Melo v Grullon
2011 NY Slip Op 34063(U)
July 25, 2011
Supreme Court, Bronx County
Docket Number: 309086/09
Judge: Stanley Green
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BRONX
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NEW YORK SUPREME COURT - COUNTY OF BRONX

IA-6

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6

-- X

PEDRO MELO,

Plaintiff(s),

INDEX No.:309086/09

-against-

JOSE GRULLON,

Defendant(s)

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

-- X

The following papers numbered 1 to 2 read on this motion
No. on the Calendar of April 11, 2011

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

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

Dated: July 25, 2011

STANLEY GREEN, J.S.C.

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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF BRONX: IA-6

--X

PEDRO MELO,

Plaintiff(s),

INDEX No.: 309086/09

- against-

JOSE GRULLON,

Defendant(s).

DECISION

--X

HON. STANLEY GREEN:

The motion by defendant for an order pursuant to CPLR §3212 granting summary judgment dismissing the complaint is granted.

Plaintiff commenced this action to recover damages for personal injuries he sustained in a motor vehicle accident on June 8, 2008. Following the accident, plaintiff declined medical attention and drove himself home.

Plaintiff claims that as a result of the accident he sustained herniated discs at L1-2, L3-4, L4-5 and endplate fractures at L2 and L3.

Defendant seeks dismissal of the complaint on the ground that plaintiff did not sustain a serious injury within the meaning of Insurance Law §5102(d) as a result of the June 8, 2008 accident.

In support of the motion, defendant submits: (1) the affirmed report of Dr. De Jesus, who performed a neurological examination of plaintiff in September 2010, which revealed that he had normal range of motion of his cervical spine and lumbar spine and no disability; (2) the MRI report of Dr. Weisel, one of plaintiff's radiologists, which indicates that the MRI of plaintiff's lumbar spine performed on August 28, 2008 revealed degenerative disc disease at multiple levels

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and a central and left-sided disc herniation at L4-5, but makes no mention of a fracture; and (3) a portion of plaintiff's deposition testimony, which shows that after the accident, he missed only one and a half weeks from his usual employment as an assistant to a claims analyst at an insurance company.

Plaintiff contends defendant has failed to establish, prima facie, that he did not sustain a serious injury because Dr. Dr. DeJesus did not review his medical records, does not address the alleged fracture and cannot show that he did not sustain an injury under the 90/180 day category because she did not examine him until September 17, 2010. In the alternative, plaintiff submits: (1) the affidavit of Dr. Statler, who provided chiropractic treatment to plaintiff from June 26, 2008 through April 2009, when he determined that plaintiff had reached maximum medical improvement; (2) the affirmation of Dr. Weisel, affirming that an MRI of plaintiff's lumbar spine performed on August 28, 2008 revealed a herniated disc at L4-5; (3) the affirmation of Dr. Shapiro, affirming that an MRI performed on June 29, 2009 revealed suspicion of an acute compression fracture of the superior endplate of L3 and central disc herniations at L1-2, L3-4 and L4-5; (4) the affirmation of Dr. Lattuga, an orthopedist who examined plaintiff on November 19, 2009 and February 24, 2011; (5) the affirmation of Dr. Siventra, an internist who treated plaintiff from March through May 2010; (6) the affirmed report of Dr. Waldman, who examined plaintiff in January 2011 and opines that the restrictions in the range of motion of plaintiff's lumbar spine that is causally related to the June 8, 2008 accident; and (7) a transcript of his deposition testimony.

Dr. Statler's report shows that at the time he first treated plaintiff, he complained of lower back pain that increased with prolonged sitting and physical activities. His examination revealed

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that plaintiff had tenderness and restriction of motion of the lumbar spine on flexion (75/90 degrees normal), extension (20/30degrees normal), R. lateral flexion (25/40 degrees normal), L. lateral flexion (30/40 degrees normal), r. rotation (25/30 degrees normal). Left lateral rotation was normal. Dr. Statler referred plaintiff for an MRI of the lumbar spine and he prescribed a course of chiropractic therapy. which plaintiff underwent twice a week for approximately nine months. After treatment, plaintiff had "mild to little improvement." Dr. Statler decided that plaintiff had reached maximum medical improvement and further treatment would be palliative and that since plaintiff's No Fault benefits were curtailed and he could not afford to continue treatment, "paying out of pocket was not an option."

Dr. Statler opines that as a result of the June 8, 2008 accident, plaintiff sustained traumatic injuries to his lower back which resulted in a significant and permanent limitation to his lumbar spine.

Dr. Lattuga's affirmation shows that he first examined plaintiff on November 19, 2009. At that time, plaintiff complained of continued severe low back pain, lower extremity radiation with numbness, tingling and dysesthesias. Dr. Lattuga performed range of motion testing which revealed limitations in the range of motion of plaintiff's lumbar spine, which he quantifies and compares to normal. He discussed treatment options and plaintiff decided to proceed with conservative treatment. On February 24, 2011, Dr. Lattuga re-examined plaintiff. Plaintiff continued to have restricted range of motion of the lumbar spine.

Dr. Lattuga opines, based upon his examination of plaintiff and his review of the June 29, 2009 MRI of plaintiff's lumbar spine, that as a result of the June 9, 2008 accident, plaintiff suffers from an endplate fracture of L3 and disc herniations at L1-2, L3-4 and L4-5 and that he

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has sustained a significant limitation and a permanent disability in the lumbar spine.

Dr. Sivendra's report shows that he first examined plaintiff on March 29, 2010. At that time, there was restricted range of motion of the lumbar spine. He prescribed physical therapy, which plaintiff underwent approximately three times a week for one month. He also performed EMG studies, which revealed right L4-5 lumbar radiculopathy. Dr. Sivendra reviewed the June 9, 2009 MRI's of plaintiff's lumbar spine and concurs that they revealed an acute compression fracture superior endplate of L3, central disc herniations at L1-2, L3-4 and L4-5. He opines that as a result of the accident, plaintiff sustained traumatic injuries to his lower back resulting in diminished range of motion and a significant and permanent limitation to his lumbar spine.

The affirmed report of Dr. Waldman shows that he first examined plaintiff on January 11, 2011. At that time, plaintiff had restricted range of motion of his lumbar spine on flexion to 45 degrees (90 degrees normal) and extension to 20 degrees (30 degrees normal). There was also a positive straight leg raise on the right. He, too, opines that as a result of the accident, plaintiff sustained traumatic injuries to his lower back resulting in diminished range of motion and a significant and permanent limitation to his lumbar spine.

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). Objective proof of a plaintiff's injury is required in order to satisfy the statutory serious injury threshold (Id). Subjective complaints of pain are insufficient to establish a serious injury (Scheer v. Koubek 70 NY2d 678). In order to prove the extent or degree of physical limitations, an expert's designation of a numeric percentage of a plaintiff's loss of range of motion can be used to substantiate a claim of serious injury (Dufel, supra). An expert's qualitative or quantitative

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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). Proof of a herniated disc or that one underwent arthroscopic surgery, without additional objective medical evidence establishing that the accident resulted in significant physical limitations, is not alone sufficient to establish a serious injury (Pommells v. Perez, 4 NY3d 566; Ortiz v. Ash Leasing, 60 AD3d 556).

Where there is evidence that plaintiff's alleged injuries are due to a pre-existing or degenerative condition, plaintiff's physician must provide a factually based medical opinion ruling out degenerative conditions as the cause of plaintiff's limitations (Rose v. Citywide Auto Leasing,Inc., 60 AD3d 520). A doctor's failure to mention and explain why he ruled out degenerative changes as the cause of plaintiff's injuries, renders his opinion that they were caused by the accident speculative (Santana v. Khan, 48 AD3d 318 Valentin v. Pomilla, 59 AD3d 184). An issue of fact cannot be created by the plaintiff's doctor's simply repeating the mantra that the injuries were caused by the accident (Roses, supra).

While a cessation of treatment is not dispositive, a plaintiff who terminates therapeutic measures following the accident, while claiming "serious injury," must offer some reasonable explanation for having done so (Pommells v. Perez, 4 NY3d 566).

As the proponent of this summary judgment motion, it is defendants' burden to demonstrate, prima facie, entitlement to judgment as a matter of law with evidence sufficient to eliminate any material issue of fact (Alvarez v. Prospect Hosp., 68 NY2d 320; Winegrad v. New

York Univ. Med. Ctr., 64 NY2d 851). The burden then shifts to plaintiff 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).

Despite plaintiff's contention to the contrary, the evidence presented by defendants is sufficient to establish, prima facie, that plaintiff did not sustain a serious injury as a result of the June 8, 2008 accident.

Defendants met their initial burden of establishing that plaintiff did not sustain a permanent or significant limitation by submitting the affirmed report of Dr. DeJesus, which shows that plaintiff had normal ranges of motion of his lumbar spine and no disability (Onishi v. N& B Taxi, Inc., 51 AD3d 594). The fact that Dr. DeJesus did not discuss plaintiffs' medical records indicating herniated discs does not require denial of the motion since she details the tests that she performed in her examination which revealed full range of motion (Clemmer v. Drah, 74 AD3d 660).

Defendants met their burden with respect to the 90/180 days category by submitting plaintiff's deposition testimony which shows that he missed only one and a half weeks from his usual employment (Copeland v. Kasalica, 6 AD3d 253).

With respect to the alleged fracture to the lumbar spine, defendants met their initial burden by submitting the affirmed report of plaintiff's radiologist, Dr. Weisel, which makes no

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mention of a fracture (Franchini v. Palmieri, 1 NY3d 536).

Thus, the burden shifted to plaintiff to come forward with evidence sufficient to overcome defendants' submissions (Gaddy v. Eyler, 79 NY 2d 955).

While plaintiff has submitted the affidavit of his treating chiropractor and affirmations of other physicians whom he subsequently consulted, only Dr. Statler treated plaintiff during the 180 days immediately following the accident and nothing in his report, nor the reports of the other physicians, supports plaintiff's claim that he was unable to perform substantially all of his usual daily activities for not less than ninety days during that time period.

With respect to the alleged fracture, Dr. Weisel's report shows that an MRI performed three months after the accident revealed only degenerative disc disease at multiple levels and a disc herniation at L4-5. While Dr. Lattuga and Dr. Sivendra opine that plaintiff sustained a fracture, both physicians reviewed only the June 2009 MRI and neither physician reviewed the August 2008 MRI films, nor do they address Dr. Weisel's reported findings. This renders their opinions that plaintiff sustained a fracture of the lumbar spine as a result of the accident conclusory and insufficient to raise a material issue of fact.

With respect to plaintiff's claim that he suffered a permanent and significant limitation of use of his lumbar spine, while Dr. Statler's affidavit shows that plaintiff had restriction of motion of his lumbar spine at the time he first examined him and that after nine months of therapy there was "mild to little improvement," he does not quantify or provide a qualitative analysis of plaintiff's limitations at the time he ceased treatment. In addition, his explanation for the cessation of treatment, to wit, that plaintiff had reached maximum medical improvement; his No Fault benefits were curtailed and he could not afford to pay for further treatment because he had

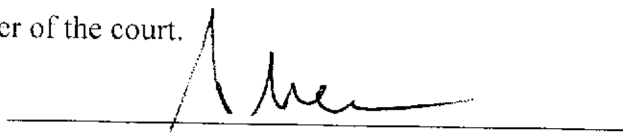
no health insurance, appears to be tailored in order to explain the gap in treatment. However, his statement that plaintiff had no health insurance and could not afford to pay for further treatment is belied by plaintiff's deposition testimony that he had Blue Cross/Blue Shield insurance through his employer and that he had a full-time job. It is also noted that Dr. Statler, to whom the August 28, 2008 MRI report is addressed, does not mention the report or correlate his findings to the MRI findings.

While Dr. Lattuga, Dr. Sivendra and Dr. Waldman opine that the herniated discs reported in the June 2009 MRI are causally related to the accident pf June 8, 2008, their opinions are conclusory and insufficient to raise a triable issue of fact as they rely solely on their examinations and review of the MRI of plaintiff's lumbar spine taken more than a year after the accident and they do not address Dr. Weisel's findings of degenerative disc disease at multiple levels of the lumbar spine. Nor do they address plaintiff's treatment prior to the time they examined him or provide any explanation for the gap in treatment. Thus, the evidence presented is insufficient to raise a material issue of fact as to whether he sustained a serious injury as a result of the June 8, 2008 accident. Accordingly, defendant's motion for summary judgment is granted.

Movant shall serve a copy of this order with notice of entry on the Clerk of the Court who shall enter judgment dismissing the complaint.

This constitutes the decision and order of the court.

Dated: July 25, 2011



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