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

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ROCIO ORTEGA,

Plaintiff,

-against- Index No.: 115422/09

LATOYA POWELL, WILLIE AND LULA POWELL, AND NGAGNE GNING,

Defendants.

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HON. ARLENE P. BLUTH, JUSTICE.

In this action, plaintiff alleges that, on September 2, 2008, she sustained serious personal injuries as the result of an automobile accident in which she was a passenger in the back seat of a taxi involved in a collision. Defendants Latoya Powell and Willie and Lula Powell move for an order granting summary judgment dismissing this action on the ground that plaintiff did not sustain a "serious injury" within the meaning of Insurance Law § 5102 (d). Defendant Ngagne Gning cross-moves for the same relief.[1] The motion is denied in part, and granted in part.

BACKGROUND

Plaintiff, in her bill of particulars and/or supplemental bill of particulars, asserts that she has suffered knee, back and hip injuries, miscarriage and post-traumatic stress which constitute serious injuries under the Insurance Law § 5102 (d) grounds of: (1) significant limitation of use of a body function or system; (2) permanent loss of use of a body organ, member function or

[1]In moving, defendant Ngagne Gning relies on and adopts the other defendants' submissions on this motion.

system;[2] (3) a permanent consequential limitation of same; (4) a medically determined injury or impairment of a non-permanent nature that prevented plaintiff from performing substantially all of the material acts which constituted her usual and customary activities for at least 90 days during the 180 days immediately following the accident [the 90/180 Day Ground]; and (5) the loss of a fetus.

Concerning her alleged back injury, plaintiff's bill of particulars asserts that plaintiff suffered: spinal disc herniation; derangement of the thoracolumbar spine; lumbar and cervical spine sprain and strain; cervical and low back syndrome; and bilateral L5 and S1 radiculopathies. Although plaintiff's initial bill of particulars states that she was not employed on the date of the accident, plaintiff supplemented her particulars, stating that she had been employed as a cashier at a restaurant on the date of the accident and has been incapacitated from then until the December 29, 2010 date of the document, thereby sustaining lost wages of $30,396.60.

DISCUSSION

> "On a motion for summary judgment, facts must be viewed in the light most favorable to the non-moving party. Summary judgment is a drastic remedy, to be granted only where the moving party has tender[ed] sufficient evidence to demonstrate the absence of any material issues of fact, and then only if, upon the moving party's meeting of this burden, the non-moving party fails to establish the existence of material issues of fact which require a trial of the action. The moving party's [f]ailure to make [a] prima facie showing [of entitlement to summary judgment] requires a denial of the motion, regardless of the sufficiency of the opposing papers"

(*Vega v Restani Constr. Corp.*, 18 NY3d 499, 503 [2012] [internal citations and quotation marks

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[2]A search of this record reveals that plaintiff does not claim the permanent loss of use of any body organ, member function or system, and the evidence reveals no support for such a claim. Therefore, the complaint, as to this Insurance Law § 5102 (d) ground, will be dismissed.

omitted]). The No-Fault Law "bars recovery in automobile accident cases for 'non-economic loss' (e.g., pain and suffering) unless the plaintiff has a 'serious injury' as defined in [Insurance Law § 5102 (d)]" (*Perl v Meher*, 18 NY3d 208, 215 [2011]). In moving for summary judgment in a serious injury case pursuant to Insurance Law § 5102 (d), 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, 397 [1st Dept 1992]). Such evidence includes the "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] [citation and quotation marks omitted]).

In support of their motion, defendants submit the affirmations of Dr. Maurice C. Carter, Dr. Jerome M. Block and the affidavit and report of Dr. Alan A. Kessler. In opposition, plaintiff provides the affirmations of her treating physician, Dr. Larry Neuman, and Dr. Paul Post, who examined plaintiff on an orthopedic consultation in 2012.

The Loss of a Fetus

While the "loss of a fetus" is a serious injury under Insurance Law § 5102 (d), defendants submit the affidavit and report of Dr. Alan A. Kessler. Dr. Kessler avers that he is board certified in Obstetrics and Gynecology and that based on plaintiff's medical records, she was not yet pregnant on the date of the accident and so her miscarriage could not have been related to the accident. The Court notes that you don't have to be a gynecologist to figure that out, either – clearly, she got pregnant after the accident and miscarried very early on in her pregnancy.

The accident was on September 2, 2008. Her last menstrual period was October 12,

2008. She went to the hospital with moderate vaginal bleeding on November 18, 2008 - a little more than ten weeks after the accident and five weeks after her last period. At the hospital, they did an ultrasound and found no fetus. At the hospital they also tested her pregnancy level hormone (beta HCG), which Dr. Kessler indicated a pregnancy of greater than five weeks and probably 7-8 weeks; and two days later she came back to the hospital and her HCG levels had dropped, indicating she was no longer pregnant. They did a procedure to clean out her uterus and tested the specimens - it showed an inflamed and degenerated placenta, and no fetal parts. Because no fetus was identified at the time that plaintiff went into the hospital for treatment for a miscarriage, because of her hormone levels and because no fetus was indicated on ultrasound, pathology specimens or even the plaintiff/patient, and because of simple math, Dr, Kessler opines that plaintiff was not pregnant at the time of the accident.

Additionally, Dr. Block, defendants' examining neurologist, avers that when questioned, plaintiff did not indicate that she has been told that her miscarriage was due to the accident.

In opposition, plaintiff submits no medical evidence to raise an issue of fact demonstrating that she was pregnant at the time of the accident or that the accident proximately caused her miscarriage (*see Alladkani v Daily News*, 262 AD2d 511, 511 [2d 1999]). Notably, she does not even allege that she thought she was pregnant at the time of the accident or give any clue that the loss of a fetus claim had any good faith basis. In an ambiguously worded statement, in her affidavit in opposition (which did not have numbered paragraphs) she says "At the time of the accident I did not know I was pregnant but I found out later". She does not show any proof that she was pregnant at the time of the accident, and clearly got pregnant very shortly after the accident. On that note, her statement that "I was in bed for 5 months following the accident. I

did not get up except to go to the bathroom, to eat and to go to the doctor" is clearly not true.

As there is no fact issue raised as to this category of serious injury, it is dismissed.

Significant Limitation of Use of a Body Function or System or Permanent Consequential Limitation of Use of a Body Organ or Member

To meet the threshold regarding the significant or permanent consequential limitation categories, the limitation must be more than minor, mild or slight and the claim must be supported by credible medical evidence of an objectively measured and quantified condition (*see Gaddy v Eyler*, 79 NY2d 955, 957-958 [1992]; *Licari v Elliot*, 57 NY2d 230, 236 [1982]). Plaintiff alleges that she suffers significant limitations from post-traumatic stress syndrome and cervical and lumbar spine injury.

Post-Traumatic Stress Syndrome

As just stated, to constitute a serious injury, symptoms of post-traumatic stress would need to be more than mild or minor, and the First Department has stated that a claim of this disorder also must be established by objective medical evidence (*see Williams v Baldor Specialty Foods, Inc.*, 70 AD3d 522, 523 [1st Dept 2010]). In support of their motion, defendants offer the affidavit of Dr. Jerome Block, who examined plaintiff in November 2011, and whose curriculum vitae states that he is board-certified in neurology, psychiatry and rehabilitative medicine. Upon examination of plaintiff, Dr. Block found no evidence of any emotional disorder, determining that plaintiff had normal cognition and emotional status, and no complaints of cognitive change or lack of concentration. Dr. Block avers that while plaintiff had not affirmatively complained

about depression, when asked about it indicated that she had "poquito depression" (Block affirmation [aff.] at 2]). These findings establish defendants' burden on this motion.[3]

In opposition, plaintiff provides an unsworn report from September 16, 2008, two weeks after the accident, signed by two psychologists who then saw plaintiff. The psychologists rendered a diagnosis of an adjustment disorder with mixed anxiety and depressed mood, a pain disorder associated with a general medical condition, and "automobile accident" (plaintiff's opposition, exhibit [exh.] 1). In the report, the psychologists opine that plaintiff's symptoms, and the results of the evaluation, were causally and directly related to plaintiff's accident. This report was reviewed by Dr. Block, who discussed the findings therein, and stated that he based his conclusions on the medical records reviewed. Consequently, plaintiff is permitted to rely upon the same report (*see Clemmer v Drah Cab Corp.*, 74 AD3d 660, 662 [1st Dept 2010] [unsworn "MRI reports were referred to by both defendants' and plaintiff's experts in their affirmations and hence, were properly before the court"]; *Kearse v New York City Tr. Auth.*, 16 AD3d 45, 47 n 1 [2d Dept 2005] ["this court has held that even a reference to the unsworn or unaffirmed reports in the moving papers is sufficient to permit the plaintiff to rely upon and submit these reports in opposition to the motion"]).[4]

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[3]Block avers that he reviewed plaintiff's medical records from Dr. Francico Rosario-Amaro, who indicated that on July 26, 2010, plaintiff denied feeling depressed or hopeless in the prior weeks and denied having little interest or pleasure in doing things and exhibited appropriate mood and affect (Block aff. at 9). Dr. Block avers that he reviewed records of Christ Hospital, recorded less than three months post-accident, in which it is noted that plaintiff denied musculo-skeletal aches or pain and psychiatric problems including emotional distress. These records have not been submitted by either party.

[4]The report recommended follow-up psychological care, but if there is admissible, objective, nonconclusory evidence in the record demonstrating that plaintiff received care for serious manifestation of post-traumatic stress after the report, plaintiff has not cited to it.

To demonstrate duration of limitation, plaintiff submits the affidavit of Dr. Larry M. Neuman who provided medical care to plaintiff, at Urgent Medical Care, soon after the accident. Dr. Neuman states that his clinical impression is of post-traumatic stress syndrome. However, other than stating that he based his impression upon plaintiff's complaints of anxiety and depression with manifestations including phobias and flashbacks, the report is devoid of details concerning these complaints or symptoms, any indication that he inquired further concerning her assertions, notation concerning review of records with such complaints, or evidence of any psychological/mental health assessment performed upon which Dr. Neuman formed his impression. Dr. Neuman also does not opine as to the seriousness of plaintiff's self-reported complaints, and his single conclusory assertion is insufficient to demonstrate a current serious limitation, or to defeat summary judgment (*see Banco Popular N. Am. v Victory Taxi Mgt.*, 1 NY3d 381, 383-384 [2004] [averments that are conclusions are insufficient to defeat summary judgment]; *see also Toure v Avis Rent A Car Sys.*, 98 NY2d 345, 350 [2002] [subjective complaints alone are not sufficient]).

Cervical and Lumbar Spine Injury

Curiously, none of the doctors who submitted reports mentioning range of motion appear to have used any kind of objective measuring tool to quantify plaintiff's range of motion – not the moving doctors Carter or Block nor the opposing doctors Neuman and Post. Dr. Neuman actually crossed off from his affidavit all references to using a goniometer.

Plaintiff was examined by Dr. Carter, a board-certified orthopedic surgeon, on November

12, 2011.[5] In his affidavit, Dr. Carter remarked that upon examination plaintiff had good upper extremity reflexes, but less right upper body sensation, for which there is no medical basis. Dr. Carter also states that he performed cervical spine range of motion testing, but states only approximate results of the testing, and that plaintiff complained of pain; he does not state that he used any objective tool to measure the range of motion and does not compare it to normal. Dr. Carter also opined that a cervical spine MRI of plaintiff, conducted in November 2008, showed no cause for subjective complaint.

Dr. Carter reported that plaintiff had negative seated straight leg raising signs, but had positive supine straight leg raising for back pain, with plaintiff emitting a large shriek at about 10 to 15 degrees. Dr. Carter stated that the difference between the seated and supine straight leg raising signs defied medical explanation, but does not explain the basis for this conclusion. Dr. Carter also found that lower extremity sensation showed reduced sensation in the right lower leg, but, similar to plaintiff's upper body sensation pattern, that this finding followed no anatomic pathway, and therefore could not be accepted as real. Dr. Carter reviewed a report of a lumbar MRI, conducted on December 2, 2008, which, he stated, indicated a 2 mm herniation at L5/S1, without indication that this displacement was anywhere near the nerve root. Dr. Carter opined that is a common finding, even in the third decade of life. Dr. Carter opined that a note concerning electrodiagnostic tests performed on plaintiff, that were positive for sub-acute bilateral L5 and S1 radiculopathies, was not concordant with plaintiff's lumbar MRI findings of a disc herniation compressing the sac, and eccentric to the right. Dr. Carter stated that the findings

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[5]Dr. Carter states that he reviewed plaintiff's medical records from St. Luke's-Roosevelt Hospital, Urgent Medical Care and Christ Hospital.

findings described in the MRI report did not indicate a condition that could produce bilateral radiculopathy at any level, including L5/S1.

Dr. Carter described medical records from plaintiff's treating physicians, at Urgent Medical Care, as lacking in diagnostic and quantitative information. Dr. Carter notes that plaintiff underwent various injections that he indicates would not have been effective for plaintiff's medical condition. Dr. Carter stated that his review of plaintiff's medical records did not reveal objective evidence indicating that plaintiff has any residual problem from the accident, or that supports plaintiff's complaints of a constant little bit of neck and low back pain, which he deemed the product of symptom magnification. Dr. Carter also concluded that plaintiff was capable of her prior employment and enjoyment of life.

Dr. Block affirms that his examination of plaintiff revealed sightly better sensation in her left hand and foot, over her right. Dr. Block stated that this finding did not conform to any neurological pathway. Dr. Block also stated that plaintiff exhibited normal appreciation of thermal, vibration and position stimulation, and exhibited normal strength, tone, muscle bulk, gait, balance, and heel and toe walking. Dr. Block remarked that the examination was negative for pathological reflexes, or evidence of spasm or trigger points, but that plaintiff reported discomfort in the back of her neck upon manual testing of her proximal arm muscles. Dr. Block noted that plaintiff's complaint that she must lean to the right when sitting was inconsistent with her actions in sitting without leaning on the examining table and after examination.

Dr. Block acknowledged mild limitation of plaintiff's cervical spine range of motion, stating that plaintiff demonstrated 80% of cervical flexion and 65% of extension, but with normal bilateral rotation and tilt, and that plaintiff indicated that the flexion and extension limitations

were caused by cervical neck discomfort. Dr. Block also stated that plaintiff demonstrated significant limitations of all lumbar motions, and that while seated straight leg raising was bilaterally negative, plaintiff complained of low back ache upon right straight leg raising to 90 degrees. Dr. Block found no evidence of paravertebral muscle spasm, trigger points, elicitable Tinel's signs over superficial nerves, or pain over sciatic nerves, notches or brachial plexii, and the remainder of the neurological exam to be normal.

Dr. Block analyzed the report of plaintiff's lumbar MRI study, and opined that a 2 mm protrusion does not cause spinal canal, neural foramina or lateral recess stenosis, and does not impinge on any nerve root, but that, generally, such changes are asymptomatic, and that "there is no clinical correlation between those changes and her continued complaints" (Block aff. at 14).[6] Dr. Block opined that plaintiff's electrodiagnostic study results were inconsistent with plaintiff's history, physical examination and the change reported in the lumber MRI study, and concluded that he found no indication of any abnormality of the central, peripheral, or autonomic nervous system, with plaintiff neurologically sound.

In opposition, to demonstrate contemporaneous injury, plaintiff submits a treatment record, from Urgent Medical Care, dated September 10, 2008, slightly over a week after the accident, which notes that plaintiff exhibited cervical, thoracic and lumbosacral spasm, as well as impaired range of motion of the cervical and lumbar spine. Plaintiff also submits a more formal, typed, treatment note, dated September 17, 2008, of the now deceased Dr. Frank Carr, who was

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[6]Defendants assert that "such changes are totally asymptomatic," but this is not an accurate reflection of Dr. Block's assertion (Rutter moving aff., ¶ 16).

affiliated with Urgent Medical Care,[7] which notes that straight leg raising produced pain and discomfort of plaintiff's thoracolumbar spine at 20 degrees, and that forward bending at 8 degrees produced pain with paraspinal spasm, as did left to right lateral bending. It is undisputed that plaintiff underwent cervical and lumbar spine MRIs, and that the lumbar MRI demonstrates lumbar disc herniation and desiccation. Defendants do not dispute that plaintiff was taken by ambulance for treatment at St. Luke's-Roosevelt Hospital on the date of the accident, or that there was an accident.

To demonstrate current limitation, plaintiff has submitted the affidavit of Dr. Paul Post, who affirms that he examined plaintiff in his office on April 18, 2012, for an orthopedic consultation, and states that his examination was remarkable for tenderness, tightness, and restricted trunk motion, which are based upon the patient's complaints, not objective medical findings. Although he does not state that he used a goniometer or other measuring tool, he states that she had specific decreased range of motion in the lumbar spine, with losses, in many planes, of between 10-60 degrees, as well as spasm of the paravertebral lumbar musculature. Dr. Post also affirmed that seated straight leg raising produced back pain and tightness on the right prior to full extension, but that left leg raising could be accomplished fully to a normal 90 degrees. He

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[7]Plaintiff seeks to submit documents as business records and "a physician's office records, supported by the statutory foundations set forth in CPLR 4518 (a), are admissible . . .as business records" (*Matter of Bronstein-Becher v Becher,* 25 AD3d 796, 797 [2d Dept 2006] [day-to-day business entries of a treating physician, but not medical reports containing opinion or expert proof, are admissible under business records exception]). However, it is not clear that all of the records submitted meet the rule's requirements, where they do not appear to have been both created and maintained by Urgent Medical Care in the ordinary course of business. As all of the evidence upon which the court relies in making this determination was reviewed and referenced or relied upon by defendants' experts, it is unnecessary, for purposes of this motion, to determine whether any particular record might also be admissible as a business record.

further affirmed that supine straight leg testing revealed back pain and was restricted at 30 degrees, with left leg normal at 90 degrees. Dr. Post's report states "sporadic decreased sensation involving the right lower" and appears to record decreased right ankle reflexes (Post aff. at 2). Dr. Post concluded, based on plaintiff's history and clinical findings, that she exhibited objective evidence of an L5-S1 herniated disc with root irritation on the right as a result of the September 2, 2008 accident, that permanence is present and that persistence of symptoms and worsening of the condition would make plaintiff a surgical candidate.

Plaintiff's treating physician, Dr. Neuman, of Urgent Medical Care, states that he performed objective lumbar and cervical testing of range of motion but specifically crossed out all references to using a goniometer in his affirmation. He lists the tests performed, the ranges of normal, and concludes that plaintiff's cervical spine testing revealed a range of motion limited by 25-50% and a lumbar range of motion limited by 50% in all planes. Dr. Neuman opined to a reasonable degree of certainty that the injuries sustained by Ortega are the permanent and direct result of the accident, and not preexisting or degenerative. He bases this opinion on "the magnitude of injuries sustained, with persistence of symptoms spanning a one year period, as well as objective findings of disc herniation" (Neuman aff., Neuman report at 2).

In a case involving plaintiff's allegedly injured spine, to meet its burden on summary judgment, a defendant must demonstrate that the plaintiff currently does not have a significant range of motion limitation with objective evidence (*see Collazo v Anderson,* 103 AD3d 527, 528, [1st Dept 2013] ["[d]efendants failed to meet their prima facie burden of showing the absence of a serious injury to plaintiff's lumbar spine" where "orthopedist did not adequately explain his finding of a significant limitation in forward flexion"]; *Vega v MTA Bus Co.*, 96 AD3d 506, 507

[1st Dept 2012] [defendant must "submit [ ] expert medical reports finding normal ranges of motion in the claimed affected body parts and no objective evidence that any limitations resulted from the accident"]; *cf. Osborne v Diaz*, 104 AD3d 486 [1st Dept 2013] [burden met with among other things, "affirmed reports of an orthopedic surgeon who found full range of motion in every plane"]).

Here, defendants did not demonstrate normal range of motion of plaintiff's cervical and lumbar spine, and both of defendants' experts note that plaintiff has restricted range of motion, with Dr. Block noting that plaintiff exhibited significant lumbar spine restriction. In addition, neither expert demonstrates objective testing of the magnitude of the limitation. Furthermore, while Dr. Block states that the findings in plaintiff's MRI "generally" do not result in symptoms, he does not state that they *cannot* cause symptoms. In addition, both Drs. Block and Carter note positive straight leg testing (*see Osborne,* 104 AD3d 486 [positive finding for straight leg raising test provides objective evidence of lumbar injury]).

While defendants correctly argue that a MRI result demonstrating lumbar spine disc herniation is not sufficient to establish serious injury, without competent objective evidence of limitations or duration of injury (*Williams v Horman*, 95 AD3d 650, 651 [1st Dept 2012] ["existence of ... bulging and herniated discs is not evidence of serious injury in the absence of objective proof of the extent of the alleged physical limitations resulting from the injury, and its duration"]), defendants do not provide proof of the absence of limitation. Therefore, defendants have not met their burden to demonstrate the absence of a serious injury to plaintiff's spine.

Because defendants have failed to make a prima facie showing, their summary judgment motion, with respect to the categories of permanent consequential limitation and significant

limitation, must be denied regardless of the claimed insufficiency of the opposing papers (*see Offman v Singh*, 27 AD3d 284, 284 [1st Dept 2006]). Furthermore, it is unnecessary to consider the sufficiency of the evidence submitted in opposition to the motion with respect to these categories (*see Caballero v Fev Taxi Corp.*, 49 AD3d 387, 387-388 [1st Dept 2008) or any additional injuries (*see Delgado v Papert Tr., Inc.*, 93 AD3d 457, 458 [1st Dept 2012]).

In reply, defendants assert that plaintiff has not established the absence of a preexisting condition, as her MRI indicates disc dessication, and her expert must address causation. In moving, however, neither of defendants' experts opined that plaintiff suffered from a degenerative or preexisting condition. In fact, Dr. Carter states that the MRI report did not reveal *any* underlying pathology that would have cause plaintiff's complaints; he did not say that the MRI showed preexisting degenerative disc issues. Dr. Block also did not indicate that plaintiff is suffering from this, or another, preexisting condition that caused the claimed injuries. Defendants may not shift this burden to plaintiff when they did not meet their own burden to demonstrate the existence of preexisting injury or degenerative disc disease (*see Farrington v Go On Time Car Serv.*, 76 AD3d 818 [1st Dept 2010] [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]),[8] and also may not raise a new argument on reply (*see Calcano v Rodriguez,* 103 AD3d 490, 491 [1st Dept 2013]).

In any event, with plaintiff's affidavit and the admissible medical records, the record is sufficient to raise a fact issue as to spinal injury contemporaneous to the accident (*Perl*, 18 NY3d

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[8]At trial the plaintiff will, of course, be required to establish causation (*see Valentin v Pomilla*, 59 AD3d 184 [1st Dept 2009]).

at 217-218 [no requirement of contemporaneous quantitative measurements]), contains evidence of treatment thereafter for such injuries, including physical therapy for approximately nine months thereafter (*see* Block aff. at 2), and plaintiff provides evidence of some objective medical indicia of current limitation.[9] Defendants' submissions suggest that plaintiff is feigning signs and symptoms. This may be true, but on this record, this is a fact issue for a jury, and summary judgment is denied as to this category of serious injury.

The *90/180 Ground*

Plaintiff claims that due to the accident she was prevented from performing substantially all of the material acts which constituted her usual and customary daily activities for a period of at least ninety days during the 180 days immediately following the accident, as she was confined to home and bed, and could not work, leaving her bed only to eat and her home only to visit the doctor. As discussed above, in her supplemental bill of particulars, plaintiff asserts that she was prevented from working after the accident because of the injuries she suffered.

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

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[9]Plaintiff asserts that testing was performed with a goniometer, but Dr. Post's affirmation does not state that he used this or any other instrument to measure range of motion and the reference to a goniometer in Dr. Neuman's affirmation is crossed out, although he affirms that he performed objective testing. However, defendants experts also do not identify any instrument used to measure range of motion. In addition, Dr. Post does report straight leg raising indications of back injury, affirms that he reviewed the lumbar MRI report and what it states, and opines that plaintiff demonstrates objective evidence of the herniation as a result of the accident. On summary judgment this evidence must be viewed in a light most favorable to plaintiff, the non-moving party (*Martin v Briggs*, 235 AD2d 192, 196 [1st Dept 1997]).

days of normal activity during the first 180 days following the accident" or other evidence, "such as the plaintiff's own deposition testimony or records demonstrating that he or she was not prevented from performing all of the substantial activities constituting customary daily activities for the prescribed period" (*Elias v Mahlah*, 58 AD3d 434, 435 [1st Dept 2009]). To meet their burden, defendants submit plaintiff's testimony that no doctor advised her not to work (Rutter moving aff., exh. H at 10-11) and the record of plaintiff's clinic/doctors' office, Urgent Medical Care, of September 10, 2010, in which the check off box for impaired functionality in the impressions section of the form medical record was left blank, while other boxes in that same section were checked off.

In opposition, plaintiff relies on her own affidavit and those affirmations of her treating physician, Dr. Neuman, and expert, orthopedic physician, Dr. Post. In her affidavit, plaintiff avers that she was confined to bed and home for five months after the accident due to her injuries, except to eat, go to the bathroom or visit the doctor (she was able to get pregnant, however). Plaintiff also contrasts differences in her social life and ability to exercise prior to the accident to the five-month period thereafter, during which time she avers that she could not work, bend down, go shopping, clean house, and that her mother helped plaintiff care for her child, because plaintiff could not do so due to pain and soreness. Plaintiff continues that currently she cannot dance, go for long walks, run after or pick up her son, or help her mother with household chores.

Plaintiff argues that her affidavit, considered with Drs. Neuman and Post's affirmations, in which they address her inability to perform her usual and customary daily activities, such as shopping, cleaning, and social activities, demonstrate that she has raised a fact issue as to this

category of serious injury. However, neither physician's affirmation mentions any of these activities. As to function, Dr. Neuman states that plaintiff "continued to manifest functional impairment as [of the] last visit to this office on 8/25/09" (Neuman aff., Neuman report at 2),[10] but does not state that plaintiff could not, or was advised not to, engage in any particular activity or go to work after the accident. Dr. Post's April 18, 2012 affidavit, which addresses plaintiff's complaints and physical examination at that time, does not mention functional impairment after the accident in 2008. This showing is not sufficient to raise a fact issue as to whether plaintiff's injury prevented her from engaging in substantially all of her customary daily activities for the statutorily-required period; therefore, it is insufficient to sustain this category of serious injury (*Brand v Evangelista,* 103 AD3d 539, 540 [1st Dept 2013] ["The three-month period plaintiff alleged he lost from work was not substantiated by any documentation from his employer or medical documentation of his inability to perform his usual daily tasks. Therefore, plaintiff failed to satisfy the 90/180–day category"]; *Collazo,* 103 AD3d at 528 ["Plaintiff's assertion that she could not perform her usual and customary daily activities during the requisite period is unsupported by objective medical evidence"]; *cf. Jean-Louis v Gueye,* 94 AD3d 504, 505 [1st Dept 2012] [fact issue raised where "[p]laintiff submitted evidence that her orthopedic surgeon instructed plaintiff to remain out of work and substantially restrict her day-to-day activities, finding that she was 'totally disabled' during the relevant statutory period. Plaintiff testified that she had no choice but to do so given the fact that she underwent two surgeries during the relevant

[10]Plaintiff also asserts that the defendants' medical examinations and MRI reports, conducted on November 1, 2011 and November 12, 2011, over three years after the accident, are not probative of the 180 days after the accident. However, the record contains nothing to demonstrate that an MRI was conducted other than the 2008 tests previously discussed.

period"]).

CONCLUSION

Accordingly, it is hereby

ORDERED that the motion for summary judgment by defendants is granted in part, only to the extent of dismissing so much of the complaint that alleges that plaintiff suffered a serious injury within the meaning of Insurance Law § 5102 (d) with respect to the following injuries/categories: (1) post-traumatic stress disorder and (2) 90/180 (3) the permanent loss of use of any body organ, member function or system, and (4) loss of a fetus. The motion is otherwise denied; and it is further

ORDERED that the remainder of the action shall continue.

This is the Decision and Order of the Court.

Dated: May 13, 2013

MM

ENTER:

HON ARLENE P. BLUTH, JSC