SCAN

**SHORT FORM ORDER**

**SUPREME COURT - STATE OF NEW YORK**

**Present:**

**HON. ROY S. MAHON**

**Justice**

**JULIO CESAR DIAZ,**

**Plaintiff(s),**

**- against -**

**JOSE E. MURILLO and JORGE K. CARDOZA,**

**Defendant(s).**

**TRIAL/IAS PART 7**

**INDEX NO. 429/08**

**MOTION SEQUENCE NO. 1**

**MOTION SUBMISSION DATE: March 17, 2010**

**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 defendants for an Order pursuant to CPLR 3212 and Article 51 of the Insurance Law of the State of New York granting summary judgment to defendants, Jose E. Murillo and Jorge k. Cardoza and dismissing the Complaint of plaintiff, Julio Cesar Diaz on the ground that the injuries claimed do not satisfy the "serious injury" threshold requirement of New York Insurance Law §5102(d) and thus his claim for non-economic loss is barred by Section 5104(a) of the statute, is determined as hereinafter provided:

This personal injury action arises out of a motor vehicle accident that occurred on January 14, 2005 at approximately 5:20 p.m. on Grand Boulevard at or near its intersection with Dickens Street, New Cassel, New York.

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

> "5. Plaintiff, Julio Cesar Diaz, sustained the following injuries: Cervicalgia. Left C6-7 Radiculopathy. Severe loss of cervical lordosis, decreased disc height C5/6, Retrolisthesis C4/5 and C5/6, Subluxation C1/2-C6/7, L5/S1, Right Ilium. Multiple disc bulges at L4-5. Disc herniations and hypertrophic changes at C4-5, C5-6 and C6-7, which are most significant at C6-7 level. Significant central spinal stenosis as well as foraminal impingement. Myelomalacia. Muscle spasms evident in paraspinal muscles of the lower cervical and lower lumbar spine.

> Disc bulge at L44-5, which in combination with ligamentum flavum hypertrophy creates central stenosis, impingement. Central herniation at L5-S1. Low Back Syndrome. Left trapezius myofascial pain syndrome. Left Shoulder Contusion. Left Arm Contusion.
>
> The above enumerated injuries are accompanied by pain, disability and limitation of movement.
>
> As a result of the foregoing, plaintiff was forced to undergo numerous x-rays and other diagnostic tests, including but not limited to MRI and X-Rays.
>
> As a result of the foregoing, Plaintiff was forced to go to chiropractor, neurologist, orthopedist, etc.
>
> As a result of the foregoing, Plaintiff was forced to take medication; The above enumerated injuries are permanent except for those which are temporary in nature.
>
> The plaintiff reserves the right to prove upon the trial of this action, those injuries which flow from or are sequelae to the injuries above set forth. The foregoing injuries may continue to require medical treatment and intervention in the future, at which time plaintiff will serve a supplemental bill of particulars.
>
> 5a. All of the above injuries are permanent, except for those that are superficial and progressive in nature."

The defendants in support of the defendants' application, amongst other things, submit the October 21, 2008 deposition transcript of the plaintiff' an affirmed letter report dated November 13, 2008 of Jacqueline Emmanuel, MD, an orthopedist, of a November 13, 2008 orthopedic examination fo the plaintiff and two affirmed letter reports both dated June 23, 2009 of Melissa Sapan Cohn, MD a radiologist of a review of March 1, 2005 MRI of the plaintiff's cervical spine and a March 5, 2004 MRI of the plaintiff's lumbosacral spine.

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. Emmanuel sets forth:

ORTHOPEDIC EXAMINATION

Physical Examination:
Age: 53, Weight: 170 lbs, Eyes: Brown, Hair, Black, Left-hand dominant male.

On physical examination today, I found the claimant to be alert, cooperative and well oriented to person, place and time. His communication skills, recent and remote memory, insight and judgment, affect and mood are all within normal limits. He is able to follow commands and cooperate with the examination. My findings today are as follows:

Range of motion was measured with the use of a goniometer.

Cervical Spine: Examination of the cervical spine reveals skin to be intact with no visible deformity. There was no tenderness to palpation of the cervical paraspinal musculature and trapezii. No muscle spasm was noted. Range of motion of the cervical spine included flexion to 50 degrees (50 degrees normal), extension to 45 degrees (60 degrees normal), right rotation to 80 degrees (80 degrees normal), left rotation to 80 degrees (80 degrees normal), right lateral flexion to 40 degrees and left lateral flexion to 40 degrees (45 degrees normal).

Left Shoulder: There is no tenderness on palpation of the left shoulder. Range of motion of the left shoulder reveals forward flexion to 180 degrees (180 degrees normal), abduction to 180 degrees (180 degrees normal) and external rotation to 90 degrees (90 degrees normal). Internal rotation is normal to 80 degrees (80 degrees being normal). No crepitus is noted at the joints. The impingement sign is negative.

Chest: There is no tenderness or crepitus over the ribs or sternum. There is no pain on deep inspiration.

On neurological examination, there were no motor or sensory deficits in the upper extremities. Deep tendon reflexes of the biceps and triceps were at 2+ bilaterally. Muscle strength in each range was 5/5. There is firm grasping power in both hands. There is no radiation of pain or parasthesia.

Lumbar Spine: There are no spasms. There is no tenderness noted over the paraspinal musculature on palpation. Range of motion of the lumbar spine reveals forward flexion to 60 degrees (60 degrees normal), extension to 25 degrees (25 degrees normal) and right and left lateral bending to 25 degrees (25 degrees normal). Straight leg raising is negative to 90 degrees bilaterally (90 degrees being normal)

Neurological examination reveals patellar and Achilles reflexes to be 2+ bilaterally. Muscle strength of the lower extremities is graded at 5/5 bilaterally. Sensory examination of the lower extremities including the medial and lateral thighs, calves and feet were normal. There is no atrophy noted in the intrinsic muscles of the lower extremities. The claimant is able to tiptoe and heel walk.

Left Knee: There is no evidence of swelling or tenderness about the left knee. There is no effusion noted. There was no evidence of patello-femoral crepitus. No atrophy of the quadriceps was present. The McMurray test was negative. The anterior drawer sign was negative. The Lachman test was negative. The posterior drawer sign was negative. The pivot shift test is negative. No valgus or varus instability was present. Range of motion of the left knee reveals extension to 0 degrees (0 degrees being normal) and flexion to 150 degrees (150 degrees being normal).

Normal range of motion are as per the A.M.A. "Guides To The Evaluation Of Permanent Impairment", fifth edition.

. . .

DIAGNOSIS:

- Cervical and lumbar sprain/strain, resolved.
- Left shoulder sprain/contusion, resolved.

IMPRESSION:

The claimant has no disability at this time. He is capable of working and performing all of his normal activities of daily living without any limitations. Although there is decreased range of motion, this is subjective."

The respective reports of Dr. Cohn provide:

"I have reviewed the cervical spine MRI on Julio Cesar Diaz. The examination consists of sagittal T1 and T2 and gradient echo axial images. The study was performed on 3/1/05 at Doshi Diagnostic and is diagnostic.

There is straightening of the normal cervical lordosis.

The C2-C3 and C3-C4 disc spaces are normal.

At the C2-C3 level, there is disc desiccation and disc space narrowing. There is a central disc herniation and bone spur effacing the ventral aspect of the thecal sac and resulting in moderate central canal stenosis. Hypertrophic degenerative changes of the uncovertebral joints are present.

At the C5-C6 level, there is disc desiccation and disc space narrowing. There is a central disc herniation and bone spur effacing the ventral aspect of the thecal sac. There are bilateral uncovertebral joint hypertrophic degenerative changes.

This is the commencement of degenerative disc disease. The association of disc desiccation with the disc herniation also indicates that the disc herniations are chronic in nature. Acute disc herniations normally occur in well-hydrated discs. It is the central, gelatinous portion of the disc, known as the nucleus pulposus which insinuates itself through a tear in the outer fibers to result in an acute disc herniation. Once this central, gelatinous portion dries up, the incidence of acute disc herniation rapidly diminishes. The more likely scenario is that this disc herniation occurred when the disc was healthy and well-hydrated, leading to the inevitable degeneration and desiccation of the disc.

Uncovertebral joint hypertrophic changes are present at the C4-C5, C5-C6 and C6-C7 levels as well. The uncovertebral joints represent articulations between adjacent vertebral bodies. These commonly enlarge in the setting of the degenerative process. This can contribute to central canal stenosis.

There is disc space narrowing at these three levels as well. This indicates that the disc has lost its normal internal architecture, allowing it to collapse upon itself.

There is faint signal abnormality within the spinal cord at the C6-C7 level. This likely represents edema and/or gliosis from chronic cord compression. When the cord is chronically compressed, there may be damage to the cord which can result in this appearance.

In my opinion, this patient does have disc herniations at the C4-C5, C5-C6

and C6-C7 levels. All three are associated within underlying degenerative changes indicating that they are chronic in nature. This has also contributed to abnormality of the underlying spinal cord. There is no evidence for an acute trauma-related injury on the submitted study.

At the C6-C7 levels, there is disc desiccation and disc space narrowing. There is a central disc herniation and bone spur which just touches the ventral aspect of the spinal cord. Bilateral uncovertebral joint hypertrophic degenerative changes are present. There is faint elevated signal intensity within the spinal cord on T2 weighted images, likely representing gloisis and/or edema from chronic cord compression.

The C7-T1 disc space is normal.

The marrow signal is normal.

IMPRESSION:

Straightening of the normal cervical lordosis.

C4-C5, C5-C6 central disc herniation and bone spur efface the ventral aspect of the thecal sac and contribute to central canal stenosis.

C6-C7 central disc herniation and bone spurs abuts the spinal cord.

DISCUSSION:

There is straightening of the normal cervical lordosis. This may reflect muscular spasm. Alternatively, this may be the result of positioning of the patient's neck within the cervical coil necessary to perform the examination.

There are disc herniations at the C4-C5, C5-C6 and C6-C7 levels. These are associated with bone spurs, also known as hypertrophic changes. The association of the disc herniation with bone spur indicates that is chronic in nature. Bone spurs represent actual bone formation which takes years to develop. Their presence, in association with the disc herniation, indicates that the disc herniation is chronic in nature.. Disc desiccation is present at these levels as well. Disc desiccation indicates that the disc has dried out and lost its normal water content."

"I have reviewed the lumbosacral spine MRI on Julio Cesar Diaz. The examination consists of sagittal and axial T1 and T2 weighted images. The study was performed on 3/5/05 at Doshi Diagnostic and is diagnostic.

The normal lumbar lordosis is maintained.

At the L1-L2 level, there is mild disc desiccation, disc space narrowing and disc bulging.

The L2-L3 disc space is normal.

At the L3-L4 level, there is very subtle disc desiccation and disc bulging.

At the L4-L5 level, there is subtle disc desiccation and disc bulging. There is mild posterior ligamentous hypertrophy. This contributes to mild central canal and mild bilateral neural foraminal stenosis.

At the L5-S1 level, there is disc desiccation and circumferential disc bulging. There is mild bilateral neural foraminal stenosis.

The marrow signal is normal. The conus is within normal limits.

IMPRESSION:

Multilevel degenerative disc disease.

DISCUSSION:

This patient has diffuse multilevel degenerative disc disease. There is evidence for disc desiccation at L1-L2, L3-L4, L4-L5 and L5-S1. Dis desiccation indicates that the disc has dried out and lost its normal water content. This is the commencement of degenerative disc disease.

There is disc bulging at L1-L2, L3-L4, L4-L5 and L5-S1 as well. Disc bulging is unrelated to trauma. Disc bulging occurs as the outer fibers of the disc, also known as the annulus fibrosis, lose their normal elasticity. This allows the central, more gelatinous portion of the disc to bulge circumferentially.

At the L4-L5 level, there is posterior ligamentous hypertrophy. The ligaments are supporting elements along the posterior aspect of the central canal. These may enlarge or hypertrophy in the setting of degenerative disc disease. This ligamentous hypertrophy, in conjunction with disc bulging, is contributing to narrowing of the central canal and the neural foramina at the L4-L5 level.

At the L5-S1 level, there is also mild narrowing of the neural foramina. This is due to the underlying disc bulging. There is no evidence of disc herniation at this level. A disc herination is delineated from a disc bulge in that a disc herniation is a focal abnormality. A disc herination would not result in narrowing of the neural foramina bilaterally whereas a disc bulge would do such.

In my opinion, this patient has diffuse multilevel degenerative disc disease. There is no evidence for disc herniation or acute trauma-related injury on the submitted examination."

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 requested relief, the plaintiff submits his own affidavit and an affirmation of David Khanan, MD, PHD, a treating physician of the plaintiff.

The Court initially observes that Dr. Khanan sets forth that the plaintiff was initially seen in January, 2005 and thereafter on October 22, 2009 with a four month physical therapy regime some time in 2005 to which there are no submitted records. Although Dr. Khanan opines that the plaintiff discontinued treatment due to the fact that he had "reached maximum medical improvement" there is no submission from the plaintiff that would refute the defendants' contentions as to the gap in treatment that the limitations are not related to the plaintiff's pre-existing disc condition as set forth by Dr. Cohen (see, **Pommells v Perez**, 4 NY3d 566, 797 NYS2d 380).

Based upon the foregoing, the defendants' application for an Order granting summary judgment to defendants, Jose E. Murillo and Jorge k. Cardoza and dismissing the Complaint of plaintiff, Julio Cesar Diaz on the ground that the injuries claimed do not satisfy the "serious injury" threshold requirement of New York Insurance Law §5102(d) and thus his claim for non-economic loss is barred by Section 5104(a) of the statute, is **granted**.

SO ORDERED.

DATED: 6/1/2010

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J.S.C.
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ENTERED
JUN 04 2010
NASSAU COUNTY
COUNTY CLERK'S OFFICE