Figueroa v Calhoun
2011 NY Slip Op 30248(U)
January 27, 2011
Supreme Court, Suffolk County
Docket Number: 12078/2008
Judge: William B. Rebolini
Republished from New York State Unified Court System's E-Courts Service. Search E-Courts (http://www.nycourts.gov/ecourts) for any additional information on this case.
This opinion is uncorrected and not selected for official publication.

[* 1]

COPY

Short Form Order

SUPREME COURT - STATE OF NEW YORK

I.A.S. PART 7 - SUFFOLK COUNTY

PRESENT:

WILLIAM B. REBOLINI
Justice

Ricardo Figueroa and Jeannette Figueroa,

Plaintiffs,

-against-

John Joseph Calhoun,

Defendant.

Motion Sequence No.: 001; MD
Motion Date: 9/23/10
Submitted: 12/29/10

Index No.: 12078/2008

Attorney for Plaintiff:

Tinari, O'Connell, Osborn & Kaufman
320 Carleton Avenue, Suite 6800
Central Islip, New York 11722

Attorney for Defendant:

Frankini & Grammatico
45 Crossways Park Drive
Woodbury, New York 11797

Clerk of the Court

Upon the following papers numbered 1 to 8 read upon this motion for summary judgment: Notice of Motion and supporting papers, 1 - 8.

The instant action arises from a motor vehicle accident which occurred on December 31, 2006 at the intersection of County Road 83 and Long Island Avenue in the Town of Brookhaven, New York. The accident allegedly occurred when a vehicle owned and operated by the defendant collided with a vehicle operated plaintiff Ricardo Figueroa (hereinafter the plaintiff). The plaintiff alleges that he sustained serious and permanent injuries as a result of the defendant's negligence in causing the accident. A derivative cause of action is alleged on behalf of the plaintiff's wife, Jeanette Figueroa.

By way of the bill of particulars, the plaintiff alleges that he sustained injuries including, *inter alia*, C2/3 disc bulge; C3/4 and C6/7 disc herniations; aggravation and exacerbation of disc herniations at C4/5 and C5/6; straightening of the cervical lordosis; cervical sprain/strain; cervical

radiculitis; L2/3 and L3/4 posterior disc bulges; L4/5 posterior disc herniation; aggravation and exacerbation of herniated disc at L5/S1; lumbar sprain/strain; lumbar radiculitis; T7/8 posterior disc herniation; thoracicsprain/strain; thoracic radiculitis; concussion; post-concussion syndrome; contusion of the abdomen; injury to left wrist; and injury to left hand. The plaintiff alleges that, as a result of the injuries he sustained in the accident, he received emergency room treatment, was substantially confined to bed from December 31, 2006 to January 30, 2007, was substantially confined to home from December 31, 2006 to present, was totally disabled from December 31, 2006 through March 31, 2007 and remains partially disabled to date. By way of the supplemental bill of particulars, the plaintiff further alleges that as a result of the accident he was treated at Stony Brook University Hospital on August 30, 2007 and September 10, 2007, treated at and confined to Southside Hospital from September 24, 2007 through October 1, 2007, had a lumbar selective nerve block administered to L4/5 and L5/S1 on September 26, 2007, and had a cervical epidural steroid injection administered to C6/7 on September 28, 2007. The bill of particulars alleges that the injuries sustained by the plaintiff were serious within the meaning of the Insurance Law in that he sustained a permanent loss of use of a body organ, member, function or system; a permanent consequential limitation of use of a body organ, member, function or system; 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 an injury which prevented him from performing substantially all of the material acts which constituted his usual and customary daily activities for more than 90 days of the first 180 days immediately following the accident.

The defendant now moves for summary judgment dismissing the complaint on the grounds that the plaintiff did not sustain a "serious injury" as defined by Insurance Law Section § 5102 (d).

A "serious injury" is defined as a personal injury which "results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, 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 constitutes 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" (Insurance Law § 5102[d]). The Court of Appeals has held that the issue of whether a claimed injury falls within the statutory definition of a "serious injury" is a question of law for the courts in the first instance, which may properly be decided on a motion for summary judgment (see, Licari v. Elliott, 57 NY2d 230 [1982]; Charley v. Goss, 54 AD3d 569 [1st Dept 2008] *affd* 12 NY3d 750 [2009]).

A defendant moving for summary judgment on the issue of whether the plaintiff sustained a serious injury has the initial burden of making a *prima facie* showing that the injured plaintiff did not sustain a "serious injury" within the meaning of Insurance Law § 5102 (d) (see, Alvarez v. Prospect Hosp., 68 NY2d 320 [1986]; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851 [1985]; Zuckerman v. City of New York, 49 NY2d 557 [1980]; Pagano v. Kingsbury, 182 AD2d 268 [2nd

Dept., 1992]). A defendant can establish that the plaintiff's injuries are not serious within the meaning of Insurance Law § 5102 (d) by submitting the affidavits or affirmations of medical experts who examined the plaintiff and conclude that no objective medical findings support the plaintiff's claim (see, Grossman v. Wright, 268 AD2d 79 [2nd Dept., 2000]). Failure to make such *prima facie* showing requires a denial of the motion, regardless of the sufficiency of the opposing papers (see, Alvarez v. Prospect Hosp., 68 NY2d 320 [1986]; Winegrad v. New York Univ. Med. Ctr., 64 NY2d 851 [1985]).

In support of the motion, the defendant submits, *inter alia*, the plaintiff's medical records with neurologist Steven A. Rosen, M.D. including numerous evaluation reports, the independent radiology review reports of A. Robert Tantleff, M.D. and the plaintiff's deposition testimony.

As is relevant to the instant motion, Dr. Rosen's evaluation reports indicate that he treated and evaluated the plaintiff from September of 1991 with respect to a work-related injury and that the plaintiff suffered chronic neck and low back pain throughout that time. Following the subject accident, Dr. Rosen continued to treat the plaintiff. On his first visit following the subject accident, February 26, 2007, Dr. Rosen noted that the plaintiff had increased neck and back pain and headaches. In addition he noted that the plaintiff was also complaining of middle back pain, that he was sore all over and that he had pain radiating down his extremities. He noted that his increased symptoms resulted in increased use of his lumbar brace, increased use of a TENS unit and an increased number of visits to the chiropractor. Dr. Rosen noted that MRI imaging was performed on the plaintiff's cervical, thoracic and lumbar spine which revealed degenerative bulging disc disease with herniation. He stated that in comparison to the 1993 MRI studies performed on the plaintiff's cervical and lumbar spine there was significant change.

On April 11, 2007, Dr. Rosen's evaluation report indicates that the plaintiff continued to complain of low back pain and right-sided neck pain. He noted that the plaintiff underwent an EMG study which showed active right S1 radiculopathy. He reported that a musculoskeletal exam revealed moderate spasm and restricted mobility in the entire length of the plaintiff's back from his neck down to his tail bone. Dr. Rosen's impression was chronic and low back pain; cervical, thoracic and lumbar myofascial pain with spasm; active right S1 radiculopathy; and previous diagnoses of degenerative bulging and herniated disc disease at the cervical, thoracic and lumbar spine. He concludes that given the exacerbations of his underlying condition following the subject accident, the plaintiff is an excellent candidate for chronic pain management, including possible epidural steroid injections.

On August 31, 2007, Dr. Rosen continued to list the patient's evaluation status as disabled. He noted that the plaintiff was very upset and crying because of pain and the frustrating nature of his conditions. He found the plaintiff was suffering chronic pain with respect to his back, neck, and now left knee. With respect to his neck and back, Dr. Rosen found the treatment options were limited and that chronic pain management may be a reasonable alternative.

Dr. Tantleff performed an independent radiology review of an MRI performed on the plaintiff's lumbar spine on February 8, 1992 and an MRI performed on the plaintiff's cervical spine dated December 12, 1993. Dr. Tantleff avers that the lumbar spine MRI reveals a pre-existing acute disc herniation at L5/S1. Dr. Tantleff avers that the cervical spine MRI reveals chronic degenerative discogenic changes and cervical spondylosis with regional facet arthropathy and a focal degenerative disc protrusion at C3/4 and disc herniatons at C4/5 and C5/6. He notes that the findings on both MRIs pre-existed the date of the subject accident by approximately fifteen years.

As is relevant to the instant motion, the plaintiff testified, *inter alia*, that he has been on social security disability since 1992 because of a work-related injury which occurred in 1991. He injured his back and neck in the work-related accident and his back pain never improved. He treated with several physicians continuously for his neck and back injuries for the work-related accident and was still actively treating with those physicians at the time of the subject accident. He wore a back brace and used a cane. Following the subject accident, he was taken to Brookhaven Hospital by ambulance. He could not move his neck, had pain in his neck, had pain in his entire back especially his lower back and mid back and had pain in his left hand. He was treated and released. The following day he went to his family doctor and complained about pain in his back, neck and hand and that he was sore and achy all over his body. He testified that his injuries were different and greater as a result of the subject accident. His neck and back both got worse. He also has injuries to three more discs and injuries in his mid-back. Following the subject accident, Dr. Rosen sent him for an EKG and MRIs of his back and neck. Dr. Rosen told him that the MRI revealed injury to his center back which he never had before, injury to two or three disks in the neck which he never had before and additional injury to his lower back. As a result of the injuries he sustained in the subject accident and the severe pain he suffered he was, for the first time, referred to a pain management specialist. He was hospitalized and given an epidural to his neck in January of 2007. From September 24, 2007 through October 1, 2007 he was admitted to Southside Hospital and treated with Morphine. He was also diagnosed with fibromyalgia at that time. He was given epidural injections to his neck and cortisone injections to his lower back. The plaintiff was, thereafter, treated at Stony Brook Hospital for approximately ten or twelve days. The plaintiff testified that as a result of the injuries he sustained in the accident that the pain is greater than the pain he suffered before and is unbearable. The spasms in his neck and back have gotten worse. As a result of the accident, he has not had sexual relations with his wife for over a year. Following the accident, he tried to commit suicide. Before the accident he was classified with Social Security as totally partially disabled and now he is classified as permanently disabled. He admits, however, that he does not know if his new classification was attributable to the injuries he sustained in the accident.

The evidence submitted fails to demonstrate the defendant's *prima facie* entitlement to summary judgment on the grounds that the plaintiff did not sustain a "serious" injury as a result of the subject accident (see, Toure v. Avis Rent a Car Sys., 98 NY2d 345 [2002]; Gaddy v. Eyler, 79 NY2d 955 [1992]. The defendant failed to meet his initial burden of establishing that all of the injuries alleged to have been sustained in the subject accident were pre-existing (see, Schreiber v. Krehbiel, 64 AD3d 1244 [4th Dept., 2009]; see also, Menezes v. Khan, 67 AD3d 654 [2nd Dept., 2009]; Sajid v. Murzin, 52 AD3d 493 [2nd Dept., 2008]; Joseph v. Hampton, 48 AD3d 638 [2nd

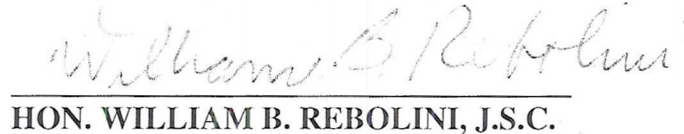
Dept., 2008]). Moreover, the defendant failed to negate the existence of a triable issue of fact as to whether the plaintiff's injuries from his prior work-related accident were exacerbated by the subject accident (see, Colavito v. Steyer, 65 AD3d 735 [3rd Dept., 2009]; Carr v. Macaluso, 64 AD3d 741 [2nd Dept., 2009]; Scarano v. Wehrens, 46 AD3d 797 [2nd Dept., 2007]; Gentile v. Snook, 20 AD3d 389 [2nd Dept., 2005]).

Inasmuch as the evidence submitted by the defendants failed to establish their *prima facie* entitlement to judgment as a matter of law, it is unnecessary to consider whether the plaintiffs' opposition papers were sufficient to raise a triable issue of fact (see, Nembhard v. Delatorre, 16 AD3d 390 [2nd Dept., 2005]; McDowall v. Abreu, 11 AD3d 590 [2nd Dept., 2004]; Coscia v. 938 Trading Corp., 283 AD2d 538 [2nd Dept., 2001]).

Accordingly, it is

ORDERED that the motion by the defendant for summary judgment dismissing the complaint is denied.

Dated: January 27, 2011



HON. WILLIAM B. REBOLINI, J.S.C.

______ FINAL DISPOSITION ___X___ NON-FINAL DISPOSITION