

Kazina v Miller Transp. Inc.

2013 NY Slip Op 30485(U)

March 12, 2013

Supreme Court, New York County

Docket Number: 108689/2010

Judge: Arlene P. Bluth

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

HON. ARLENE P. BLUTH

PRESENT: _____
Justice

PART 22

Index Number : 108689/2010
KAZINA, ANNA
vs.
MILLER TRANSPORTATION
SEQUENCE NUMBER : 002
SUMMARY JUDGMENT

INDEX NO. _____
MOTION DATE _____
MOTION SEQ. NO. _____

The following papers, numbered 1 to 3, were read on this motion to/for summary judgment / reply

Notice of Motion/Order to Show Cause -- Affidavits -- Exhibits _____ No(s) 1
Answering Affidavits -- Exhibits _____ No(s) 2
Replying Affidavits _____ No(s) 3

Upon the foregoing papers, it is ordered that this motion is

DECIDED IN ACCORDANCE WITH
ACCOMPANYING DECISION/ORDER

FILED

MAR 11 2013

NEW YORK
COUNTY CLERK'S OFFICE

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE
FOR THE FOLLOWING REASON(S):

Dated: 3/11/13

Arlene P. Bluth, J.S.C.
HON. ARLENE P. BLUTH

- 1. CHECK ONE: CASE DISPOSED NON-FINAL DISPOSITION
- 2. CHECK AS APPROPRIATE: MOTION IS: GRANTED DENIED GRANTED IN PART OTHER
- 3. CHECK IF APPROPRIATE: SETTLE ORDER SUBMIT ORDER
- DO NOT POST FIDUCIARY APPOINTMENT REFERENCE

SUPREME COURT OF THE STATE OF NY
COUNTY OF NEW YORK: PART 22

Index No.: 108689/10
Seq 002

Anna Kazina,

-against-

Miller Transportation Inc. and
Debra Lewis,

Plaintiff,

FILED **DECISION/ORDER**

Defendant

MAR 11 2013

HON. ARLENE P. BLUTH, JSC

NEW YORK
COUNTY CLERK'S OFFICE

Defendants' motion for summary judgment dismissing this action on the grounds that plaintiff did not sustain a "serious injury" within the meaning of Insurance Law §5012(d) is denied.

In this action, plaintiff alleges that on June 11, 2010 she sustained personal injuries when her vehicle was struck by a vehicle driven by defendant Lewis and owned by defendant Miller Transportation, Inc. In item 6 of her bill of particulars, plaintiff alleges that she suffered injuries to her neck (bulging discs at C3-C4 and C5-C6 with right sided neuroforaminal narrowing) and left shoulder (acromioclavical joint impingement with hypertrophic changes) (exh D to moving papers).

To prevail on a motion for summary judgment, the defendant has the initial burden to present competent evidence showing that the plaintiff has not suffered a "serious injury" (*see Rodriguez v Goldstein*, 182 AD2d 396 [1992]). Such evidence includes "affidavits or affirmations of medical experts who examined the plaintiff and conclude that no objective medical findings support the plaintiff's claim" (*Shinn v Catanzaro*, 1 AD3d 195, 197 [1st Dept 2003], quoting *Grossman v Wright*, 268 AD2d 79, 84 [1st Dept 2000]). Where there is objective proof of injury, the defendant may meet his or her burden upon the submission of expert

affidavits indicating that plaintiff's injury was caused by a pre-existing condition and not the accident (*Farrington v Go On Time Car Serv.*, 76 AD3d 818 [1st Dept 2010], citing *Pommells v Perez*, 4 NY3d 566 [2005]). In order to establish prima facie entitlement to summary judgment under the 90/180 category of the statute, a defendant must provide medical evidence of the absence of injury precluding 90 days of normal activity during the first 180 days following the accident (*Elias v Mahlah*, 2009 NY Slip Op 43 [1st Dept]). However, a defendant can establish prima facie entitlement to summary judgment on this category without medical evidence by citing other evidence, such as the plaintiff's own deposition testimony or records demonstrating that plaintiff was not prevented from performing all of the substantial activities constituting customary daily activities for the prescribed period (*id.*).

Once the defendant meets his or her initial burden, the plaintiff must then demonstrate a triable issue of fact as to whether he or she sustained a serious injury (*see Shinn*, 1 AD3d at 197). A plaintiff's expert may provide a qualitative assessment that has an objective basis and compares plaintiff's limitations with normal function in the context of the limb or body system's use and purpose, or a quantitative assessment that assigns a numeric percentage to plaintiff's loss of range of motion (*Toure v Avis Rent A Car Sys.*, 98 NY2d 345, 350-351 [2002]). Further, where the defendant has established a pre-existing condition, the plaintiff's expert must address causation (*see Valentin v Pomilla*, 59 AD3d 184 [1st Dept 2009]; *Style v Joseph*, 32 AD3d 212, 214 [1st Dept 2006]).

Cervical Spine

In support of the branch of their motion that plaintiff did not sustain a serious injury to her cervical spine, defendants refer to the emergency room report (exh G to moving papers)

wherein she was diagnosed with a head contusion, headache, cervical strain and back pain, and told to take Tylenol; no x-rays were taken. Defendants also refer to the report of Ruth Fernandez, D.C., a chiropractor who treated plaintiff the evening of the accident (exh H) who indicated that plaintiff had a restricted range of motion, and cervical, thoracic and lumbar sprain/strain. Plaintiff had x-rays taken three days later; in her report of those x-rays (exh I), Dr. Fernandez noted no osseous or periosteal injuries to plaintiff's cervical, thoracic or lumbar spine. Approximately two weeks later, Dr. Fernandez referred plaintiff to Dr. Daniel Schlusberg of Olympic Open MRI who diagnosed plaintiff as having a muscle spasm and a right lateral bulge at C3-C4 and C5-C6 (exh J).

Additionally, defendants submit the report of the independent chiropractic examination of Richard Sollazo, D.C. conducted at the request of plaintiff's No Fault Carrier, who examined plaintiff on September 3, 2010 (exh K). Dr. Sollazo found no trigger points or spasms of the cervical or thoracic spine. He noted a decreased range of motion of 20% in rotation, lateral bending, flexion and extension in the cervical spine and a normal range of motion in the thoracic spine. Dr. Sollazo diagnosed plaintiff with "resolving cervical and thoracic sprain/strain".

Defendants also submit the report of the independent orthopedic examination of Dr. Mark Kramer conducted at the request of plaintiff's No Fault Carrier, who also examined plaintiff on September 3, 2010 (exh L). Dr. Kramer found a diminished forward flexion and extension of the cervical spine, but normal left and right rotation and normal left and right lateral bending. Additionally, he noted that his examination of plaintiff's lumbosacral spine revealed a normal forward flexion, normal extension, rotation and lateral bend.

At defendants' request, Dr. Leon Sultan conducted an orthopedic examination of plaintiff

on August 15, 2011. In his report (exh M), Dr. Sultan, noted, inter alia, the results of range of motion tests in head and neck and upper back (all normal), the absence of paracervical or parathoracic muscle spasm and trigger points, and proper alignment of her spinal column. Dr. Sultan stated that plaintiff was orthopedically stable and neurologically intact, and that plaintiff had no causally related orthopedic or neurological impairment with regard to the subject accident.

Defendants also submit is the report of Dr. Daniel Feuer who conducted an orthopedic examination of plaintiff at defendants' request on October 17, 2011. In his report (exh N), Dr. Feuer indicated that plaintiff had subjective tenderness and restricted range of motion in her cervical spine which appeared to be musculoskeletal, not neurogenic in etiology. He also noted a normal range of motion and, with no tenderness or spasm, in plaintiff's lumbar spine. Dr. Feuer concluded that plaintiff did not demonstrate any objective neurological disability or permanency causally related to the accident at issue.

Left Shoulder

In support of the branch of their motion that plaintiff did not sustain an serious injury to her left shoulder, defendants submit the report of Dr. David Neuman (exh O), an orthopedist who Dr. Fernandez referred plaintiff to a few days after the accident. Dr. Neuman diagnosed plaintiff as having left rotator cuff injury and impingement; he prescribed physical therapy and an MRI of her left shoulder. Also submitted is (1) the report of Dr. Schlusberg, a radiologist who reviewed that MRI taken on July 8, 2010 (exh P), and found that plaintiff had hypertrophic changes of the acromioclavical joint with a degree of superimposed impingement, and (2) the July 20, 2010 follow-up report of Dr. Neuman (exh Q) who found impingement and bursitis,

rotator cuff tendonitis, AC joint sprain, and persistent pain and stiffness in the left shoulder.

Defendants contrast these findings with Dr. Kramer's September 3, 2010 examination of plaintiff's shoulders (exh L) (full internal and external rotation, with abduction and forward flexion minimally diminished on the left, and normal external and internal rotation against resistance), and with Dr. Sultan's August 15, 2011 examination and report of plaintiff's left shoulder (exh M) (normal range of motion of abduction, forward elevation and external rotation and internal rotation complete; no reactionary spasm, and Hawkin's test, drop arm test and left shoulder impingement test all negative).

Defendants submit the report of its radiologist, Dr. Panasci (exh R), who reviewed the MRI of plaintiff's left shoulder on July 8, 2010 and concluded that it was normal (no fracture, dislocation or joint effusion, and acromioclavical and glenohumeral joints unremarkable).

90/180

Finally, defendants assert that plaintiff was not incapacitated from her customary daily activities for at least 90 days during the 180 days following the accident because while she stated in her bill of particulars that after the accident she was confined to bed for one week and confined to her home for three months but she testified at her deposition that none of her treating providers restricted her from doing any activity for a period of time after the accident (T. at 63, exh E).

Based on the foregoing, defendants have satisfied their burden of establishing prima facie that plaintiff did not suffer a serious injury, and the burden shifts to plaintiff to raise a triable factual question as to whether she sustained a serious injury.

In opposition, plaintiff submits the affirmed report of Dr. Fazzini (exh A to opp.), who

treated plaintiff from October 2010 until August 2011. Dr. Fazzini made his report after his recent examination of plaintiff on May 29, 2012, wherein he detailed her treatment and current condition.

Dr. Fazzini first saw plaintiff on October 19, 2010 for a neurological evaluation; he then saw her for a follow-up examination on October 28, 2010 at which time he administered cervical paraspinals bilaterally in response to her complaints of pain. Dr. Fazzini repeated this procedure on December 21, 2010, and noted that plaintiff received trigger points on March 22, 2011, May 17, 2011 and August 9, 2011, at which time she stopped this treatment because she felt it did not relieve her pain for any significant amount of time.

Dr. Fazzini states his impression is that plaintiff has bulging discs at C3-C4, C4-C5 and C5-C6 resulting in left sided cervical radiculopathy, most severe at C5, and cervical myofascial pain syndrome. He noted that plaintiff continued with physical therapy and chiropractic care until February 2012 when Dr. Fernandez felt that while plaintiff was still symptomatic, she had obtained maximum medical improvement. Dr. Fazzini sets forth his findings of limitations in qualitative and quantitative terms including specific decreased range of motion in the cervical spine (losses in all planes of between 20-45%) measured at plaintiff's May 29, 2012 visit. He concluded that plaintiff suffers from chronic cervical myofascial pain syndrome in addition to cervical radiculopathy caused by her bulging disc as confirmed by MRI and his own clinical findings, including plaintiff's restricted range of motion. Further, Dr. Fazzini stated that the condition of plaintiff's cervical spine is permanent and causally related to the subject accident, noting that no degenerative changes were seen in the MRI of her cervical spine and because plaintiff had no prior symptoms or complaints before the subject accident. Through her treating

doctor's detailed report and findings, plaintiff has raised an issue of fact that she sustained a serious injury as a result of the subject accident. It is up to the jury to decide which doctors to believe.

Accordingly, defendants' motion for summary judgment dismissing this action on the grounds that plaintiff did not sustain a "serious injury" within the meaning of Insurance Law §5012(d) is denied; and it is

ORDERED that defendants are directed to serve a copy of this order with notice of entry on plaintiff within 20 days.

This is the Decision and Order of the Court.

Dated: March 1, 2013
New York, New York



HON. ARLENE P. BLUTH, JSC

HON. ARLENE P. BLUTH

FILED

MAR 11 2013

NEW YORK
COUNTY CLERK'S OFFICE