

Weiss v City of Long Beach
2012 NY Slip Op 30481(U)
February 21, 2012
Sup Ct, Nassau County
Docket Number: 5460/10
Judge: Jeffrey S. Brown
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SHORT FORM ORDER**SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NASSAU****P R E S E N T : HON. JEFFREY S. BROWN
JUSTICE**-----X
MARY WEISS,**Plaintiff,****-against-****CITY OF LONG BEACH, CITY OF LONG BEACH
POLICE DEPARTMENT, POLICE OFFICER JAMES
CANNER,****Defendants.**
-----X**TRIAL/IAS PART 17****INDEX # 5460/10****Motion Seq. 2
Motion Date 9.13.11
Submit Date 12.1.11****XXX**

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The following papers were read on this motion:

Papers Numbered

Notice of Motion, Affidavits (Affirmations), Exhibits Annexed.....	1
Answering Affidavit	2
Reply Affidavit.....	3

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Motion by Defendants, City of Long Beach, City of Long Beach Police Department, and Police Officer James Canner, for an order awarding them summary judgment dismissing the plaintiff Mary Weiss' complaint on the grounds that Mary Weiss' injuries do not satisfy the "serious injury" threshold requirement of Insurance Law § 5102(d), and as such, plaintiff has no cause of action, is

GRANTED.

This action arises out of a motor vehicle accident that occurred on August 14, 2009 at approximately 9:00 a.m. on East Park Avenue at or near its intersection with Roosevelt Boulevard, Long Beach, Nassau County, New York.

Plaintiff Mary Weiss claims that she sustained, *inter alia*, the following serious injuries as a result of the subject accident: cervical disc herniation at C5/6 abutting the spinal cord; lumbar disc bulges at L4/5 and L5/S1 impinging on the spinal canal; range of motion; headaches and dizziness; post-traumatic hearing deficits; post-traumatic abdominal pain; post-traumatic nervousness and depression; post-concussion headaches; cervical neuralgia; post-concussion syndrome; severe sprain/strain of the cervical spine with loss of use; and severe sprain/strain of the lumbar spine with loss of use (Bill of Particulars, ¶ 14).

At her oral examination before trial, plaintiff testified that after the subject accident, but before the ambulance arrived, she was taken back to her home by the driver of the car that hit her (Transcript at 89). At that time, she was able to enter her house without any assistance (*Id.* at 94). Plaintiff signed herself out of the hospital the day after the accident, while still in pain, against medical advice (*Id.* at 100). Plaintiff did not receive any medication for her injuries from the hospital (*Id.* at 101). Plaintiff spent approximately one week in bed between discharging herself from the hospital and seeking further treatment for her injuries (*Id.* at 102).

Upon continuing medical treatment, plaintiff complained of pain to her head, neck, shoulders, arms, fingers and toes (*Id.* at 105). Dr. Tolat sent plaintiff for an MRI, referred her to other doctors, and continued to treat her for approximately one year (*Id.* at 106). Plaintiff ceased treatment with Dr. Tolat over one year prior to her oral examination (*Id.* at 108).

Plaintiff continued treatment with a local neurologist, Dr. Naqvi (*Id.* at 110). Dr. Naqvi prescribed Flexeril for plaintiff to take twice a day to alleviate her pain and discomfort, which she took for approximately one year (*Id.* at 112-3). Dr. Naqvi referred plaintiff to pain management (*Id.* at 113). Plaintiff ceased treatment with Dr. Naqvi over one year prior to her oral examination (*Id.* at 113).

At pain management, plaintiff saw Dr. Rauchwerger for approximately one year, who relied on the plaintiff's MRIs and his own evaluations in treating plaintiff (*Id.* at 114). Dr. Rauchwerger gave plaintiff sessions of trigger point injections approximately six to eight times, each session consisting of four injections to whichever areas were experiencing the most pain, including her neck, shoulders, lower back, and once in her elbows (*Id.* at 115-6). The injections gave plaintiff temporary relief to the areas injected, which returned after three to four days (*Id.* at 117). Plaintiff also received acupuncture treatments on a weekly basis from Dr. Rauchwerger's office, and Dr. Rauchwerger performed approximately six spinal blocks on plaintiff on a monthly basis (*Id.* at 117-8).

Plaintiff went to three different places for physical therapy (*Id.* at 120). At the first, Premier, she attended five times a week for the first two weeks, and then two to three times a week for approximately six months (*Id.* at 120). There was a gap of approximately one month between the plaintiff's ending physical therapy at Premier and beginning again at Vitaris, where she treated three times a week for approximately two to three months (*Id.* at 122). Finally, plaintiff began seeing another neurologist, Dr. Fazzini, and continued physical therapy at Five Towns Physical Therapy after another gap of approximately one month following the end of her physical therapy with Vitaris (*Id.* at 123-4).

At some point before beginning treatment with Dr. Fazzini, plaintiff saw a spinal orthopedic surgeon and a neurosurgeon (*Id.* at 127-8). The neurosurgeon suggested an electrode spinal stimulator, and plaintiff told she was a candidate for surgery, which she chose not to pursue (*Id.* at 130-1).

At other points in time, plaintiff saw an endocrinologist and a gynecologist for problems with her menstrual cycle, that the doctor claimed could possibly be causally connected to the subject accident (*Id.* at 156-8). Plaintiff also saw an ENT doctor for hearing loss (*Id.* at 163).

Plaintiff stated that, as a result of the subject accident, she was confined to her home and bed for one week (*Id.* at 102). At the time of the accident, plaintiff was in training to begin a job working at a Japanese restaurant (*Id.* at 13). Plaintiff has not returned to her training since the subject accident (*Id.* at 14). Plaintiff has not attempted to seek employment of any kind (*Id.* at 190.)

Following the accident, plaintiff testified to being unable to do household chores including dishes, laundry, making beds, as well as holding things in her hands, writing, walking, bicycling and driving (*Id.* at 165-6). She is unable to open cans and bottles because of weakness in her hands (*Id.* at 178). Plaintiff complains of constant pain to her neck, back and shoulders, as well as headaches, abdominal pain, stiffness, and discomfort laying in bed or standing up in any position (*Id.* at 167-8).

Plaintiff, who was 39 years old at the time of the subject accident, claims that her injuries fall within the following three categories of the serious injury statute: to wit, permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; and 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 constitute 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 (Bill of Particulars, ¶ 34).

Plaintiff's claims that her injuries satisfy the 90/180 category of Insurance Law § 5102(d) are unsupported. Plaintiff does not provide any evidence that she was "medically" impaired from doing any daily activities for 90 days within the first 180 days following the subject accident. While noting subjective complaints of pain, plaintiff's medical evidence failed to articulate any activities that the plaintiff could no longer do as a result of the subject accident. Plaintiff's doctors discuss plaintiff's difficulty performing some activities of daily living, but make no mention of activities that plaintiff cannot do. Thus, this court determines that plaintiff has effectively abandoned her 90/180 claim for purposes of defendants' initial burden of proof on a threshold motion (*Joseph v. Forman*, 16 Misc. 3d 743 [Sup. Ct. Nassau 2007]).

Accordingly, this court will restrict its analysis to the remaining two categories as it pertains to the plaintiff; to wit, "permanent consequential limitation of use of a body organ or member;" and "significant limitation of use of a body function or system."

Under the no-fault statute, to meet the threshold for significant limitation of use of a body function or system or permanent consequential limitation of use of a body organ or member, the law requires that the limitation be more than minor, mild, or slight and that the claim be supported by medical proof based upon credible medical evidence of an objectively measured and quantified medical injury or condition (*Gaddy v. Eyler*, 79 NY2d 955 [1992]; *Scheer v. Koubeck*, 70 NY2d 678 [1987]; *Licari v. Elliot*, 57 NY2d 230 [1982]). A minor, mild or slight limitation is deemed "insignificant" within the meaning of the statute (*Licari v. Elliot*, *supra*; *Grossman v. Wright*, 268 Ad2d 79,83 [2nd Dept. 2000]).

When, as in the instant case, a claim is raised under the “permanent consequential limitation of use of a body organ or member” or “significant limitation of use of a body function or system” categories, then, in order to prove the extent or degree of the physical limitation, an expert’s designation of a numeric percentage of plaintiff’s loss of range of motion is acceptable (*Toure v. Avis Rent A Car Systems*, 98 NY2d 345, 353 [2002]). Additionally, an expert’s qualitative assessment of a plaintiff’s condition is also probative, provided that: (1) the evaluation has an objective basis and, (2) the evaluation compares the plaintiff’s limitations to the normal function, purpose and use of the affected body organ, member, function or system” (*Id.*).

Recently, the Court of Appeals held that a quantitative assessment of a plaintiff’s injuries does not have to be made during an initial examination and may instead be conducted much later, in connection with litigation (*Perl v. Meher*, 2011 NY Slip Op. 08452 [2011]).

With these guidelines, the court now turns to the merits of the defendants’ motion.

In support of their motion, defendants rely on plaintiff’s deposition testimony; the affirmation of Dr. Lee Kupersmith, an orthopedic surgeon who performed an independent orthopedic evaluation of the plaintiff on June 28, 2011; the affirmation of Dr. Ira Turner, a psychiatrist and neurologist, who performed a neurological evaluation of the plaintiff on July 20, 2011; and the affirmation of Dr. Josh Werber, an otolaryngologist who performed an independent medical examination of the plaintiff on June 15, 2011.

With this evidence, defendants have established their prima facie entitlement to judgment as a matter of law.

Specifically, Dr. Kupersmith examined the plaintiff, performed quantified range of motion testing on her cervical and lumbar spine with a goniometer, compared his findings to normal range

of motion values and concluded that the ranges of motion measured were normal. Based on his clinical findings and medical records review, Dr. Kupersmith concluded that the plaintiff had no orthopedic disability at the time of the examination. Further, Dr. Kupersmith concluded that there were no objective findings to substantiate plaintiff's subjective complaints, and therefore the plaintiff did not have any permanent or residual disability (*Staff v. Yshua*, 59 AD3d 614 [2nd Dept. 2009]).

Additionally, Dr. Turner performed a neurological examination, including physical, cranial nerve, motor and sensory examinations, and concluded that there was no objective medical evidence of any neurological problem causally related to the accident of August 14, 2009. Dr. Turner adds, "from a neurological perspective, there is no disability nor is there any need for restriction of her activities of daily living or work."

Finally, Dr. Werber performed an independent medical examination and reviewed plaintiff's medical records including her CT scan and emergency room records. Dr. Werber found plaintiff's complaints to be consistent with a tympanic membrane perforation, but concluded that plaintiff's medical records indicated no head trauma that could create a causal connection between the accident of August 14, 2009, and the plaintiff's complaints of hearing loss.

Having made a prima facie showing that the injured plaintiff did not sustain a "serious injury" within the meaning of the statute, the burden shifts to the plaintiff to come forward with evidence to overcome the defendants' submissions by demonstrating a triable issue of fact that a "serious injury" was sustained (*Pommels v. Perez*, 4 NY3d 566 [2005]; see also *Grossman v. Wright*, supra).

In opposition, plaintiff relies on the unsworn Long Beach Medical Center's Emergency Department Physician Record from the day of the accident, August 14, 2009; the affirmation of Dr.

Raj Tolat, plaintiff's treating physician who examined plaintiff on August 20, 2009, September 18, 2009, December 4, 2009, January 20, 2010, and September 14, 2011; the affirmation of Dr. Steven Mendelsohn, a physician who discussed plaintiff's MRI results from August 24, 2010 with the plaintiff; and the affirmation of Dr. Richard Rizzuti, a physician who performed an MRI on plaintiff on August 24, 2009, along with plaintiff's MRI results from that date.

The emergency room records prove the occurrence of the accident, but do not provide any indication that a serious injury was suffered, and are not relevant for the purpose of determining whether a permanent or significant limitation resulted (*Partlow v. Meehan*, 548 NYS2d 239 [2nd Dept. 1989]; *Licari v. Elliot*, *supra*).

The court notes that the MRI report of plaintiff's cervical spine was not sworn, therefore, any reference to it by a physician for plaintiff is disregarded (see, *Mahoney v Zerillo*, 6 AD3d 403; *Friedman v U-Haul Truck Rental*, 216 AD2d 266; *Bycinthe v. Kombos*, 29 A.D.3d 845, 815 N.Y.S.2d 693). Plaintiff's attempt to submit an affirmation of another physician swearing to the accuracy of a report not prepared by him approximately one year after the examination is disregarded especially in light of the fact that there is no indication that Dr. Mendelsohn reviewed the MRI films themselves.

The court further notes that the MRI report of the lumbar spine was not sworn by Dr. Rizzuti until May 26, 2011, almost two years after the examination. Additionally, plaintiff's doctor, Raj Tolat, referred to the unsworn report in all his evaluations save for the last one conducted in anticipation of this application. Moreover, the MRI report of the lumbar spine as well as the affirmation of Dr. Rizzuti fail to causally link the injuries to the accident.

Plaintiff failed to raise an inference that her injury was caused by the accident by not refuting the results of the MRI of the cervical spine showing a preexisting degenerative condition. Missing from all of plaintiff's submissions is any mention of the preexisting degenerative changes in her cervical spine by plaintiff's own experts, Drs. Tolat, Mendelson and Gelves, in their evaluation of plaintiff's cervical spine (see *Pommells v Perez*, 4 NY3d 566, 580).

The MRI reports of the plaintiff's spine which showed bulging discs did not, alone, raise a triable issue of fact whether she sustained a serious injury (see *Yakubov v CG Trans Corp.*, 30 AD3d 509, 510. The mere existence of a bulging or herniated disc is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the disc injury and its duration (*Id.* at 510). Since the plaintiff's treating physiatrist, Dr. Raj Tolat, failed to address the findings in the report of the respondents' radiologist, including the findings of degenerative disease (see *Passaretti v Ping Kwok Yung*, 39 AD3d 517; *Khan v Finchler*, 33 AD3d 966, 967; *Giraldo v Mandanici*, 24 AD3d 419, 420), his opinion that the plaintiff's injuries were causally related to the subject accident was speculative (see *Passaretti v Ping Kwok Yung*, 39 AD3d at 517; *Tudisco v James*, 28 AD3d 536, 537; *Giraldo v Mandanici*, 24 AD3d at 420). Moreover, neither his affirmation nor the plaintiff's affidavit adequately explained the gap in treatment evident in the record (see *Waring v Guirguis*, 39 AD3d 741, 742; *Li v Woo Sung Yun*, 27 AD3d 624, 625; *Neugebauer v Gill*, 19 AD3d 567, 568). The plaintiff also failed to submit any competent medical evidence that she was unable to perform substantially all of her daily activities for not less than 90 of the first 180 days subsequent to the subject accident (see *Nociforo v Penna*, 42 AD3d 514; *Sainte-Aime v Ho*, 274 AD2d 569, 570).

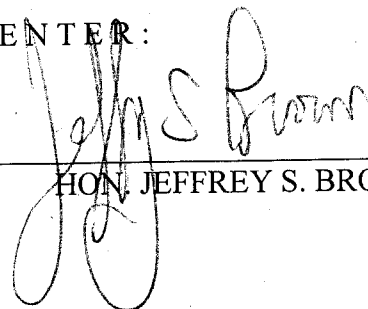
Accordingly, it is

ORDERED, that the application is GRANTED. The complaint is dismissed with prejudice.

The foregoing constitutes the decision and order of this Court. All applications not specifically addressed herein are denied.

Dated: February 21, 2012

ENTER:



HON. JEFFREY S. BROWN, JSC

Attorney for Plaintiff
Frank J. Laine, Esq.
449 South Oyster Bay Road
Plainview, NY 11803

Attorney for Defendants
Law Office of Cozen O'Connor
45 Broadway Atrium, 16th Fl.
New York, NY 10006

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