

Peripheral Pulses within acceptable limits.

DISABILITY/ADL's: There is no disability at this time.

WORK STATUS: The claimant can work at this time.

DIAGNOSIS: Normal Neurological Evaluation with no focal deficits
Resolved cervical and Lumbo-sacral sprain and strain
Resolved questionable right cervical sensory radicular symptoms without objective signs
Subjective symptoms outweigh objective signs
All other complaints are deferred to the appropriate specialty

TREATMENT: The claimant is not in need of treatment from a Neurological perspective including physical therapy."

The respective October 5, 2007 letter reports of Dr. Pfeffer state:

"<u>LUMBAR MRI</u>

Examination date is 08/09/05 approximately 4 months following trauma.

imaging sequences submitted for review include FLAIR_T1-sagittal, mixed (intermediate) sagittal, T2-sagittal, mixed (intermediate) axial and T2 axial.

There is appropriate lumbar lordosis.

There are no fractures, subluxations, or contusions of the lumbar vertebrae.

There is multi-level disc desiccation reflective of age-related degenerative disc disease the claimant in his 50s).

There is developmental Schmort's node formation at T10-11, T11-12, T12-L1, L1-2 and L2-3 (unrelated to the subject accident).

At L3-4, there is disc space narrowing, circumferential disc bulging and facet joint osteo arthropathy resulting in mild spinal and bilateral neuroforaminal stenosis.

At L4-5 there is disc space narrowing, circumferential disc bulging and facet joint osteo arthropathy resulting in moderate spinal and bilateral

neuroforaminal stenosis. Additionally noted at this level is endplate spurring.

At L5-S1, there is facet joint osteoorthrpoathy resulting in bilateral neuroforaminal stenosis.

A normal conus medullaris is visualized. There are no intradural intraspinal masses.

Normal facet joint articulation is maintained.

The paraspinal soft tissues are intact.

SUMMARY

Lumbar MRI performed approximately 4months following trauma reveals degenerative disc disease and posterior element spondylosis manifested by circumferential disc bulging, disc space narrowing, disc desiccation and facet joint osteoorthropathy with spinal and bilateral neuroforaminal stenosis at L3-4 and L4-5; facet joint osteoorthropathy with bilateral neuroforaminal stenosis at L5-S1; multi-level disc desiccation at levels exclusive of L3-4 and L4-5; and developmental Schmorl's node formation at T10-11, T11-12, T12-L1, L1-2 and L2-3.

None of the aforesaid findings are trauma-related."

"CERVICAL MRI

Examination date is 09-09-05, approximately 4 months following trauma.

Imaging sequences submitted for review include FLAIR-T1-sagittal, mixed (intermediate) sagittal, T2-sagittal, T2-gradient axial, and T2-axial.

There is appropriate cervical lordosis.

There are no fractures, subluxations, or contusions of the cervical vertebrae.

There is multi-level disc desiccation reflective of age-related degenerative disc disease (the claimant in his 50s).

At C2-3, there is minimal if any posterior disc bulging.

At C3-4, there is minor posterior midline disc herniation absent cord compromise.

At C4-5, there is broad-based left posterior paracentral disc-osteophyte formation, with left uncovertebral hypertrophy resulting in left lateral recess and left neuroforaminal stenosis. There is subtle left anterolateral cord flattening.

At C5-6, there is broad-based left posterior paracentral disc-osteophyte

formation, disc space narrowing, anterior disc bulging with endplate spurring, and bilateral uncovertebral hypertrophy resulting in bilateral neuroforaminal narrowing. In addition, there is left anterolateral cord flattening.

At C6-7, there is broad-based left posterior paracentral disc-osteophyte formation, mild anterior disc bulging with endplate spurring and bilateral uncovertebral hypertrophy resulting in bilateral neuroforaminal narrowing and left anterolateral cord flattening.

There are no cord contusions or other intrinsic cord lesions.

Normal facet joint articulation is maintained.

The paraspinal soft tissues are intact.

<u>SUMMARY</u>

Cervical MRI performed approximately 4 months following trauma demonstrates broad based posterior disc-osteophyte formation favoring the left at C4-5, C5-6 and C6-7; disc space narrowing at C5-6; anterior disc bulging with endplate spurring at C5-6 (and to a lesser extent C6-7); multi-level disc desiccation; minimal (if any) posterior disc bulging at C2-3; and uncovertebral hypertrophy at C4-5, C5-6 and C6-7. These findings are indicative of long-standing spondylitic disease processes pre-dating the subject accident. Although there is also minor posterior midline disc herniation of uncertain etiology at C3-4 there is no accompanying cord or nerve root compression to render the latter functionally significant from a radiological perspective.

"Disc herniations" reported at C5-6 and C6-7 are in essence disc-osteophyte complexes (hard, or chronic disc herniations) clearly pre-dating the subject accident."

The Court finds that the defendants have submitted evidence in admissible form to make a "prima facie showing of entitlement to judgment as a matter of law" **(Winegrad v. New York University Medical Center, 64 NY2d 851, 853; Pagano v. Kingsbury, supra at 694)** and is sufficient to establish that the plaintiff did not sustain a serious injury. Accordingly, the burden has shifted to the plaintiff to establish such an injury and a triable issue of fact **(see Gaddy v. Eyler, 79 NY2d 955, 582 NYS2d 990, 591 NE2d 1176; Jean-Meku v. Berbec, 215 AD2d 440, 626 NYS2d 274, Second Dept., 1995; Horan v. Mirando, 221 AD2d 506, 633 NYS2d 402, Second Dept., 1995).**

In opposition to the defendant's requested relief, the plaintiff offers an affirmation of David L. Kasow, MD, a radiologist as to a review of an MRI of the plaintiff's lumbar spine and an MRI of the plaintiff's cervical spine both performed on August 9, 2005; an affidavit of Bruce Ross, MD, an orthopedist and a treating physician of the plaintiff and an affidavit of the plaintiff Steven A. Haas.

As to Dr. Kasow's affirmation, a review of Dr. Kasow findings as to the MRI of the plaintiff's lumbar spine and the MRI of the plaintiff's cervical spine does not causally relate the findings as to the respective MRIs to the accident in issue (see, **Ukonu v Velazquez**, 213 AD2d 628, 624 NYS2d 195 (Second Dept.,

SCAN

1995).

Dr. Ross sets forth in said physician's affidavit that he initially saw the plaintiff on April 12, 2005 and thereafter for a "follow-up visit" on July 15, 2005 with the "most recent examination" of the plaintiff on March 11, 2008 and April 9, 2008. The Court observes that while Dr. Ross refers to a course of physical therapy, and that the plaintiff in his affidavit in opposition alludes to physical therapy there is no submission of any office notes from Dr. Ross with this affidavit as to his treatment and whether therapy was done in his office and there is no submission from the plaintiff of any physical therapy records in either admissible or inadmissible form to substantiate the respective contentions of either Dr. Ross or the plaintiff himself. In light of the fact that Dr. Ross' affidavit sets forth office visits of April 12, 2005, July 15, 2005, March 11, 2008 and April 9, 2008 and does not contain any notes or records to substantiate the plaintiff's affidavit as to dates of treatment, Dr. Ross has failed to offer an explanation for the gap in treatment (see, **Pommells v Perez**, 4 NY3d 566, 797 NYS2ds 380; also see, **Nemckyonok v Peng Lui Ying**, 2 AD3d 421, 767 NYS2d 811 (Second Dept., 2003).

Based upon all of the foregoing, the defendant's application for an Order granting the defendant(s), Donna J. Wiseberg, summary judgment pursuant to CPLR 3212 dismissing the complaint on the basis that the plaintiff, Steven A. Haas did not sustain a "serious injury" under §5102(d) of the Insurance Law, is **granted**.

SO ORDERED.

DATED: 9/22/2008

J.S.C.

ENTERED

SEP 26 2008

NASSAU COUNTY
COUNTY CLERK'S OFFICE