Rivera v City of New York

2013 NY Slip Op 30896(U)

April 24, 2013

Sup Ct, New York County

Docket Number: 112356/2010

Judge: Kathryn E. Freed

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SCANNED ON 4/29/2013

[* 1]

SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. KATHRYN FREED, JUSTICE OF SUPREME COURT — Justice

PART 5

Index Number : 112356/2010
RIVERA, NOEMI
vs.
CITY OF NEW YORK
SEQUENCE NUMBER : 001
SUMMARY JUDGMENT CAL #77

INDEX NO. ______
MOTION DATE ______
MOTION SEQ. NO. ______

The following papers, numbered 1 to ____, were read on this motion to/for ______

Notice of Motion/Order to Show Cause — Affidavits — Exhibits ______ | No(s). ______

Answering Affidavits — Exhibits ______ | No(s). ______

Replying Affidavits ______ | No(s). ______

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

DECIDED IN ACCORDANCE WITH ACCOMPANYING DECISION / ORDER

FILED
APR 29 2013
NEW YORK COUNTY CLERK'S OFFICE

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

Dated: 4-24-13 ______, J.S.C.
APR 24 2013

HON. KATHRYN FREED
JUSTICE OF SUPREME COURT

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

[* 2]

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: Part 5
---X
NOEMI RIVERA,

Plaintiff,

-against-

THE CITY OF NEW YORK, and P.O.
JUAN LOPEZ,

Defendants.
---X

DECISION/ORDER
Index No.: 112356/2010
Seq. No.: 001

PRESENT:
Hon. Kathryn E. Freed
J.S.C.

HON. KATHRYN E. FREED:

RECITATION, AS REQUIRED BY CPLR §2219(a), OF THE PAPERS CONSIDERED IN THE REVIEW OF THIS MOTION.

PAPERS	NUMBERED
NOTICE OF MOTION AND AFFIDAVITS ANNEXED	1
ORDER TO SHOW CAUSE AND AFFIDAVITS ANNEXED	
ANSWERING AFFIDAVITS	2
REPLYING AFFIDAVITS	3
EXHIBITS	
STIPULATIONS	
OTHER	

FILED
APR 29 2013
NEW YORK
COUNTY CLERK'S OFFICE

UPON THE FOREGOING CITED PAPERS, THIS DECISION/ORDER ON THIS MOTION IS AS FOLLOWS:

Defendants The City of New York and P.O. Juan A. Lopez, (hereinafter, "the City"), move for an Order pursuant to CPLR§ 3212, granting summary judgment, alleging that plaintiff fails to meet the "serious injury" threshold mandated by Insurance Law§ 5102(d). Plaintiff opposes.

After a review of the papers presented, all relevant statutes and case law, the Court grants the motion.

Factual and procedural background:

Plaintiff seeks damages for serious injuries she allegedly sustained when her vehicle was

struck by P.O. Lopez's police car, leaving the precinct parking lot, at First Avenue and East 124th Street in New York County. Plaintiff was issued a summons for running a red light by a nearby officer on foot patrol, who witnessed the instant accident.

Plaintiff first sought medical treatment on May 28, 2010, two days after the accident, as a "walk in" to Lincoln Medical Center Emergency Room. Said Emergency Room records indicate that she complained of pain to her left flank, describing her pain as a level "2." She claimed that she was not doing anything to relieve her pain. Plaintiff's medical records from that date do not indicate that plaintiff complained of injury and/or pain to her right shoulder.

The City specifically notes that plaintiff has a history of herniated discs. At the hospital, in response to her complaint of back pain, plaintiff underwent a lower spine scan which indicated mild degenerative changes with marginal osteophytes. The report following said scan states that mild degenerative changes are evident. After a full description of where the degenerative changes were located, plaintiff was diagnosed with a "backache, unspecified" and released.

After retaining counsel and filing her Notice of Claim, plaintiff next sought medical treatment 1½ months later, on July 1, 2010, at a clinic, where she was examined by Ronald Lambert of Bestcare PT and Chiropractor. There, she received chiropractic and physical therapy treatment including chiropractic manipulation, hot/cold packs, electric stimulus, as well as therapeutic massage. Plaintiff continued receiving physical therapy until December 2, 2010, when she started receiving therapeutic massages. At the same clinic, plaintiff was also seen by Dr. Schottenstein, for pain management on August 17, 2010.

In his report, Dr. Schottenstein states that on the date of his examination of plaintiff, she complained of pain and tightness in her lower back, with minimal radiation to the left buttock. Dr.

Schottenstein performed an orthopedic spine exam, leg raises and unspecified range of motion tests on plaintiff's spine. As a result of his initial examination, Dr. Schottenstein determined that plaintiff was suffering from lumbar radiculitis and advised her that an MRI would be prudent. Subsequently, on August 29, 2010, plaintiff underwent an MRI at Lenox Hill Radiology. The results of this MRI were similar to those obtained from the MRI initially conducted in the emergency room two days after plaintiff's accident- posterior bulges at L3-4, L4-5 and LF-S1.

On September 17, 2010, plaintiff saw Dr. Neil Morgenstern for a consultation and a nerve conduction study. Dr. Morgenstern's consultation report indicates that plaintiff complained of persistent lower back pain as well as intermittent tingling and numbness in her right leg. Interestingly, Dr. Morgenstern's report does not indicate whether plaintiff made any complaints regarding pain in her right shoulder. After conducting a straight leg raise test and a range of motion test of the lumbar spine, he determined that plaintiff had bulging discs at L3-S1.

A second visit to Dr. Schottenstein on September 28, 2010, resulted in a report which states that plaintiff again made subjective complaints of pain and tightness in the lower back, with minimal radiation of pain to the left buttocks at a pain intensity level of 7/10. A subsequent orthopedic exam of plaintiff yielded the same results as the initial exam. Upon reviewing the results of the MRI, Dr. Schottenstein noted spine bulges, and also noted that the results of the EMG tests indicated radiculopathy. His final diagnosis was that plaintiff had lumbar radiculitis secondary to disc bulges and neuropathy.

Consequently, plaintiff commenced the instant action via the filing of a Summons and Complaint on November 1, 2010. The City joined issue by service of its Answer on October 8, 2010. On November 5, 2010, the City served an Amended Answer. On December 1, 2010, plaintiff

served a Verified Bill of Particulars, wherein she alleged that as a result of the subject accident, she suffered injuries to her right shoulder, specifically a tear of the right anterior/inferior labrum, adhesive capsulistis, supraspinatus, infraspinatus tendinosis, and internal derangement. She also alleges that she suffers from "L1-L2 left lateral disc herniation, lumbar disc bulges at L3-4, L4-5, L5-S1, right L-4 radiculitis and neuropathy, limitations in range of motion in spine, and lumbar spine sprain/strain (see plaintiff's Bill of Paticulars ¶ ¶ 3-4). On August 10, 2011, the City also served various discovery responses. On July 11, 2012, plaintiff served a Verified Amended Supplemental Bill of Particulars. Her Note of Issue was subsequently filed on August 6, 2012.

It is important to note that plaintiff's Affirmation in Opposition consists solely of the sworn narrative report of Dr. Maxim Tyorkin, Board Certified Orthopedic Surgeon. Plaintiff initially saw Dr. Tyorkin at the same clinic on September 2, 2010, for an orthopedic consultation. His report indicates that plaintiff complained of dull pain at a level of 8/10, joint pain, stiffness and swelling, back pain and difficulty walking. He reviewed plaintiff's August 27, 2010 MRI and concluded that said MRI revealed multiple disc bulges. The City notes that he fails to indicate whether said bulges were degenerative in nature. Additionally, with regard to plaintiff's right shoulder, Dr. Yyorkin ruled out adhesive capsulitis and diagnosed her with right shoulder supraspinatus syndrome. Plaintiffs further notes that he also made no mention of any existing tears.

Dr. Tyorkin performed a range of motion test of plaintiff's right shoulder, noting that she experienced pain with range of motion, and also performed a range of motion test of the lumbar spine. His diagnosis was lumbar radiculopathy and supraspinatus syndrome of the right shoulder. He referred plaintiff for an MRI of her right shoulder. Unfortunately, on September 12, 2010, plaintiff was rushed via ambulance from her home to Lincoln Medical Center Emergency Room after

[* 6]

losing consciousness and collapsing. It was determined that plaintiff, who is diabetic, neglected to take her medication. She was treated and released.

On September 20, 2010, plaintiff underwent an MRI of her right shoulder. The results of said MRI were supraspinatus , infraspinatus tendinosis and an anteroinferior labrel tear. No mention was made of adhesive capsulitis. Plaintiff saw Dr. Tyorkin again on October 7, 2010. Dr. Tyorkin noted that plaintiff had been obtaining physical therapy and thus, had experienced minimal improvement with her right shoulder. He performed a range of motion test. Upon reviewing the results of the MRI of plaintiff's right shoulder, Dr. Tyorkin assessed right shoulder supraspinatus syndrome. No mention was made of any injury to plaintiff's back.

On November 4, 2010, plaintiff saw Dr. Tyorkin for the final time. His report noted that she was receiving physical therapy and was experiencing some relief. After the performance of another range of motion test of the right shoulder, Dr. Tyorkin's final assessment was right shoulder supraspinatus syndrome. He also injected a steroid into plaintiff's right shoulder. His final report again did not mention any injury to plaintiff's back.

On November 14, 2011 and December 1, 2011, Dr. Sheldon P. Feit, M.D., a Board Certified Radiologist, conducted an independent review of plaintiff's medical records. Upon reviewing the August 29, 2010 MRI of the lumbosacral spine, he determined that plaintiff had mild disc bulges at the L4-L5 and L5-S1 levels, degenerative spondylosis, with no evidence of focal herniation. He also reviewed plaintiff's September 20, 2010 MRI taken of her right shoulder. He noted that there was no evidence of any rotator cuff tear, any acute fractures or dislocations. He also noted that there was no gross labral tears and no soft tissue masses. Dr. Feit further determined that the film indicated a mild impingement on the supraspinatus muscle secondary to hypertrophic change at the

acromioclavicular joint.

On February 13, 2012, Dr. Julio V. Westerband, M.D., a Board Certified Orthopedic Surgeon, also conducted an independent orthopedic examination of plaintiff. His report indicates that at the time of his examination, plaintiff was no longer continuing treatment, did not report missing any days from work as a result of the accident, and was currently working on a full time basis performing modified duties. Contrary to what she had informed Dr. Tyorkin, plaintiff advised Dr. Westerband that she had not found the chiropractic and physical therapy she had received to be helpful. Also contrary to the contents of Dr. Tyorkin's records, she denied receiving any injections as a result of the accident.

Like the preceding physicians, Dr. Westerband also performed range of motion tests. However, unlike his predecessors, his report indicates that the method he utilized to obtain the measurements and range of motion measurements were via a subjective maneuver. Specifically, Dr. Westerband conducted a test using a hand held goniometer which he used to objectively measure plaintiff's subjective efforts. The values of all the measurements obtained were compared to an American Medical Association publication. He also performed a range of motion test of plaintiff's right shoulder. Following his examination of plaintiff and his review of her records, he determined that she had right shoulder derangement, and also that her lumbar spine strain/sprain had been resolved.

In her Affirmation in Opposition, plaintiff relies exclusively on the test results and conclusions of Dr. Tyorkin. In his affirmation, Dr. Tyorkin specifies what records he reviewed in formulating his assessment, which is a right shoulder antero-labral tear, right shoulder adhesive capsulitis and lumbar radiculopathy. Underneath the heading "OPINION AND COMMENT," he

opines that "[b]ased on history, review of records, review of diagnostic tests, MRI studies and results of range of motion testing and physical examination, I can state with a reasonable degree of medical certainty that the patient's injuries are consistent with trauma from motor vehicle accident which I find to be the competent producing cause of the injuries cited. The patient's injuries, in particular to the right shoulder, are permanent, and consequential and represent a significant limitation to the 58 year old patient's ability to perform her usual and customary daily functions which include her job in Child Care Program work."

Positions of the parties:

Plaintiff contends that her injuries, resulting from the motor vehicle accident, qualify as "serious injuries" pursuant to Article 51 of the New York State Insurance Law. Under this law, "serious injury" is defined as (1) death; (2) dismemberment; (3) significant disfigurement; (4) fracture; (5) loss of a fetus; (6) permanent loss of use of a body organ, member, function or system; (7) permanent consequential limitation of use of a body organ or member; (8) significant limitation of use of a body function or system; or (9) 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 (*see* McKinney's Consolidated Laws of New York, Insurance Law § 5102(d)).

The City asserts and plaintiff does not dispute, that only numbers 7,8 and 9 of the aforementioned categories are applicable to the instant set of facts. The City asserts that it has demonstrated that plaintiff has utterly failed to meet the "serious injury" threshold as to these specific categories, and that plaintiff's opposition fails to raise a genuine issue of fact. The City argues that

plaintiff fails to specifically dispute the City's arguments and fails to cite any case law, merely referring to and relying on a conclusory, speculative report produced by her expert, Dr. Tyorkin.

The City also notes that plaintiff's November 8, 2012 examination by Dr. Tyorkin was in response to the instant motion, in that plaintiff had not sought treatment for her alleged injuries since December 2, 2010, when she received a therapeutic massage during a physical therapy session. Thus, the City argues that this fact alone undermines the veracity of plaintiff's claims. The City specifically argues that plaintiff fails to create an issue of fact that plaintiff suffered a significant limitation of use of a bodily function or system, that her injury amounts to a permanent consequential limitation of use of a body organ or member or that she suffered a significant limitation of use of a body function or system, as a result of her accident.

Conclusions of law:

"The proponent of a summary judgment motion must demonstrate that there are no material issues of fact in dispute, and that it is entitled to judgment as a matter of law" (Dallas-Stephenson v. Waisman, 39 A.D.3d 303, 306 [1st Dept. 2007], citing Winegrad v. New York Univ. Med. Ctr., 64 N.Y.2d 851, 853 [1985]). Once the proponent has proffered evidence establishing a prima facie showing, the burden then shifts to the opposing party to present evidence in admissible form raising a triable issue of material fact (*see* Zuckerman v. City of New York, 49 N.Y.2d 557 [1989]; People ex rel Spitzer v. Grasso, 50 A.D.3d 535 [1st Dept. 2008]). "Mere conclusory assertions, devoid of evidentiary facts, are insufficient for this purpose, as is reliance upon surmise, conjecture or speculation" (Morgan v. New York Telephone, 220 A.D.2d 728, 729 [2d Dept. 1985]). If there is any doubt as to the existence of a triable issue of fact, summary judgment must be denied (Rotuba Extruders v. Ceppos, 46 N.Y.2d 223 [1978]; Grossman v. Amalgamated Hous. Corp., 298 A.D.2d

224 [1st Dept. 2002]).

In cases such as the one at bar, a defendant must make out a prima facie showing that the plaintiff did not sustain a "serious injury" within the meaning of the statute. Once this is established, the burden then shifts to the plaintiff to come forward with evidence to overcome the defendant's submissions by demonstrating a triable issue of fact that a "serious injury" was sustained (*see* Pommels v. Perez, 4 N.Y.3d 566 [2005]; Grossman v. Wright, 268 A.D.2d 79 [2d Dept. 2000]).

In order for a plaintiff to satisfy the statutory "serious injury" threshold, a plaintiff's proof of injury must be supported by objective medical evidence paired with the doctor's observations during the physical examination of the plaintiff (*see* Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345 [2002]). "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 A.D.2d at 83).

"With this established, the burden shifts to the plaintiff to come forward with evidence to overcome the defendant's submissions by demonstrating a triable issue of fact that a serious injury was sustained within the meaning of the Insurance Law. The plaintiff in such a situation must present "objective proof of the injury" because "subjective complaints alone are not sufficient (Toure v. Avis Rent A Car Sys., 98 N.Y.2d at 350). However, even where there is ample objective proof of the plaintiff's injury, additional contributing factors, such as a gap in treatment, an intervening medical problem, or a pre-existing condition, would interrupt the chain of causation between the accident and the claimed injury (*see* Pommels v. Perez, supra).

The Court finds that defendant City has established its prima facie burden of showing that plaintiff did not sustain a "serious injury" within the meaning of Insurance Law§ 5102(d), as a result of the subject accident, and that plaintiff failed to meet her burden to come forward with competent medical evidence specifically refuting the claimed lack of a causal connection to the accident (*see* Pommels v. Perez, supra; Charley v. Goss, 54 A.D.3d 569 [1st Dept. 2008]). Plaintiff's proffered evidence fails to demonstrate a "permanent consequential limitation of use of a body organ or member," or a "significant limitation of use of a body function or system," or a "medically determined injury or impairment of a non-permanent nature," which endured for 90 days or more and substantially limited the performance of her daily activities" (Insurance Law§ 5102[d]).

To qualify as a "permanent consequential limitation of use of a body organ or member," the limitation must be important or significant, total, as well as permanent (*see* Toure v. Avis Rent ACar Sys., 8 N.Y.2d at 353; Oberly v. Bangs Ambulance Inc., 96 N.Y.2d 295, 299 [2001]). Proof under the significant limitation of use category "requires a comparative determination of the degree or qualitative nature of the injury based on the normal function, purpose and use of the body part and must be supported by objective medical evidence (Best v. Bleau, 300 A.D.2d 858, 860 [3d Dept. 2002] citing Toure v. Avis Rent A Car Sys., 98 N.Y.2d at 350-351), usually through diagnostic test results. The limitation must be more than minor, mild or slight (*see* Toure v. Avis Rent A Car Sys., supra; Gaddy v. Eyler, 79 N.Y.2d 955 [1992]; Licari v. Elliott, 57 N.Y.2d 230 [1982]).

In the case at bar, the first two MRIs indicate disc bulges, some degeneration and radiculopathy. It is well established that bulging or herniated discs, mild cervical and lumbar sprains and impairment are not sufficient to constitute "serious injury" (*see* Toure v. Avis Rent A Car Sys.,supra; Rhind v. Naylor,187 A.D.2d 498 [2d Dept.1992];Pommels v. Perez, supra).

Furthermore, while the Court finds that although there is evidence of plaintiff's subjective pain, there is no evidence supporting her claim of permanency (*see* Scheer v. Loubek, 70 N.Y.2d 678 [1987]).

The Court notes that plaintiff received treatment for approximately six months subsequent to the accident and failed to seek further treatment for nearly two years thereafter. The Court finds that this cessation of treatment certainly undermines the veracity of her alleged injuries. The Court also finds Dr. Tyorkin's diagnosis unavailing, in that it fails to provide an objective medical basis supporting the conclusion that plaintiff sustained any serious injury. Indeed, after reviewing plaintiff's August 27, 2010 MRI, Dr. Tyorkin ruled out adhesive capsulitis and diagnosed plaintiff with right shoulder supraspinatus syndrome. Most importantly, he did not make any mention of any tears.

In response to Dr. Tyorkin's advice, plaintiff underwent an MRI of her right shoulder on September 20, 2010. The results were supraspinatus, infraspinatus tendinosis and anteroinferior labral tear. No mention was made of adhesive capsulitis. However, in his report following his latest examination of plaintiff on November 8, 2012, he states unequivocally " Right Shoulder, antero-inferior Labral tear (per 9/23/2010 MRI), Right Shoulder Adhesive capulitis....." The Court also notes that when Dr. Feit reviewed plaintiff's September 20, 2010 MRI of her right shoulder, he concluded that "[r]eview of the MRI of the right shoulder obtained just under four months following the date of the injury fails to demonstrate evidence of any rotator cuff tear or fracture. The impingement on the supraspinatus muscle at the acromioclavicular joint is entirely degenerative. No posttraumatic changes are identify and there are no abnormalities causally related to the injury of May 26, 2010" (see Exhibit "P").

The Court also finds that plaintiff fails to submit sufficient evidence supporting her claim of "a medically determined injury or impairment of a non-permanent nature" which endured for 90 days or more and substantially limited the performance of her daily activities. In order to prove "serious injury" under the 90-out of- 180- day rule, plaintiff is required to prove that she was "curtailed from performing [her] usual activities to a great extent rather than some slight curtailment (Licari v. Elliot, 57 N.Y.2d at 236). Plaintiff's proffered evidence indicates that she has suffered "minor, mild or slight limitation in use" and also that some semblance of improvement has occurred. The only medical documentation that addresses plaintiff's prospective ability to perform her daily activities is Dr. Torkin's report. However, the Court finds that this report is replete with conclusory assertions tailored to meet the statutory requirements (*see* Lopez v. Senatore, 65 N.Y.2d 1017 [1985]).

"It is well settled that absent supporting credible medical evidence or documentation, subjective complaints of pain and discomfort, and the resulting impact on plaintiffs' daily routine, are insufficient to sustain a finding of serious injury (Campbell v. Finke, 187 A.D.2d 780, 782 [3d Dept. 1992]. Furthermore, it is also insufficient that plaintiff's physician merely repeats plaintiff's own subjective complaints of pain (*see* Antorino v. Mordes, 202 A.D.2d 528 [2d Dept. 1994]; Rhind v. Naylor, supra).

Finally, the record is devoid of any objective medical evidence that plaintiff suffered an injury which prevented her from performing substantially all of her daily activities for a period of 90 days out of the 180 days after the accident. Plaintiff's allegations that she cannot blow dry her hair properly, cannot sweep, knit or clean properly is insufficient. Moreover, no evidence has been presented which proves that plaintiff's ability to do her job has been adversely affected. The simple statement that her duties have been modified, without further explanation, is simply not enough.

Therefore, in accordance with the foregoing, it is hereby

ORDERED that defendant's motion for summary judgment is granted; and the complaint and any cross-claims against it are hereby severed and dismissed against it, and the Clerk is directed to enter judgment in favor of defendant; and it is further

ORDERED that any scheduled conferences are cancelled; and it is further

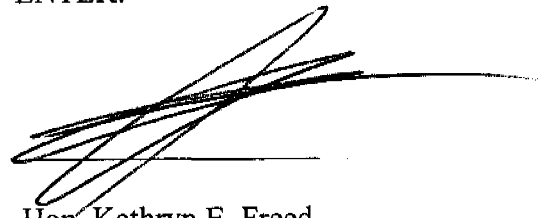
ORDERED that defendant movant shall serve a copy of this order on all other parties and the Trial Support Office at 60 Centre Street, Room 158; and it is further

ORDERED that this constitutes the decision and order of the Court.

DATED: April 24, 2013

APR 24 2013

ENTER:



Hon. Kathryn E. Freed
J.S.C.
HON. KATHRYN FREED
JUSTICE OF SUPREME COURT

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