Trivigno v Public Adm'r of Suffolk County
2015 NY Slip Op 31677(U)
August 18, 2015
Supreme Court, Suffolk County
Docket Number: 12-27455
Judge: John H. Rouse

SHORT FORM ORDER

INDEX No. 12-27455
CAL. No. 14-02090MV

SUPREME COURT - STATE OF NEW YORK
I.A.S. PART 12 - SUFFOLK COUNTY

PRESENT:

Hon. JOHN H. ROUSE
Acting Justice of the Supreme Court

MOTION DATE 1-28-15
ADJ. DATE 3-25-15
Mot. Seq. # 001 - MG; CASEDISP

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NANCY TRIVIGNO,

Plaintiff,

- against -

PUBLIC ADMINISTRATOR OF SUFFOLK COUNTY as Administrator of the Estate of CRAIG M. STEINBERG,

Defendant.

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DAVIS & FERBER, LLP
Attorney for Plaintiff
1345 Motor Parkway, Suite 201
Islandia, New York 11749

RUSSO, APOZNANSKI & TAMBASCO
Attorney for Defendant
115 Broad Hollow Road, Suite 300
Melville, New York 11747

Upon the following papers numbered 1 to 37 read on this motion for summary judgment; Notice of Motion/ Order to Show Cause and supporting papers 1 - 26; Notice of Cross Motion and supporting papers ____; Answering Affidavits and supporting papers 27 - 34; Replying Affidavits and supporting papers 35 - 37; Other ____; (~~and after hearing counsel in support and opposed to the motion~~) it is,

ORDERED that this motion by defendant for an order pursuant to CPLR 3212 granting summary judgment in defendant's favor dismissing the complaint on the ground that plaintiff did not sustain a serious injury as defined in Insurance Law § 5102 (d) as a result of the subject accident is granted.

This is an action to recover damages for injuries allegedly sustained by plaintiff on March 29, 2012 at approximately 7:15 pm when her vehicle was struck in the rear by the vehicle operated by Craig M. Steinberg. The accident occurred on northbound Indian Head Road in Kings Park, New York. Plaintiff alleges that as a result of the subject accident she sustained serious injuries, including concussion with post concussion syndrome, herniation at C6-7, disc bulges at C5-6 and L3-4, and effusion and edema of the left knee. In addition, plaintiff alleges that following said accident, she was confined to bed and home for approximately three weeks.

Defendant now moves for summary judgment dismissing the complaint on the ground that plaintiff did not sustain a serious injury as defined in Insurance Law § 5102 (d). Defendant's submissions include

the pleadings, plaintiff's bill of particulars, plaintiff's deposition transcript, and the affirmed reports of defendant's examining orthopedic surgeon and neurologist.

Insurance Law § 5102 (d) defines "serious injury" as "a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or 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."

In order to recover under the "permanent loss of use" category, plaintiff must demonstrate a total loss of use of a body organ, member, function or system (***Oberly v Bangs Ambulance***, 96 NY2d 295, 727 NYS2d 378 [2001]). To prove the extent or degree of physical limitation with respect to the "permanent consequential limitation of use of a body organ or member" or a "significant limitation of use of a body function or system" categories, either objective evidence of the extent, percentage or degree of plaintiff's limitation or loss of range of motion must be provided or there must be a sufficient description of the "qualitative nature" of plaintiff's limitations, with an objective basis, correlating plaintiff's limitations to the normal function, purpose and use of the body part (*see* ***Perl v Meher***,18 NY3d 208, 936 NYS2d 655 [2011]; ***Toure v Avis Rent A Car Systems, Inc.***, 98 NY2d 345, 746 NYS2d 865 [2000]). In order to qualify under the 90/180-days category, an injury must be "medically determined" meaning that the condition must be substantiated by a physician, and the condition must be causally related to the accident (*see* ***Damas v Valdes***, 84 AD3d 87, 921 NYS2d 114 [2d Dept 2011]). A preexisting condition does not foreclose a finding that the injuries were causally related to the accident (*see* ***Rodgers v Duffy***, 95 AD3d 864, 944 NYS2d 175 [2d Dept 2012]).

On a motion for summary judgment, the defendant has the initial burden of making a prima facie showing, through the submission of evidence in admissible form, that the injured plaintiff did not sustain a "serious injury" within the meaning of Insurance Law § 5102 (d) (*see* ***Gaddy v Eyler***, 79 NY2d 955, 582 NYS2d 990 [1992]; ***Akhtar v Santos***, 57 AD3d 593, 869 NYS2d 220 [2d Dept 2008]). The failure to make such a prima facie showing requires the denial of the motion regardless of the sufficiency of the opposing papers (*see* ***Winegrad v New York Univ. Med. Ctr.***, 64 NY2d 851, 487 NYS2d 316 [1985]; ***Boone v New York City Tr. Auth.***, 263 AD2d 463, 692 NYS2d 731 [2d Dept 1999]). "Once this showing has been made, however, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (***Alvarez v Prospect Hosp.***, 68 NY2d 320, 324, 508 NYS2d 923 [1986], citing to ***Zuckerman v City of New York***, 49 NY2d 557, 562, 427 NYS2d 595 [1980]).

Plaintiff's deposition testimony reveals that as she was approaching a traffic light her vehicle was hit in the rear and flipped over multiple times then hit a tree. Her front and side air bags deployed. Plaintiff hit her head on the side of the vehicle and her left knee and shin on the lower dashboard. She did not lose consciousness but lost her vision temporarily. Plaintiff was taken by ambulance to St. Catherine of Siena Medical Center with complaints of pain in her head, neck, left knee and shin. At the emergency room, plaintiff underwent x-rays of her upper body and was told that she had no fractures; she received an injection

to relieve pain; and then she was discharged with a neck brace. She was told to follow-up with an orthopedist. Plaintiff then went to her primary care physician who referred her to North Shore Orthopedic Surgery, where she received treatment from Dr. Scheman, Dr. Mark Sterling, and Dr. Vessey in four to six visits. Plaintiff underwent MRI's, was told that she had herniated discs in her neck and a mildly bulging disc of her lower back, and then began physical therapy two days a week for three months. She stopped going to physical therapy because she felt that she was not making further progress. Thereafter, plaintiff received treatment at least twice a week for three or four months from a chiropractor, Dr. Robert Berney. After she told her primary care physician that she sustained a concussion in the accident, he referred her to a neurologist, Dr. Que, whom she saw two or three times. Plaintiff underwent a CAT scan and an EEG after which Dr. Que told her that she had post concussion symptoms that could last up to a year. Plaintiff received treatment for her left knee from an orthopedist, Dr. Germano, of Orlin & Cohen who gave her three injections that stopped the pain. At the time of the accident, plaintiff was applying for a part time sales position at Macy's. She began training in June following the accident and began working in July, for 12 hours a week for three weeks. Plaintiff stopped working due to pain in her neck and left knee. She currently helps her husband in his business by answering the phones and doing paperwork. Plaintiff no longer has any pain or complaints concerning her lower back. She also had no current complaints regarding her left knee. However, the pain in her neck "comes and goes," and she has difficulty with her memory and comprehension. Plaintiff stated that she can no longer run, sleep on her back, swim or jump off the diving board, lift groceries or clean house. She has difficulty looking over her shoulder when driving and needs help to carry or pull heavy items. Plaintiff has no current appointments with her treatment providers and sees her chiropractor when necessary.

By his affirmed report dated October 3, 2013, defendant's examining orthopedic surgeon, Gary Kelman, M.D., indicated that he examined plaintiff on said date and performed range of motion testing using a standard goniometer with normal range of motion values based on AMA guidelines. He reported range of motion testing results for plaintiff's cervical spine, lumbar spine, and right and left knee, which when compared to normal values were all normal. His examination of plaintiff's cervical spine revealed no spasms but minimal to moderate paraspinal tenderness and bilateral trapezii tenderness to palpation. His neurological examination of her upper extremities showed that muscle testing was 5+/5 throughout with no giveaway weakness, her sensory responses were intact, and her deep tendon reflexes of the biceps, triceps and brachioradialis were 2+ and equal bilaterally with no atrophy of the intrinsic muscles. Dr. Kelman noted that Spurling's test was negative. His examination of plaintiff's lumbar spine revealed no paraspinal spasms or tenderness upon palpation, patellar and Achilles reflexes were 2+ and equal bilaterally, and the straight leg raising test was negative. The results of Dr. Kelman's examination of plaintiff's knees revealed no tenderness to palpation; negative effusion; no atrophy of the quadriceps; and negative results for the McMurray's test, Lachman's test, anterior drawer sign, posterior drawer sign, and Sag test. He also noted that patello-femoral crepitus was not present and that the Valgus & Varus stress test was stable for both knees. Dr. Kelman diagnosed sprain and strain of the cervical spine, lumbar spine and left knee, and opined that there was no orthopedic disability with regard to the alleged injuries sustained in the subject accident.

Defendant's examining neurologist, Uriel Davis, D.O., indicated in his affirmed report dated January 27, 2014 that he performed a neurological examination of plaintiff on said date, and reported findings which include no deficits in cognitive function, recent and remote memories intact, atraumatic head, normal cranial nerves, and grossly normal fundi and visual fields with no photophobia. He diagnosed status post motor

vehicle accident; status post closed head trauma/post concussion syndrome; cervical sprain and strain, resolved, and lumbar sprain and strain, resolved.

Here, defendant met the 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 (*see* ***Paredes v Boudreau***, 129 AD3d 1046, 10 NYS3d 879 [2d Dept 2015]; ***Olivencia v Depompeis***, 129 AD3d 1045, 12 NYS3d 236 [2d Dept 2015]). Defendant submitted competent medical evidence establishing, prima facie, that the alleged injuries to the cervical and lumbar regions of plaintiff's spine and to her left knee did not constitute serious injuries under either the permanent consequential limitation of use or significant limitation of use categories of Insurance Law § 5102 (d) (*see* ***Guevara v Keen***, 129 AD3d 1024, 10 NYS3d 460 [2d Dept 2015]). Defendant also established that plaintiff's head injuries had resolved. Defendant further established that plaintiff did not sustain a serious injury under the 90/180-day category of Insurance Law § 5102 (d) (*see id.*; ***Marin v Ieni***, 108 AD3d 656, 969 NYS2d 165 [2d Dept 2013]).

The burden then shifted to plaintiff to show, by admissible evidentiary proof, the existence of a triable issue of fact (*see* ***Marietta v Scelzo***, 29 AD3d 539, 815 NYS2d 137 [2d Dept 2006]).

Plaintiff opposes the motion arguing that defendant did not meet the burden for summary judgment inasmuch as defendant's examining physicians failed to review all of plaintiff's pertinent medical records rendering their reports procedurally defective. In addition, plaintiff argues that her medical records raise triable issues of fact as to whether she sustained a serious injury as defined in Insurance Law § 5102 (d) as a result of the subject accident. Plaintiff submits her affidavit together with color photographs of her damaged vehicle, the affirmed report dated March 6, 2015 of her treating neurologist Schenley H. Que, M.D. of North Shore Neurological Consultants, and the records of North Shore Neurological Consultants, Orlin & Cohen Orthopedic Associates, LLP, North Shore Orthopedic Surgery & Sports Medicine, PC, and Long Island Spine Specialists, PC.

In reply, defendant contends that many of the medical records submitted by plaintiff are not in admissible form and therefore should not be considered; that the references in Dr. Que's report to plaintiff's medical records should not be considered as it is unclear whether they were sworn records; that there is no explanation for the gap in her treatment; and that since plaintiff was not under the constant care of Dr. Que, he is not in the best position to determine the duration of plaintiff's injuries. In addition, defendant contends that plaintiff's affidavit is self-serving and that the portion concerning knee pain should not be considered because it contradicts her deposition testimony. Defendant further contends that plaintiff has failed to raise a triable issue of fact as she did not provide any objective evidence of physical limitations that are contemporaneous with the subject accident.

By her affidavit, plaintiff details her medical treatment beginning with her visit to her primary care physician on April 2, 2012 through to her chiropractic treatment between July 25, 2012 and June 17, 2013. She explains that she was initially examined by neurologist Dr. Que on April 23, 2012, that he recommended massage therapy and trigger point injections, and that she received four trigger point injections on September 13, 2013, October 18, 2013, January 31, 2014, and February 24, 2015, and that she continues to treat with Dr. Que. Plaintiff informs that she is currently receiving trigger point massage therapy for her neck and that she continues to have daily pain and discomfort in her neck and left knee. She states that her neck has a

limited turning range and "constant degrees of pain." Plaintiff avers that she is unable to sleep on her side without constant neck pain; she has daily headaches; she cannot dive off of a diving board; she cannot participate in "fast activities" that could cause her neck to jerk; and she is unable to lift heavy items.

Initially, the Court notes that defendant's experts were not required to review plaintiff's medical records before forming their opinions nor were they required to specifically address any diagnostic findings therein (*see* ***Mena v White City Car & Limo Inc.***, 117 AD3d 441, 985 NYS2d 234 [1st Dept 2014]; ***Levinson v Mollah***, 105 AD3d 644, 963 NYS2d 653 [1st Dept 2013]). Also, plaintiff's records from North Shore Neurological Consultants, Orlin & Cohen Orthopedic Associates, LLP, North Shore Orthopedic Surgery & Sports Medicine, PC, and Long Island Spine Specialists, PC. are not in admissible form because they are either unaffirmed or uncertified (*see* ***Lozusko v Miller***, 72 AD3d 908, 899 NYS2d 358 [2d Dept 2010]; ***Bernier v Torres***, 79 AD3d 776, 913 NYS2d 299 [2d Dept 2010]; ***Sutton v Yener***, 65 AD3d 625, 884 NYS2d 163 [2d Dept 2009]).

The affirmed report of plaintiff's treating neurologist, Dr. Que, indicates that upon his initial examination on April 23, 2012, he reviewed plaintiff's imaging studies, tested plaintiff's cervical range of motion and found forward flexion to be normal, extension 0 to 20 degrees, left rotation 0 to 70 degrees and right rotation 0 to 80 degrees, and noted muscle spasms in the trapezius region bilaterally. Plaintiff's neurological examination was otherwise normal and she was diagnosed with post concussion syndrome and cervical sprain. Dr. Que also reports that an EEG performed on May 21, 2012 was normal. During plaintiff's follow-up visit on August 8, 2013, he recorded her complaints of a non-throbbing headache in the middle of her head that occurred 5 to 10 times a day but disappeared when she did movements that "unlocked" her neck. Dr. Que noted that plaintiff reported that her back and knee pain had improved significantly. He found that cervical range of motion testing showed mild limitation in extension and rotation and that plaintiff had significant muscle spasm in the right paracervical and right trapezius muscles but that the neurological examination was otherwise normal. He diagnosed plaintiff as having cervicogenic headaches, noting that she had persistent localized muscle spasm mainly in the right paracervical and trapezius region. Dr. Que informs that plaintiff had monthly trigger point injections for three months. On her recent visit on February 24, 2015, plaintiff complained of constant neck pain, that when intense caused a dull headache in the back of her head and limitation in her cervical range of motion. Upon examination, Dr. Que noted a moderate limitation in cervical extension and rotation to the left as well as mild limitation in rotation to the right with significant muscle spasms in the paracervical and trapezius regions bilaterally. He diagnosed chronic neck pain with cervicogenic headache. In concluding his report, Dr. Que opines that plaintiff sustained a neck injury, a lower back injury as well as post concussion syndrome as a result of the subject accident but that the post concussion syndrome and low back pain have improved.

Sprains and strains are not serious injuries within the meaning of Insurance Law § 5102 (d) (*see* ***Rabolt v Park***, 50 AD3d 995, 858 NYS2d 197 [2d Dept 2008]; ***Washington v Cross***, 48 AD3d 457, 849 NYS2d 784 [2d Dept 2008]; ***Maenza v Letkajornsook***, 172 AD2d 500, 567 NYS2d 850 [2d Dept 1991]). Thus, plaintiff's cervical spine sprain injuries do not constitute serious injuries for which plaintiff can recover under the No Fault Law. In addition, the mere existence of a herniated disc, a bulging disc, or radiculopathy is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the injury and its duration (*see* ***Keith v Duval***, 71 AD3d 1093, 898 NYS2d 184 [2d Dept 2010]; ***Casimir v Bailey***, 70 AD3d 994, 896 NYS2d 122 [2d Dept 2010]). There

is no indication as to whether Dr. Que's range of motion testing results were objectively measured inasmuch as there is no mention of any instrument such as a goniometer or inclinometer or arthroidal protractor being used to take said measurements (*see* ***Geliga v Karibian, Inc.***, 56 AD3d 518, 867 NYS2d 519 [2d Dept 2008]; ***DeLeon v J & J Towing, Inc.***, 32 AD3d 986, 822 NYS2d 120 [2d Dept 2006]; ***Desulme v Stanya***, 12 AD3d 557, 785 NYS2d 477 [2d Dept 2004]; *see also* ***Perl v Meher***, 18 NY3d 208). Thus, it cannot be said that his report provides objective evidence of the extent of plaintiff's alleged physical limitations. Moreover, he did not provide normal values for comparison purposes for the range of motion testing results from his initial examination (*see* ***Quintana v Arena Transport, Inc.***, 89 AD3d 1002, 933 NYS2d 379 [2d Dept 2011]), and he failed to set forth any quantified range-of-motion findings or a qualitative assessment for his subsequent examinations (*see* ***Strenk v Rodas***, 111 AD3d 920, 976 NYS2d 151 [2d Dept 2013]). Furthermore, it is well settled that medical opinions based upon subjective complaints of pain or headaches are insufficient to establish "serious injury" (***Kivlan v Acevedo***, 17 AD3d 321, 322, 792 NYS2d 573 [2d Dept 2005]; *see* ***Downie v McDonough***, 117 AD3d 1401, 984 NYS2d 710 [4th Dept2014], *lv denied* 24 NY3d 906, 995 NYS2d 715 [2014]). Therefore, Dr. Que's report fails to raise a triable issue of fact as to whether plaintiff sustained a serious injury as a result of the subject accident.

Moreover, plaintiff's affidavit, with no objective medical evidence to support it, is insufficient to raise a triable issue of fact (*see* ***Riley v Randazzo***, 77 AD3d 647, 908 NYS2d 445 [2d Dept 2010]; ***Shvartsman v Vildman***, 47 AD3d 700, 849 NYS2d 600 [2d Dept 2008]). Furthermore, plaintiff failed to raise a triable issue of fact as to whether she sustained a serious injury under the 90/180–day category of Insurance Law § 5102 (d) (*see* ***Griffiths v Munoz***, 98 AD3d 997, 950 NYS2d 787 [2d Dept 2012]).

Accordingly, the instant motion is granted and the complaint is dismissed in its entirety.

Dated: August 18, 2015

A.J.S.C.

__X__ FINAL DISPOSITION ____ NON-FINAL DISPOSITION