

**Porter v Bajana**

2010 NY Slip Op 33899(U)

July 15, 2010

Supreme Court, Bronx County

Docket Number: 302815/08

Judge: Stanley B. Green

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L.W.

NEW YORK SUPREME COURT - COUNTY OF BRONX

IA-27

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF BRONX: IA-27

----- X  
FRANCES PORTER,

Plaintiff(s),

- against-

FRANKLIN BAJANA,

Defendant(s).

----- X

INDEX No.:302815/07

Present:  
HON. STANLEY GREEN  
J.S.C.

The following papers numbered 1 to 4 read on this motion.  
No. on the Calendar of March 15, 2010

	<u>PAPERS NUMBERED</u>
Notice of Motion -Exhibits and Affidavits Annexed.....	1
Answering Affidavit and Exhibits.....	3
Replying Affidavit and Exhibits.....	4
Sur-reply Affidavits and Exhibits.....	
Stipulation(s) - Referee's Report - Minutes.....	
Memoranda of Law.....	2

Upon the foregoing papers, this motion is decided in accordance with the attached memorandum decision.

Dated: July 15, 2010

  
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STANLEY GREEN, J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF BRONX: IA-27

-----X

FRANCES PORTER,

INDEX No.: 302815/08

Plaintiff(s),

- against-

FRANKLIN BAJANA,

Defendant(s).

DECISION

-----X

**HON. STANLEY GREEN:**

The motion by defendant for an order pursuant to CPLR §3212 granting summary judgment dismissing the complaint on the ground that plaintiff did not sustain a serious injury within the meaning of Insurance Law §5102(d) is granted to the extent that plaintiff's claims that she sustained a permanent consequential limitation and a significant limitation of use of her cervical spine and lumbar spine are dismissed.

Plaintiff, who was employed as a school bus matron, commenced this action to recover damages for personal injuries she sustained on July 25, 2006, when the school bus she was riding in was involved in an accident with defendant's vehicle.

After the accident, plaintiff was taken to Montefiore Hospital with complaints of headache, neck and back pain. She was treated in the emergency room and released. A few days later, plaintiff sought treatment at the office of Dr. Cabatu, who had previously treated her for a work-related injury to her left foot. Dr. Cabatu referred plaintiff for x-rays and MRI's and prescribed a course of physical therapy, which plaintiff underwent for approximately 2 ½ years.

Plaintiff alleges that as a result of the accident she sustained soft tissue injuries, including: (1)straightening of the cervical and lumbosacral curvature; (2) disc herniations at L2-

3, L3-4, L4-5 and L5-S1 with flattening of the ventral thecal sac at L3-4 and L4-5; (3) disc bulge at C2-3; (4) posterior disc herniations at C3-4, C4-5, C5-6 and C6-7 with ventral CSF impression and canal stenosis; and (5) left ventral cord impression at C5-6 and C6-7. She also alleges that she was confined to bed and home for approximately four months and incapacitated from her employment for approximately six months.

Plaintiff alleges that she sustained a serious injury as defined in Insurance Law §5201(d) in that she suffered a permanent consequential limitation of use of a body organ or member, a significant limitation of use of a body function or system and/or a medically determined injury or impairment of a non-permanent nature which prevented her from performing substantially all of the material acts which constituted her usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the accident.

Defendant seeks dismissal of the complaint on the ground that physical examinations by a board certified neurologist and orthopedist revealed no objective evidence of accident-related injuries or disabilities and plaintiff's testimony that she was confined to home for approximately 2 ½ to four months is not supported by any proof of a medical directive indicating that she had to stay home and could not return to work.

In support of the motion, defendant submits: (1) the report of Dr. Katz, an orthopedist who examined plaintiff on October 14, 2009; (2) the affirmed report of Dr. Weiland, a neurologist who examined plaintiff on September 9, 2009; (3) the affirmed reports of Dr. Tantleff, who reviewed the MRI films of plaintiff's cervical spine and lumbar spine conducted on September 9, 2006; and (4) a transcript of plaintiff's deposition testimony.

Initially, it is noted that Dr. Katz' report is missing an affirmation and signature.

Therefore, it is not in admissible form and is not considered (Friends of Animals v. Associated Fur Mfrs., 46 NY2d 1065).

Dr. Weiland's affirmed report shows that his examination of plaintiff on September 9, 2009 revealed that she had full range of motion of her cervical spine, lumbar spine and shoulder, (which he quantifies and compares to normal) and negative findings on the Laseque's Maneuver, Fabere-Patrick Sign, Adson's Maneuver, Soto-Hall Sign and Kempf's Test. Dr. Weiland opined that no further neurological studies or treatment is necessary and that plaintiff was capable of performing activities of daily living and gainful employment without restriction.

Dr. Tantleff's affirmed reports show that he reviewed the MRI of plaintiff's cervical spine and lumbar spine performed on 9/28/06. It is his opinion that the MRI of plaintiff's cervical spine revealed diffuse, advanced discogenic changes of the cervical spine, including degenerative disc bulges at C4-5, C5-6 and left parasagittal degenerative disc herniation at C6-7, consistent with plaintiff's age and unrelated to the date of the accident. His report also shows that there was no evidence of acute or recent injury.

Dr. Tantleff's review of the MRI of plaintiff's lumbar spine revealed regional discogenic changes throughout the lumbar spine with disc desiccation, degeneration and variable loss of height and spondylitic spurring most pronounced at L3-4 through L5-S1. He opined that these findings are unrelated to the date of the accident and that there is no evidence of acute or recent injury. Dr. Tantleff also noted an underlying congenital transitional lumbosacral junction and that plaintiff had "an increased body habitus which is a comorbidity for the development of degenerative disc disease."

Plaintiff's deposition testimony shows that after the accident, she remained at home for

approximately "2 ½ to 4 months," except for doctor visits and that she remained home from work for approximately six months.

Plaintiff contends that the evidence presented is insufficient to establish defendant's entitlement to summary judgment because: (1) Dr. Katz' report is incomplete and cannot be considered; (2) the range of motion measurements in the reports of Dr. Katz and Dr. Weiland which differ as to the normal range of motion for cervical flexion and extension, raise triable issues of fact as to whether plaintiff had normal range of motion; (3) if Dr. Katz' numbers are used, then Dr. Weiland's report shows plaintiff had limitation of motion more than three years after the accident, indicating permanence; (4) neither Dr. Katz nor Dr. Weiland reviewed plaintiff's medical records; (5) Dr. Tantleff's report is not dispositive because he never examined plaintiff or took a medical history; and (6) it is immaterial whether plaintiff was confined to bed or home for at least 90/180 days because her testimony shows that she was confined to home for 2.5 to 4 months after the accident, going out to see doctors only and that she was unable to cook, clean, shop or do laundry without assistance. Insofar as defendant contend that there is no evidence of a medical directive to stay home from work, plaintiff was never asked this question at her deposition, but her treating doctors did tell her to rest and take it easy, as indicated in Dr. Jacobson's affirmation and she was out of work for six months after the accident, which she contends satisfies the "threshold that she was unable to perform substantially all of her normal daily activities during the 90 days out of the first 180 days following the accident."

In opposition to the motion, plaintiff submits: (1) the affirmation of Dr. Jacobson, a Physical Medicine and Rehabilitation specialist who first treated plaintiff in January 2009; (2) an affidavit by plaintiff; and (3) a certified copy of Dr. Cabatu's records of treatment of plaintiff

following the accident.

Dr. Jacobson's affirmation shows that he first examined plaintiff in January 2009, after she was referred to him by Dr. Cabatu. Dr. Jacobson states that his report is based upon his review of plaintiff's medical records maintained by his facility, that were received from Dr. Cabatu. Dr. Jacobson certifies that the records are true and accurate copies of the medical records. According to Dr. Jacobson, Dr. Cabatu first treated plaintiff on July 28, 2006 and at that time, he noted limitations of motion in plaintiff's cervical spine and lumbar spine. Dr. Cabatu did not compare his findings to the normal range of motion. Thus, Dr. Jacobson created a chart comparing Dr. Cabatu's findings to "the normal ranges of motion" with associated percentages of loss of use. Dr. Jacobson reports that plaintiff was referred for MRI testing and was started on a course of physical therapy, which she received for approximately 2 ½ years. He also noted that the MRI tests revealed bulging and herniated discs in plaintiff's neck and back, which he opines are causally related to the accident of July 25, 2006.

Dr. Jacobson states that he first examined plaintiff in January 2009 and that as part of his examination, he performed range of motion testing. However, he does not indicate the date of the examination or the results of his range of motion testing at that time. He recommended that plaintiff undergo a series of injections to reduce the inflammation in her lumbar spine, but she declined to do so.

Dr. Jacobson states that he examined plaintiff on February 8, 2010 for an updated assessment. At that time, range of motion testing revealed that plaintiff's range of motion was 45 degrees (80 degrees is normal) on right cervical rotation and 40 degrees (90 degrees is normal) on lumbar flexion. Dr. Jacobson opines that: (1) these limitations are permanent in nature; (2)

the injuries sustained are causally related to the accident of July 25, 2006; (3) any further treatment plaintiff receives will be only palliative in nature; and (4) that she has sustained a permanent consequential and significant limitation of use of her cervical spine and lumbar spine as a result of the accident.

Plaintiff's affidavit shows that at the time of the accident she was a passenger in a vehicle operated by a co-worker. Plaintiff states that she began treating with Dr. Cabatu and has continued treatment with his office since the accident, "with the exception of perhaps a few months when her medical coverage was suspended by Worker's Compensation." Plaintiff claims that the injuries she sustained "negatively affected" her activities of daily living, that she was unable to perform cook, clean, do laundry or shop as she had prior to the accident and had to have her children assist her and she missed approximately six months from work.

While plaintiff's medical records are certified as true copies, they are unsworn and cannot be considered in opposition to the motion (Grasso v. Angerami, 79 NY2d 813; Black v. Regalado, 36 AD3d 437; Hernandez v. Ramirez, 19 AD3d 192).

The legislative intent underlying the No-Fault Law was to weed out frivolous claims and limit recovery to significant injuries (Dufel v. Green, 84 NY2d 795; Toure v. Avis Rent A Car Sys., 98 NY2d 345). Thus, objective proof of a plaintiff's injury is required in order to satisfy the statutory serious injury threshold (*Id.*). Subjective complaints alone are not sufficient (Scheer v. Koubek, 70 NY2d 678).

An expert's qualitative or quantitative assessment of a plaintiff's condition can be used to substantiate a claim of serious injury, provided that the testing method is objective and compares the plaintiff's limitations to normal function and an expert's opinion that is supported by medical

findings creates a factual issue for the jury that is available to be tested on cross-examination (Toure v. Avis Rent A Car Systems, Inc. 98 NY2d 345). However, proof of a bulging or herniated disc, without additional objective medical evidence establishing that the accident resulted in significant physical limitations, is not alone sufficient to establish a serious injury (Id).

Where there is persuasive evidence that a plaintiff's alleged pain and injuries were related to a pre-existing condition, plaintiff has the burden of coming forward with evidence addressing defendants' claimed lack of causation (Franchini v. Palmieri, 1 NY3d at 537).

As the proponent of this motion for summary judgment, it is defendant's burden to demonstrate, prima facie, that he is entitled to judgment as a matter of law with evidence sufficient to eliminate any material issue of fact; failure to do so requires denial of the motion regardless of the sufficiency of the opposing papers (Alvarez v. Prospect Hosp., 68 NY2d 320; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851). The burden then shifts to the party opposing the motion to demonstrate by evidentiary proof in admissible form that a triable issue of fact exists (Zuckerman v. City of New York, 49 NY2d 557). A court's task is issue finding rather than issue determination (Sillman v. Twentieth Century-Fox Film Corp., 3 NY2d 395) and the court must view the evidence in the light most favorable to the party opposing the motion, giving that party the benefit of every reasonable inference and ascertaining whether there exists any triable issue of fact (Boyce v. Vazquez, 249 AD2d 724).

Here, the affirmed report of Dr. Weiland, which describes the tests he used in his examination of plaintiff which revealed full range of motion and no disability or permanency, coupled with the affirmed reports of Dr. Tantleff's, which shows that the MRI's of plaintiff's cervical and lumbar spine revealed pre-existing degenerative conditions throughout plaintiff's

cervical spine and lumbar spine, as well as a congenital condition and no evidence of recent injury or trauma, are sufficient to establish, prima facie, that plaintiff did not sustain a permanent consequential limitation or a significant limitation of use of her cervical spine and lumbar spine as a result of the subject accident. The fact that neither Dr. Weiland or Dr. Tantleff reviewed plaintiff's medical records does not require denial of defendant's motion (DeJesus v. Paulino, 61 AD3d 605). Nor does the conflict between Dr. Katz' and Dr. Weiland's range of motion findings require denial of the motion, since Dr. Tantleff's reports establish that plaintiff's alleged injuries are due to a pre-existing condition (Depena v. Sylia, 63 AD3d 504).

Thus, the burden shifted to plaintiff to present competent evidence sufficient to raise a material issue of fact. She has failed to meet this burden.

Plaintiff's certified, but unsworn, medical records lack probative value and are insufficient to raise a triable issue of fact to defeat defendant's motion (Black v. Regalado, 36 AD3d 437; Hernandez v. Ramirez, 19 AD3d 192).

While plaintiff has also submitted the affirmation of Dr. Jacobson, his affirmation is insufficient to raise a material issue of fact as to whether plaintiff sustained a serious injury because: (1) his conclusions are based, in part, upon unsworn medical records and reports of MRI's that he did not review (Wagman v. Bradshaw, 292 AD2d 84; Graham v. Shuttle Bay, Inc., 281 AD2d 372); (2) to the extent that his opinion is based upon his own examination and treatment of plaintiff, it is too remote to raise an inference that plaintiff's purported limitations are causally related to the accident (Pou v. E&S Wholesale Meats, Inc., 68 AD3d 446; Reyes v. Esquillin, 54 AD3d 61); and (3) he fails to rebut defendant's evidence that plaintiff suffers from pre-existing degenerative disc disease throughout her cervical and lumbar spine (Valentin v

Pomilla, 59 AD3d 184).

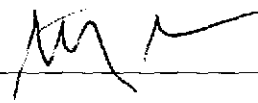
With respect to plaintiff's claim that she sustained a serious injury under the 90/180 day category, in support of the motion defendant contends that plaintiff's deposition testimony, that she was confined to her home for 2 ½ to 4 months, without proof of a medical directive stating that she had to stay home and could not work, does not satisfy the 90/180 day requirement. However, as the proponent of the motion, it is defendant's burden to present competent evidence to show that plaintiff did not sustain a serious injury under this category. While defendant contends that there is no evidence that plaintiff was directed to stay home or that she was unable to work, he offers no medical records or other evidence to show that she was able to return to work or was not substantially disabled from performing her usual activities (cf. Amamedi v. Archibala, 70 AD3d 449; Uddin v. Cooper, 32 AD3d 270).

While the fact that a plaintiff is out of work for more than ninety days is not, alone, determinative of this claim (Ortiz v. Ash, Leasing, Inc., 63 AD3d 556), in this case plaintiff was injured while in the course of her employment and testified that she was out of work for six months and that she was seen by a workers compensation doctor. Under these circumstances, it was incumbent on defendant to offer more than plaintiff's deposition testimony to establish prima facie entitlement to summary judgment dismissing plaintiff's 90/180 day claim.

Accordingly, defendant's motion is granted only to the extent that plaintiff's claims under the permanent consequential and significant limitation categories are dismissed.

This constitutes the decision and order of the court.

Dated: July 15, 2010



STANLEY GREEN, J.S.C.