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Civil Court of the City of New York
County of Queens
Part 32

MARIE JANVIER,

Plaintiff,

-against-

ROSENDA TAVAREZ and
RAMON RODRIGUEZ,

Defendant.

Index Number 300048-QTS-2010
Motion Cal. #9 Motion Seq.#_____
Papers submitted to Special Term on 6/21/2010

DECISION/ORDER

Recitation, as required by CPLR §2219 (a), of the papers considered in the review of this Motion:

Papers	Numbered
Notice of Motion and Affidavits Annexed.....	1
Order to Show Cause and Affidavits Annexed.....	
Answering Affidavits.....	2
Replying Affidavits.....	3
Exhibits.....	
Other.....	

Defendants filed a motion for summary judgment seeking dismissal under Civil Practice Law and Rules(CPLR) §3212 on grounds that plaintiff failed to substantiate a claim of "serious injury" under Insurance Law §§5102 and 5104. Upon full review of all papers submitted, the defendant's motion is granted in its entirety.

Plaintiff brought suit for alleged injuries suffered in an August 23, 2007 vehicular accident at "Conduit Avenue, Atlantic Avenue and its intersection" in Queens, New York. In her bill of particulars, plaintiff alleged that as a result of defendants' negligence, she suffered the following injuries: disc bulging at the C6-7 level; cervical radiculopathy; disc bulges at L4-5 and L5-S1; lumbar radiculopathy; post concussion syndrome; contusion to the left leg; contusion to the left arm; contusion to the left shoulder; abrasions to the skin; and head trauma. Further, plaintiff alleged that defendants' negligence cause her to suffer "a significant and profound permanent-partial limitation of use and function of...joints in terms of recurring pain, stiffness, and/or discomfort...along with diminished, restricted and/or curtailed strength and flexibility range of motion..."

In their motion for summary judgment, defendants submitted the affirmed report of Stanley

Ross, M.D., who performed an independent orthopedic evaluation of the plaintiff on December 16, 2009; the affirmed report of Edward M. Weiland, M.D., who performed an independent neurological examination of the plaintiff on September 17, 2009; the affirmed cervical and lumbar spine magnetic resonance imaging (MRI) reviews of David A. Fisher, M.D. dated June 8, 2009; and the transcript of plaintiff's September 16, 2009 deposition.

Upon his independent orthopedic examination of the plaintiff, Dr. Ross' impression was: 1. Normal orthopedic examination of the cervical spine; 2. Normal orthopedic examination of the lumbar spine; and 3. Normal orthopedic examination of the left shoulder. Dr. Ross concluded in his report that there was "no evidence of a permanent orthopedic disability," and no restrictions to plaintiff performing activities of daily living.

In his examination of the plaintiff's cervical spine, he noted no muscle spasm at the paracervical muscles or at the trapezius bilaterally, and normal ranges of motion. Distraction and compression tests were negative for functional impairment and radicular pain symptoms, respectively. Plaintiff did have a complaint of mild tenderness upon palpation over the C4, C5, and C6 disc space levels bilaterally.

In his examination of plaintiff's lumbar spine, he found no muscle spasm upon palpation at the paralumbar muscles bilaterally, and full ranges of motion. Straight leg raising test was negative bilaterally for radiculopathy, and Fabere's test was negative for hip joint disease indication. The plaintiff did complain of mild tenderness upon palpation over the L3, L4 and L5 disc space levels bilaterally.

Upon the performance of a "detailed neurological examination," Dr. Weiland's impression was: 1. History of closed head trauma and subjective head disorder; 2. Cervical strain/sprain -

resolved; 2. Thoracic strain/sprain - resolved; 3. Lumbosacral strain/sprain - resolved; 4. Lumbosacral strain/sprain; and 5. Normal neurological examination. He concluded that he could "find no evidence of any lateralizing neurologic deficits at the present time" relating "to the incident date under review," and that "there is no finding of any neurologic permanency or residual based on the neurologic examination findings noted" during the examination. Dr. Weiland found full range of motion of the neck and shoulders; regarding the cervical spine, he found normal ranges of motion for flexion and extension, right and left lateral rotation, and right and left lateral flexion. For the lumbar spine, he found normal ranges of motion for flexion, extension and right and left lateral flexion. There was full range of motion for the thoracic spine.

In Dr. Fisher's review of the cervical spine MRI performed on September 12, 2007, he found degenerative changes at C5-6 and C6-7 consistent with a preexisting condition. His impression was mild degenerative changes, most pronounced at C5-6 and C6-7. In his review of the lumbar spine MRI conducted on November 20, 2007, he opined that apart from mild degeneration of the L5-S1 disc, the study was "unremarkable. He found no evidence of traumatic or causally-related injury to the lumbar spine. His impression was: 1. Mild disc dehydration at L5-S1; and 2. Otherwise unremarkable study.

Defendants submitted the deposition transcript of the plaintiff to support their argument that plaintiff failed to meet the requirement of being confined to be or home for at least 90 days out of 180 days post-accident or prevented performance of substantially all her usual and customary activities for that time period. Defendants contend that while plaintiff testified that she stayed in bed all day for a period of time immediately following the accident (*see* Janvier Dep. 46:7, Sept. 16, 2009), she failed to show that she was directed to do so by a medical professional. *(See Rennell v Horan,* 225 AD2d

939 [3rd Dept 1996], *Ramjohn v. Allstar Limousine Service, et al.,* 27 Misc3d 128[A] [2010]). The Court also notes that when asked whether her confinement to home was "a month, two months, three months...", plaintiff's answer was "more than a month" (Janvier Dep. 46:3-6). However, the statutorily-required time period in CPLR §5102(d) for a medically determined injury or impairment of a non-permanent nature preventing the performance of usual and customary activities to be deemed a "serious injury" is "not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or occurrence." Plaintiff's response failed to establish that any restriction in her usual and customary activities was "not less than ninety days."

The proponent of a motion for summary judgment must make a *prima facie* showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case *(Winegrad v New York University Medical Center,* 64 NY2d 851 [1985]). The court finds that the defendants have met their *prima facie* burden; consequently, plaintiff must demonstrate by evidence the existence of a factual issue requiring a trial of the action *(Zuckerman v City of New York,* 49 NY2d 557 [1980]).

In opposition to the defendants' motion, plaintiff offered the affidavit of merit of the plaintiff, the "medical affidavit" of William Ankobiah, M.D., and the physician's affirmations of Michael Green, M.D. and Mark Shapiro, M.D. In plaintiff's affidavit of merit, she attested to pain, discomfort and physical limitations, as well as to the treatment she received. However, plaintiff's self-serving affidavit is insufficient to demonstrate objective evidence of the extent an duration of the physical limitations resulting from the injury *(Thomas v. Weeks,* 61 AD3d 961 [2009]; *Luna v. Mann,* 58 AD3d 699 [2009]).

In his "medical affidavit" (titled an "affidavit" but in the form of an affirmation), Dr. Ankobiah, attests that he re-evaluated the plaintiff on April 21, 2010, after having examined her once before--on August 27, 2007, four (4) days after the accident. Upon his initial examination of the patient in 2007, he said he diagnosed the plaintiff as suffering from: disc bulging at the C6-7 level, cervical radiculopathy, disc bulge at L4-5 and L5-S1, lumbar radiculopathy, post concussion syndrome, contusion to the left leg, contusion to the left arm, contusion to the left shoulder, abrasions to the skin and head trauma. At the 2010 re-evaluation, Dr. Ankobiah performed range of motion tests of plaintiff's cervical and lumbar spine areas; the test results reflected limitations of motion. However, he did not indicate whether he used a goniometer to measure ranges of motion, or indeed, how he determined the measurements he cited. Further, the doctor conclusively states that plaintiff "was rendered disabled for over three (3) months following the accident as a direct result of the injuries sustained"; there was no objective evidence of disability for that time period. Also, Dr. Ankobiah's diagnoses, which include disc bulges at C6-7, L4-5 and L5-S1 levels and lumbar radiculopathy are not in and of themselves, proof of a serious injury. "The mere existence of a herniated disc, a bulging disc, or radiculopathy is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the injury and its duration" *(Keith v. Duval,* 71 AD3d 1093 [2d Dept 2010]; *see also Casimir v. Bailey,* 70 AD3d 994 [2d Dept 2010], *Patterson v. NY Alarm Response Corp.,* 45 AD3d 656 [2d Dept 2007]).

Additionally, the range of motion findings were almost two years after the accident; a such, they cannot be deemed contemporaneous findings revealing significant limitations. Consequently, Dr. Ankobiah's examination failed to raise a triable issue of fact as to whether plaintiff sustained a serious injury *(Mensah v. Badu,* 68 AD3d 945 [2d Dept 2009]). Lastly, the doctor's affidavit fails to

address defendant's doctors' findings, which contradict any evidence of a serious injury related to the accident.

The physician's affirmations of Drs. Michael D. Green and Mark D. Shapiro merely attest to the MRI results of the cervical spine and lumbar spine, respectively, evidencing bulging discs. Dr. Green's affirmation also indicates that the cervical spine MRI showed a 1-centimeter nodule on the left lobe of the plaintiff's thyroid gland. However, there is no claim in this case that such finding is related to the accident.

In addition to the deficiencies to the plaintiff's case cited herein in, she "failed to submit competent medical evidence that the injuries allegedly sustained by her in the subject accident rendered her unable to perform substantially all of her usual and customary daily activities for not less than 90 days of the first 180 days subsequent to the...accident"*(Bleszcz v. Hiscock,* 69 AD3d 890 [2dDept 2010]).

"We have repeatedly held that one opposing a motion for summary judgment must produce evidentiary proof in admissible form sufficient to require a trial of material questions of fact on which he rests his claim..." *(Zuckerman v. City of New York,* 49 NY2d 557, 562). The Court finds that plaintiff has failed to offer admissible evidence to rebut the defendants' *prima facie* by raising a triable issue of fact. Accordingly, the defendants' motion for summary judgment pursuant to CPLR §3212 is granted in its entirety.

Dated: July 7, 2010

_____/s/_____

HON. CHEREÉ A. BUGGS

Judge, Civil Court of the City of New York

County of Queens