

**Valdez v Benjamin**

2011 NY Slip Op 34034(U)

June 15, 2011

Sup Ct, Bronx County

Docket Number: 301239/10

Judge: Howard H. Sherman

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627-11

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF THE BRONX

-----x  
ANTHONY VALDEZ,

Plaintiff,

-against-

NORRIS BENJAMIN,

Defendant.  
-----x

Index No.: 301239/10

**DECISION/ORDER**

Present:

Hon. Howard H. Sherman  
Justice

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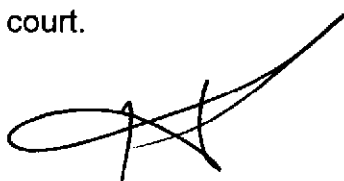
The following papers numbered 1 to 4 read on this motion for summary judgment defendant on January 18, 2011 and duly submitted on the Motion Calendar of February 25, 2011.

	<u>PAPERS NUMBERED</u>	
Notice of Motion - Exhibits A - H and Affidavits Annexed	1	
Answering Affidavit and Exhibits A - C	2	
Replying Affidavit and Exhibits	3	
Sur Reply	4	

Upon the foregoing papers this motion by defendant for an order awarding summary judgment dismissing the complaint on the grounds that plaintiff did not sustain a serious injury is decided in accordance with the accompanying decision/order filed herewith.

This constitutes the decision and order of this court.

Dated: June 15, 2011  
Bronx, New York

  
\_\_\_\_\_  
Hon. Howard H. Sherman  
J.S.C.

SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF THE BRONX

-----x  
ANTHONY VALDEZ,

Plaintiff,

-against-

NORRIS BENJAMIN,

Defendant.  
-----x

Index No.: 301239/10

**DECISION/ORDER**

Present:

Hon. Howard H. Sherman  
Justice

Plaintiff seeks recovery for injuries allegedly sustained in a motor vehicle accident that occurred on January 29, 2009 in Queens County.

This action was commenced in December 2009 and issue was joined with the service of defendant's answer in February 2010.

To date no Note of Issue has been filed.

Motion

Defendants move for an award of summary judgment dismissing the complaint on the grounds that plaintiff did not sustain a serious injury as defined by Insurance Law § 5102(d) as a result of the 1/29/09 motor vehicle accident. The motion is supported by a copy of plaintiff's testimony at a 6/23/10 examination before trial (Exhibit G) as well as the affirmed reports of independent medical evaluations (Exhibits D, E, F).

Verified Bill of Particulars

Plaintiff alleges that he sustained the following permanent injuries in the subject motor vehicle accident: tear fo the posterior horn of the meniscus of the right knee and instability and partial loss of use of function of "the right lower extremity"; posterior disc herniation at the C4 - 5 level, and bulging at L5 - S1 [Verified Bill of Particulars ¶ 5].

Plaintiff also alleges that he was confined to bed/home for four 94) months after the accident [Id. ¶ 7]. No loss of earnings claim is interposed.

Independent Medical Evaluations

On November 11, 2010, plaintiff presented for an orthopedic examination conducted by Michael J. Katz, M.D. with complaints of pain on the right side of his neck when turning.<sup>1</sup>

For purposes of his evaluation, Dr. Katz reviewed reports of plaintiff's treatment for the period 1/30/09 - 7/23/09 including physicians' and physical therapy reports and reports of x-rays performed during the hospital's emergency treatment and MRI studies conducted in February/March 2009.

Upon examination, Dr. Katz found full ranges of motion of the cervical and lumbar spine as quantified and compared to normal readings.<sup>2</sup> Adson's test was found to be negative as were Babinski and Patrick's test. Straight leg raising test was also negative.

Examination of the right knee revealed normal valgus attitude in the standing position and no swelling or effusion observed about the knee. Range of motion was normal as quantified in the flexion/extension arc. The knee was found to be stable to varus and valgus stress and there was a negative pivot shift test as well as a negative posterior drawer sign.

Dr. Katz' concluding diagnosis was of cervical and lumbosacral strain and right knee contusion, all resolved.

Dr. Katz concluded that his examination revealed "no signs or symptoms of permanence relative to the musculoskeletal system and relative to 1/29/09."

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<sup>1</sup>Exhibit D.

<sup>2</sup>The R.D.M. findings were determined with use of a goniometer.

On November 11, 2010 plaintiff also presented to Maria Audrie DeJesus, M. D. For an independent neurological examination.<sup>3</sup>

For purposes of her evaluation, Dr. DeJesus reviewed the reports of plaintiff's treating physicians and of the MRI studies.

Upon examination, Dr. DeJesus performed range of motion testing of the neck and lumbar spine with the use of a goniometer according to the AMA Guidelines 5<sup>th</sup> Edition. There was full range of motion in both areas as quantified and compared to normal readings. There was pain noted only on cervical right rotation, but no spasm nor tenderness was observed. There was no spasm palpated on the lumbar spine, and Patrick's and Kernig's tests were negative. Bilateral straight leg raising was normal at 90 degrees.

Muscle tone, reflexes, sensory and gait and coordination, were all found to be normal upon testing.

Dr. DeJesus concluded that the examination revealed no objective evidence of any disability.

Dr. David A. Fisher conducted radiological reviews of MRI studies of plaintiff's cervical and lumbar spine and right knee conducted on 1/29/09.<sup>4</sup>

Dr. Fisher's review of the MRI study of the cervical spine revealed findings of evidence of degenerative changes<sup>5</sup> throughout the cervical spine "highly unlikely to have developed in the short interval between the accident and the study and in [his] opinion

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<sup>3</sup>Exhibit F.

<sup>4</sup>Exhibit F.

<sup>5</sup> Plaintiff was born on 6/22/60.

represent a preexisting condition." Dr. Fisher found no disc herniation and concluded that the study revealed "no radiographic evidence of recent traumatic or causally related injury to the cervical spine."

Dr. Fisher found that the lumbar spine MRI also revealed evidence of preexisting degenerative changes at the L5/S1 level. He found no evidence of disc herniation but a "mild disc bulge noted at L5/S1, compatible with the amount of degenerative change present." Finally, Dr. Fisher concluded that the MRI study revealed no evidence of recent traumatic or causally related injury to the lumbar spine."

Dr. Fisher found that the MRI study of plaintiff's right knee was a "normal study" without meniscal or ligament tear. He also found no radiographic evidence of traumatic or causally related injury to the right knee.

#### Deposition

Plaintiff testified that he was traveling at a rate of about 20 to 25 miles per hour when the front end of his vehicle came into contact with the passenger front end of defendant's vehicle [Valdez EBT: 41]. As a result of the impact his forehead hit the steering wheel and his right knee hit the dashboard [EBT: 43]. Plaintiff emerged from his vehicle a few minutes after the collision [Id. 45], and after assessing the damage to the car, he called "911" and moved the car to the side of the road [Id. 46 -0 47]. After about an hour the police arrived, and after advising them of what had occurred, plaintiff drove his car home and called the body shop [Id. 55].

The following afternoon plaintiff had a friend take him to the emergency room of Jamaica Hospital because he "couldn't take the pain" in his neck, right knee and forehead [Id. 58]. X-rays were taken and plaintiff was discharged with a neck brace [Id. 60].

Plaintiff then called a friend who referred him to another friend who worked for a law firm. Upon contacting her, she referred him to Elite Medical where he commenced treatment a couple of days later [Id. 61 - 63]. He was examined by a doctor at Elite Medical and given crutches [Id. 64], and commenced physical therapy there on the same day [Id. 65]. The treatment at Elite also included chiropractic and acupuncture sessions [Id.]. By the beginning of 2010, plaintiff stopped going to the facility because he "was getting better," and "[a]fter a while [he] had other things to do..." [Id. 67: 4 - 5; 13 - 14].

Plaintiff testified that he called in sick from work a total of twenty days between the time of the accident until May 2010 [EBT: 14 - 16]. He missed two days of work immediately after the accident and two days during the following couple of weeks [EBT: 15]. He resumed his normal job duties upon his return [Id.].

Concerning his current limitations, plaintiff testified that he could not exercise, or jog, or play softball the way he had prior to the accident [Id. 76 79]. He also testified that he continues to take prescription painkillers twice a week [Id. 81].

#### Discussion and Conclusions

Upon review of the moving papers including clinical findings of full ranges of motion of the cervical and lumbar spine and of the left knee that also revealed upon recent examination several other negative clinical findings with respect to the affected areas, as well as clinical findings for the absence of evidence of trauma upon review of contemporaneous diagnostic studies, it is submitted that defendants have shouldered their initial burden to prove that plaintiff did not sustain a permanent serious injury as a result of the subject motor vehicle accident. In addition, defendants have also come forward with persuasive medical evidence of preexisting degenerative disc changes in plaintiff's cervical

and lumbar spine. Moreover, by plaintiff's own testimony, defendants have also demonstrated that plaintiff's usual and customary daily activities were not significantly curtailed as a result of his injuries in the near aftermath of the accident.

In light of defendant's prima facie showing to defeat the motion, it is incumbent upon plaintiff to come forward with medical evidence sufficient to raise an issue of fact that he sustained a serious injury as a result of the 1/29/09 motor vehicle accident. Plaintiff fails to do so.

The affirmation of plaintiff's treating physician<sup>6</sup> lacks probative value as Dr. Chacon fails to incorporate the methodology by which he conducted his range of motion testing, either on his initial examination on February 4, 2009 or upon his re-examination two years later. Dr. Chacon fails to include the results of any objective testing conducted on either examination. While referencing a straight leg raising test as having been performed on the recent examination, Dr. Chacon fails to report the findings of this test and simply states that the examination included such "objective" testing. It is also significant that even were the method of the range of motion study's sufficiently explicated, it is also incomplete; as on the initial examination, Dr. Chacon reports the recent findings with respect to only one plane of the cervical spine, and only two of the lumbar.

Further diminishing the probative value of the affirmation is the treating physician's failure to set forth any objective findings of limitations with respect to plaintiff's right knee either upon the contemporaneous or the recent examination. Indeed in his assessment of causation Dr. Chacon describes the injury as "pain in the knee." Finally, Dr. Chacon offers no clinical assessment to address the question of causation raised by defendant's

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<sup>6</sup>Exhibit B.

expert's assessment that the contemporaneous diagnostic films reveal evidence of pre-existing degenerative disc disease.

Plaintiff maintains that the issue of the gap in treatment is improperly interposed for the first time in reply papers, however, it is significant that the affidavit he submits in "sur-reply" provides a reason for cessation of treatment that is neither further documented nor entirely consistent with that offered at deposition (see, EBT: 67).

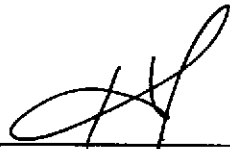
For all the reasons above stated, the motion is granted.

Accordingly, it is

ORDERED that defendants' motion be and hereby is granted and summary judgment awarded in favor of defendants dismissing the complaint.

This constitutes the decision and order of this court.

Dated: June 15, 2011  
Bronx, New York

  
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Hon. Howard H. Sherman  
J.S.C.