

Jones v Burns

2010 NY Slip Op 31625(U)

June 25, 2010

Sup Ct, Nassau County

Docket Number: 19185/08

Judge: Ute W. Lally

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SHORT FORM ORDER

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SUPREME COURT - STATE OF NEW YORK
COUNTY OF NASSAU - PART 4

Present: HON. UTE WOLFF LALLY
Justice

THADDEUS JONES,

Plaintiff,

Motion Sequence #1
Submitted April 8, 2010

-against-

INDEX NO: 19185/08

PATRICIA BURNS and JOSEPH BURNS,

Defendants.

The following papers were read on this motion for summary judgment:

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| Notice of Motion and Affs..... | 1-6 |
| Affs in Opposition..... | 7-13 |
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| Memorandum of Law..... | 16-16a |

Upon the foregoing papers, it is ordered that this motion by defendants for an order pursuant to CPLR 3212 granting summary judgment in their favor dismissing the complaint on the grounds that plaintiff did not sustain a serious injury as defined by Insurance Law § 5102(d) and required by Insurance law § 5014(d), is denied.

This is an action to recover money damages for personal injuries allegedly sustained by plaintiff in a motor vehicle accident on June 26, 2006 at approximately 10:45 A.M. The accident occurred at the intersection of Brewster Street and Cottage Row in the City of Glen Cove, State of New York.

In his bill of particulars, plaintiff alleges that he sustained the following injuries:

L3-L4 herniation impinging upon left L3 nerve;
L4-L5 herniation impinging upon left L4 nerve;
L5-S1 herniation impinging upon right S1 nerve; root
and right L5 nerve root;
Radiculopathy L4;
Radiculopathy L5;
Radiculopathy S1; and
Right knee internal derangement/strain/sprain with
edema

As a proponent of the summary judgment motion, defendants had the initial burden of establishing that plaintiff did not sustain a causally related serious injury under the permanent consequential limitation of use, significant limitation of use, and 90/180-day categories. (See *Toure v Avis Rent A Car Sys.*, 98 NY2d 345, 352; *Wadford v Gruz*, 35 AD3d 416). 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. (*Browdame v Candura*, 25 AD3d 747, 78).

In support of their motion, defendants submit, *inter alia*, plaintiff's deposition testimony; two affirmed to medical reports of Lee M. Kupersmith, M.D., a Diplomate of the American Board of Orthopedic Surgery, dated October 13, 2009 and October 29, 2009, and an affirmed to medical report of Sheldon Feit, M.D., a Board Certified Radiologist, dated July 18, 2008.

In his revised affirmed report, Dr. Kupersmith states:

"Upon review of the additional medical record at this time most specifically my prior medical examination from 10/13/09, the MRI reviews from Dr. Feit and the notes from Dr. Restivo, my opinion has changed. During the examination of 10/13/09 the claimant was specifically questioned if he had any problems

before 6/26/06 with regard to his lower back. He denied ever having back problems before any injuries. The claimant's history he gave was inaccurate. According to the records reviewed from Dr. Restivo, most specifically from 5/17/06, the claimant had a long history of low back pain. He also had a motor vehicle accident on 5/8/05 where he fell asleep at the wheel. Additional records from Dr. Restivo indicate previous complaints of low back pain and radiculopathy prior to the motor vehicle accident. Due to the fact that the claimant had a long history of low back pain prior to the examination of 10/13/09, the claimant's history has changed. The claimant did sustain a lumbosacral sprain/strain that is resolved at the time of the motor vehicle accident. However, this is superimposed on a long history of low back pain and lumbosacral herniated nucleus pulposus and radiculopathy. The claimant's lumbosacral herniated nucleus pulposus and radiculopathy is pre-existing dating back to an MRI of 1/30/04, which showed degenerative changes with an associated right-sided disc herniation at L5-S1. These MRI findings were consistent with the MRI findings seen on 7/6/06 and the MRIs were unchanged. Due to the fact that the claimant had a history of lumbosacral herniated nucleus pulposus prior to the motor vehicle accident and radiculopathy, the claimant's diagnosis would be as changed. The claimant's diagnosis based on the independent medical examination of 10/13/09 would be a lumbosacral sprain/strain resolved superimposed on a pre-existing history of lumbosacral herniated nucleus pulposus and radiculopathy with prior history of long standing back pain."

In his affirmed medical report, Dr. Feit concludes as follows:

"Review of the lumbosacral spine MRI obtained ten days following the date of injury reveals pre-existing degenerative change. Disc bulges are not posttraumatic but are degenerative secondary to annular degeneration and/or ligamentous laxity. The associated right-sided herniation at L5-S1 is also degenerative as it is seen in association with disc bulge as well as osteophyte formation. These findings are, therefore, not posttraumatic and not related to the injury of 6/26/06."

Defendant has made a *prima facie* showing of entitlement to judgment as a matter of law by submitting the affirmed medical reports of Dr. Kupersmith and Dr. Feit.

The burden now shifts to plaintiff to demonstrate, by the submission of objective proof of the nature and degree of the injury, that he sustained a serious injury or that there are questions of fact as to whether the purported injury, in fact, is serious. (*Flores v Leslie*, 27 AD3d 220, 221).

In order to satisfy the statutory serious injury threshold, a plaintiff must have sustained an injury that is identifiable by objective proof; subjective complaints of pain do not qualify as serious injury within the meaning of Insurance Law § 5102(d). (See *Toure v Avis Rent a Car Sys., Inc.*, *supra*; *Scheer v Kioubek*, 70 NY2d 678, 679; *Munoz v Hollingsworth*, 18 AD3d 278, 279).

Plaintiff must come forth with objective evidence of extent of alleged physical limitation resulting from injury and its duration. That objective evidence must be based upon a recent examination of the plaintiff (*Cornelius v Cintas Corp.*, 50 AD3d 1085; *Moore v Edison*, 25 AD3d 672; *Sharma v Diaz*, 48 AD3d 442; *Amato v Fast Repair, Inc.*, 42 AD3d 477) and upon medical proof contemporaneous with the subject accident. (*Ferraro v Ridge Car Service*, 49 AD3d 498; *Manning v Tejada*, 38 AD3d 622); *Zinger v Zylberbeg*, 35 AD3d 851).

Even where there is medical proof, when contributory factors interrupt the chain of causation between the accident and the claimed injury- - such as a gap in treatment, an intervening medical problem or pre-existing condition - - summary dismissal of the complaint may be appropriate. (*Pommels v Perez*, 4 NY3d 566, 572). Whether 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 a body part. (*Dufel v Green*, 84 NY2d 795, 798).

“The mere existence of a bulging or herniated disc is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the disc injury” (*Catalano v Kopmann*, 73 AD3d 963; *Keith v Duval*, 71 AD3d 1093; *Casimir v Bailey*, 70 AD3d 994; *Ablano v Onolfo*, 36AD3d 728).

In opposition, plaintiff submits, *inter alia*, an affidavit of Stan Velkovich, plaintiff's treating chiropractor; an affirmed to medical report of Adam Silvers, a neuroradiologist; and an affirmation of Bradley Cohen, D.O.

In his affidavit, Dr. Stan Velkovich states, in pertinent part, that plaintiff “sustained significant injuries to his lower back, namely an exacerbation, activation and aggravation of the aforementioned disc herniations with encroachment upon the spinal cord and/or nerve roots.” Dr. Velkovich further concluded that plaintiff “was totally disabled from his employment from the date of accident, June 26, 2006, through August 7, 2006 at which time he returned to work on a part-time and restricted basis.”

In his affirmed to medical report, Dr. Silvers states as follows: “I reviewed an MRI scan of the lumbosacral spine performed at Next Generation Radiology on July 6, 2006. I also reviewed a prior MR study of the lumbosacral spine performed at ProHealth on January 30, 2004 and compared the 2 studies. The January 2004 MR study pre-dates the date of injury. The July 2006 study was performed approximately 10 days following the date of injury. I also received an independent radiology review performed by Dr. Sheldon Feit of these two studies.”

Dr. Silvers' impression consists of the following:

"There is a moderate-sized right sided disc herniation at the L5-S1 level as discussed above. This is similar in size as compared to prior MR study of January 2004.

There are left-sided disc herniations at the L3-L4 and L4-L5 levels. The left-sided disc herniation at the L3-L4 level has mildly increased in size as compared to the prior MR study.

Available for review is an independent radiology review dated July 18, 2008 performed by Dr. Sheldon Feit. I disagree with Dr. Feit's findings as Dr. Feit fails to recognize the left-sided disc herniation at the L3-L4 level and L4-L5 levels.

Based on my review of the two studies, the disc herniations at the L4-L5 and L5-S1 levels appear to represent chronic long-standing processes without significant change. However the left-sided disc herniation at the L3-L4 level did increase in size from the 2004 to the 2006 study. This exacerbation of a pre-existing disc herniation may be related to the trauma suffered by the patient shortly before the 2006 study. Based on the size of this disc herniation and its effect on the adjacent nerve root, the patient would be expected to have significant pain and neurologic deficit of indeterminate duration."

In his affirmation, Dr. Cohen concluded in pertinent part that "it is my competent expert medical opinion that the injuries, as diagnosed, are causally related to Mr. Jones' car accident of June 26, 2006. Mr. Jones will experience increased pain with carrying, lifting and bending activities. I believe that Mr. Jones will continue to suffer from pain and marked limitation for an indefinite period of time."

As to the gap in treatment, (November 17, 2006 - November 19, 2010), plaintiff has offered an explanation (see *Brown v Dunlop*, 4 NY3d 566). Plaintiff asserts that he stopped treating with Dr. Cohen because his no-fault company stopped paying for his treatments and he could not afford further treatment out-of-pocket.

On this record, an issue of fact exists as to whether plaintiff suffered an aggravation of a pre-existing degenerative condition which constitutes a serious injury. (See *Pfeiffer v New York Cent. Mut. Fire Ins. Co.*, 71 AD3d 971; *McKenzie v Redl*, 47 AD3d 775; *Cebularz v Diorio*, 32 AD3d 975).

Plaintiff, however, has not satisfied the 90/180 day category.

To sustain his burden under the 90/180 day category, plaintiff is required to submit objective evidence of a "medically determined injury or enforcement of a non-permanent nature which prevents the injured person from performing substantially all of the natural acts which constitute such person's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury." Insurance Law § 5102(d).

"When construing the statutory definition of a 90/180 day claim, the words 'substantially all' should be construed to mean that the person has been prevented from performing his usual activities to a great extent, rather than some slight curtailment." (*Thompson v Abbasi*, 15 AD3d 95; see also *Gaddy v Eyler*, 79 NY2d 955).

Plaintiff has not proffered competent medical evidence indicating he sustained an injury under the 90/180 day rule. (*Doyaga v Teleeba, Inc.*, 35 AD3d 798; *Felix v New York City Transit Authority*, 32 AD3d 527; *Sainte-Aime v Ho*, 274 AD2d 569). As noted above, plaintiff's treating chiropractor concluded that plaintiff was totally disabled from his employment from June 26, 2006 through August 7, 2006.

Plaintiff's employment record is also questionable. In his bill of particulars, plaintiff alleges that he was incapacitated from employment from June 26, 2006 through

September 14, 2006 (2½ months) and intermittently thereafter. At his examination before trial, plaintiff testified that he “was out of work like 90 days, close to 90 days.” At the IME, he stated that “he missed approximately four months of work after the accident.” In his affidavit, plaintiff avers that his “lower back pain caused him to miss work completely from June 26, 2006 through August 7, 2006 . . . and he returned to work on August 7, 2006 on a restricted, part-time basis until on or about August 21, 2006.”

In view of the foregoing, defendant’s motion for summary judgment is denied.

Dated: June 25, 2010



UTE WOLFF LALLY, J.S.C.

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ENTERED
JUN 30 2010

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