SCAN

SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. ROY S. MAHON

Justice

PETER GOLD,

Plaintiff(s),

- against -

MICHAEL JOHNSON,

Defendant(s).

TRIAL/IAS PART 9

INDEX NO. 11067/07

MOTION SEQUENCE NO. 2

MOTION SUBMISSION DATE: January 12, 2009

The following papers read on this motion:

Notice of Motion	**X**
Affirmation	**X**
Affirmation in Opposition	**X**
Reply Affirmation	**X**

Upon the foregoing papers, the motion by defendant for an Order pursuant to CPLR §3212 dismissing the plaintiff's complaint upon the grounds that the plaintiff has failed to sustain a "serious injury" or an economic loss greater than a "basic economic loss" as defined in the Insurance Law of the Sate of New York, is determined as hereinafter provided:

This personal injury action arises out of a pedestrian motor vehicle accident that occurred on February 11, 2005 at approximately 7:05 pm in Municipal Parking Field 4, Farmindgale, New York.

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

> "7. The injuries to the plaintiffs are as follows:
>
> INSULT TO THE MUSCULAR SKELETAL SYSTEM OF BOTH THE CERVICAL AND LUMBER SPINE;
>
> INSULT TO THE NEUROPERIPHERAL SYSTEM OF BOTH THE CERVICAL AND LUMBAR SPINE;
>
> POST-CONCUSSION SYNDROME;

HEADACHES;

RADICULITIS THROUGHOUT THE ENTIRE SPINE;

TENDINIOSIS OF THE RIGHT SUPRASPINATUS TENDON;

COMPLETE TEAR OF THE ANTERIOR CRUCIATE LIGAMENT OF THE RIGHT KNEE;

SMALL JOINT EFFUSION OF THE RIGHT KNEE;

MILD DEGENERATIVE CHANGES OF THE POSTERIOR HORN OF THE MEDIAL MENISCUS OF THE RIGHT KNEE;

DISCOID LATERAL MENISCUS OF THE RIGHT KNEE;

AGGRAVATION OF ANY PRIOR INJURIES;

All of the above injuries are deemed to be permanent.

8. a) The plaintiff went to but was not confined to New Island Hospital;

b & c) The plaintiff was confined to his home and bed for approximately one week (1) following the accident and partial to date; d) The plaintiff was incapacitated from household duties for approximately one (1) week following the accident and partial to date."

The defendant in support of the defendant's application submits, amongst other things, the plaintiff's October 10, 2007 deposition transcript' an affirmed letter report dated July 16, 2008 of John C. Killian, MD, an orthopedist of an orthopedic examination of the plaintiff performed on July 7, 2008; the plaintiff's medical records from New Island Hospital from the date of the accident in issue; certain reports and records from treating physicians and health care providers of the plaintiff including Douglas E. Barkin, MD and John G. Fox, PT, MA, CWT; an MRI of the plaintiff's right knee performed at Island Diagnostic Imaging Associates by Steven M. Peyser, MD on March 14, 2005 and an MRI of the plaintiff's right shoulder performed by the same group and physician on February 1, 2006; certain reports from prior accidents of the plaintiff and subsequent accidents of the plaintiff.

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."

In pertinent part, the report of Dr. Killian sets forth:

> "PHYSICAL EXAMINATION:
>
> The claimant was a well developed, well nourished male, who was in no acute distress.
>
> SPINAL COLUMN
>
> On inspection in the standing position the normal cervical lordosis, thoracic kyphosis and lumbar lordosis were maintained without visible evidence of atrophy, asymmetry, deformity or muscle spasm. His head was held in a normal attitude, his shoulders and pelvis were level and there was no evidence of scoliosis. On palpation he complained of midline upper cervical tenderness and he complained of right-sided lower cervical paraspinal tenderness extending into the right upper trapezius. There was no palpable muscle spasm or deformity. He did not complain of tenderness in the thoracic or lumbar regions and there was no palpable muscle spasm or deformity. The range of motion of his cervical spine was tested (by visual observation) and it was found that flexion and extension were full at 45 degrees (normal 45

degrees), right and left rotation were mildly limited at 70 degrees (normal 90 degrees) and right and left lateral flexion were mildly limited at 35 degrees (normal 45 degrees). He did complain of pain at the extremes of rotation, flexion and lateral flexion but there was no muscle spasm. He complained of pain mainly to the right side of the neck. The range of motion of the thoracolumbar spine was tested (by visual lower shins (normal ankles) with a normal reversal of the lumbar lordosis and a complaint of pain. Extension was to 20 degrees (normal 40 degrees) with a complaint of pain. Right and left rotation were full at 30 degrees (normal 35 degrees). He complained of pain with full right lateral flexion but he did not complain of pain with the other motions of his lower back. Straight leg raising was negative bilaterally in the sitting position and in the supine position.

NEUROLOGICAL EXAMINATION

The upper and lower extremity neurological examination was done and it was found that the reflexes including the biceps, triceps, brachioradialis, knee jerks and ankle jerks were intact and symmetrical. All major muscle groups in both upper extremities and both lower extremities were 5 out of 5 in strength and symmetrical. On sensory testing he described generalized decreased sensation to pin and light touch over the entire right upper extremity compared to the left upper extremity and over the entire right lower extremity compared to the left lower extremity. The circumferential muscle masses of his upper and loser extremities were measured and found to be symmetrical with the biceps measuring 12½", the forearms 11", the thighs 18" and the calves 15½ ".

RIGHT SHOULDER

On inspection the normal bony and soft tissue contours of his right shoulder were maintained without visible evidence of atrophy, asymmetry, deformity, swelling or discoloration. On palpation he complained of tenderness over the upper trapezius but he did not complain of tenderness over the glenohumeral joint or the subacromial region. The range of motion of his shoulder was tested (by visual observation) and found to be full and symmetrical with the left shoulder with forward flexion to 180 degrees (normal 180 degrees), external rotation to 70 degrees (normal 70 degrees) and internal rotation to allow him to bring both hands symmetrically up behind his back to the mid thoracic region (normal mid thoracic), He complained of pain at the extremes of forward flexion and internal rotation but there was no restriction. He complained of pain with impingement testing but there was no crepitus and there was no weakness in external rotation. There was no instability on anterior anticipation testing.

RIGHT LOWER EXTREMITY

On inspection the normal bony and soft tissue contours of his right knee, lower leg and ankle were maintained without visible evidence of atrophy, asymmetry, deformity, swelling or discoloration. On palpation he complained

of mild anteromedial tenderness, over the right knee but there was no palpable swelling or deformity. There was no viable or palpable deformity or swelling over the tibia or over the ankle. The range of motion of his knee was tested (by visual observation) and found to be normal and symmetrical with the left knee with flexion to 140 degrees (normal 140 degrees) and extension to zero degrees (normal zero degrees). He did not complain of pain with that motion. The knee was stable to varus and valgus stress testing. There was mildly increased translation on anterior drawer testing and Lachman's testing on the right side compared to the left side. The ankle motion was tested (by visual observation) and found to be normal and symmetrical with the left ankle with dorsiflexion to 30 degrees (normal 30 degrees), plantar flexion to 60 degrees (normal 60 degrees) and a full 30 degree arc of subtalar motion (normal 300 degrees). None of the right ankle motions elicited complaints of pain. His gait was observed and he was noted to ambulate without evidence of a limp. He was able to toe walk and heel walk with symmetrical elevation although he complained of back pain with toe walking and heel walking. He was able to squat bending both ankles and knees symmetrically but he complained of pain in the right knee when he reached a full squatting position. He was able to step on and off a stool with each leg satisfactorily and symmetrically. One could appreciate mild crepitus in his left knee as he went on and off the stool which was not present in the right knee.

OPINION

Based on the available history and medical documentation I would conclude that Mr. Gold was evaluated for complaints involving mainly the right lower leg after the 2/11/05 incident. The emergency room records also mention his neck although there is no description of any significant complaints about his neck in those records. He did have x-rays of the right ankle which were described as showing soft tissue swelling over the lateral maleolus. X-rays of the right foot were negative and x-rays of the right tibia and fibula were remarkable for some type of opaque densities in the soft tissue which are of questionable clinical significance. There were reports of x-rays of his lumbosacral spine done at the time he was injured which were negative although there is no description of complaints of pain involving his back. Cervical x-rays reportedly showed preexisting degenerative disease in his neck. He was diagnosed in the hospital as having an ankle sprain and the records suggest that he was treated with a posterior splint and was put on crutches for a sprained right ankle. He went for further orthopedic treatment which was mostly focused on his right knee which was described as showing a complete tear of the anterior cruciate ligament as well as a small joint effusion and mild degenerative changes in the posterior horn of the medial meniscus. There was a discoid lateral meniscus. There is no description of any bony bruises or findings to suggest that the anterior cruciate ligament tear was acute. Given the lack of documentation of complaints related to his knee in the emergency room I do not feel that he sustained an anterior cruciate ligament tear as a result of the 2/11/05 incident. The orthopedic notes mention that at some point he began complaining of right shoulder pain although there is no documentation of an injury to his right shoulder in the emergency room records. I do not feel that his complaints of right shoulder

pain can be attributed to an injury from this accident. He was eventually sent for an MRI of his right shoulder which reportedly showed degenerative hypertrophic changes of the AC joint which were not caused by an injury from this incident. There was tendinosis of the supraspinatus tendon, a degenerative condition which was not caused by trauma from this incident. It is well documented that the claimant had previous injuries as a result of a motorcycle accident in 2004 which included injuries to the right lower extremity. I feel that the anterior cruciate ligament tear in his right knee which was discovered after this incident was caused by the 2004 accident. The claimant has had a series of traumatic events which have caused complaints involving his neck and back including the 2004 motorcycle accident, the 2/11/-5 incident and subsequent automobile accidents which occurred in 2006 and 2007. He has had a number of x-rays and MRIs of his cervical and lumbar spine which showed various degenerative abnormalities. He has gone for extensive chiropractic treatment for a number of years for all of the neck and back problems. There is no record of him having gone for increased treatment for his neck or his back after the 2/11/05 incident indicating that there was no significant aggravation of those conditions.

The physical examination of his spinal column was remarkable for complaints of tenderness in the cervical spine and complaints of pain with certain motions of the neck and back. There was minor restriction of cervical and lumbar motions which one would anticipate given the extensive degenerative disease documented on the diagnostic imaging studies. The upper and lower extremity neurological examination was remarkable for subjective sensory changes over the entire right upper extremity and the entire lower extremity which were nonanatomical in distribution and unaccompanied by objective findings including reflex alterations, weakness or atrophy. The sciatic nerve tension signs were negative. The right shoulder examination was remarkable for complaints of pain at certain extremes of motion which were unaccompanied by objective findings including crepitus, weakness, restriction of motion or atrophy. The right knee examination was remarkable for mildly increased anterior translation or drawer testing and on Lachman testing consistent with a chronic anterior cruciate ligament deficiency. There was no atrophy of the thigh to indicate disuse and there was no restriction of motion. The right ankle examination was normal, indicating a full resolution of the ankle sprain which was diagnosed after this incident.

Based on this examination I would conclude that Mr. Gold has recovered fully from the ankle sprain and minor contusions to his right lower leg for which he was treated after this incident. There is no residual impairment or disability from those problems. He does have mild impairment of his right knee due to chronic ACL deficiency which I do not feel was caused by or aggravated by this incident. There is no objective evidence of any impairment or disability from problems with his right shoulder and I do not feel that he sustained an injury to his right shoulder as a result of this incident. There is mild impairment of his spine due to loss of motion from the degenerative disease which has been ongoing for the past few years and was not aggravated or accelerated by injuries from this incident. He has no impairment or disability from injuries caused by the 2/11/05 incident and he requires no casually

related orthopedic follow-up or treatment."

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, amongst other things, submits an affirmation of Douglas E. Barkin, MD and an affirmation of Ralph K. Della Ratta, MD, both treating physicians of the plaintiff.

Dr. Barkin States:

> "PETER GOLD came to my office following an automobile accident which he reported occurred on February 11, 2005 in whish he was a pedestrian struck by a car. I took a history of the patient and he reported pain in his right knee. He treated with me for approximately (10) months post accident and during this time I referred him for MRI's which showed a tear in the ACL of the right knee. I discussed the possibilities of surgery with the patient, including a knee arthroscopy and a partial medial meniscectomy as well as ACL reconstructive surgery. On the visit of August 15, 2005 the patient was seen for follow up care, where he reported occasional weakness and questionable "giving way" during various activities.
> The patient further complained of some restriction of motion with regard to his right shoulder, which was positive for impingement sign as well as Hawking sign. I saw the patient as late at December 19, 2005, approximately (10) months post Accident.
> I find the ACL tear as well as the impingement of the shoulder is causally related to the accident of February 11, 2005. I base this on the fact that the patient reports no other accident where he injured those parts of the body, particularly the right knee. It should be noted that I last saw the patient on September 15, 2008. He reports that continued occasional leg pain and"giving way" during various activities persist to date. Exercises are to be continued for knee injury. Follow up in four weeks. I further find that the nature of the patients injuries may be permanent due to the fact that complaints persist literally years after the accident date of February 11, 2005 and that according to his history has had no problems with the knee prior to the accident on that date."

Dr. Della Ratta sets forth:

> "I am Primary Care Physician to PETER GOLD, he has been under my care since April 21, 1997.
>
> Mr. Gold is a Diabetic and I have treated him for this condition.

I understand that on February 11, 2005 as a pedestrian, he was struck by a motor vehicle, resulting in a tear of the ACL in his right knee.

Mr. Gold has discussed with me the option of surgery to repair the ACL and his concerns with regard to his Diabetes.

I informed Mr. Gold that there were indeed increased surgical risks for patients with Diabetes, particularly the added risk of infection and poor healing.

It is my understanding that Mr. Gold has chosen to abstain from said surgery.

The patient is currently under my care."

Based upon the foregoing, there is an issue of fact as to whether the plaintiff suffered a serious injury pursuant to §5102 of the Insurance Law in the accident in issue of February 11, 2005. As such, the defendant's application for an Order pursuant to CPLR §3212 dismissing the plaintiff's complaint upon the grounds that the plaintiff has failed to sustain a "serious injury" or an economic loss greater than a "basic economic loss" as defined in the Insurance Law of the Sate of New York, is **denied**.

SO ORDERED.

DATED: 3/25/2009

Ley S. Mahon
J.S.C.

ENTERED
MAR 30 2009
NASSAU COUNTY
COUNTY CLERK'S OFFICE