Mosley v Little
2016 NY Slip Op 30883(U)
May 12, 2016
Supreme Court, New York County
Docket Number: 157630/12
Judge: Arlene P. Bluth
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: IAS PART 22
---x
Shanille Mosley,

Plaintiff,

-against-

David Little, Juan Malco-Espinal and
ER Delivery Service,

Defendants.
---x

Motion Seq 01 and 02

Index No. 157630/12

DECISION AND ORDER

HON. ARLENE P. BLUTH

The motion of defendants Malco-Espinal and ER Livery Service (Seq. 01) and the motion of defendant David Little (Seq. 02) for summary judgment dismissing the complaint on the grounds that plaintiff has not demonstrated that her injuries meet the serious injury threshold pursuant to Insurance Law § 5102(d) are both granted, and the action is dismissed.

In her verified bill of particulars, plaintiff claims that she sustained cervical and lumbar sprains, pain and several disc bulges, headaches and psychological problems[1] as a result of the subject March 19, 2011 motor vehicle accident.

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*

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[1]Plaintiff did not testify about any psychological treatment at her deposition.

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]).

In support of their motions, defendants submit the affirmed report of Dr. Singh, a neurologist who examined plaintiff on 5/12/14 and found that plaintiff had normal ranges of motion in her cervical, thoracic and lumbar spine, and a normal neurological exam. Dr. Singh concluded that any alleged sprains/strains in plaintiff's back and neck had resolved.

Defendants also submitted the affirmed reports of Dr. Setton, a radiologist, who reviewed the MRI of plaintiff's cervical spine taken approximately 7½ months after the accident. Dr. Setton stated that he saw only multi-level degenerative disc disease, a chronic process which pre-dated the accident, but no evidence of a traumatic injury on the films. Additionally, Dr. Setton reviewed plaintiff's lumbar MRI also taken 7½ months after the accident and stated that is showed moderate degenerative disc disease at L5-S1 with associated bulging disc and a central annular tear, which was most likely secondary to a chronic repetitive overuse type mechanism, and in no way causally related to the subject accident.

As for the 90/180 category, defendants cite to the verified bill of particulars wherein plaintiff stated that she was confined to bed and home for one week after the accident. Defendants also cite to plaintiff's deposition testimony that she was confined to bed for a couple of days after the accident, but not confined to her home (exh G to moving papers, T at 55-56). Thus, defendants set forth a prima facie case to dismiss, and the burden shifts to plaintiff to raise a triable issue of fact.

In opposition, plaintiff submits an uncertified copy of the Harlem Hospital

Emergency Room records (opp., exh B). Because defendant's doctor, Dr. Donegan, relied on these records (exh F to moving papers), the ER records are admissible and constitute proof of a contemporaneous exam to support causation.

Many of the other medical records submitted by plaintiff are inadmissible. Dr. Neuman's 3/28/11 report (exh C to opp), Dr. Levinson's 4/5/11 and 5/31/11 reports (exhs D and G to opp), and Steven Yellin, Ph.D's 4/11/11 report (exh F to opp) are not sworn to or affirmed, and thus not admissible. Although Vanessa Pagan, the office manager of Heights Medical Care, PC, submitted affidavits "certifying" these records, only hospital records, and not physician office records, are admissible by certification. *See Bronstein-Becher v. Becher,* 25 AD3d 796, 809 NYS2d 140 (2d Dept 2006). Additionally, an office manager cannot affirm or swear that the statements contained in any of those medical reports are true and accurate. Even if these records were admissible, the records pertain to treatment that took place within 3 months of the subject accident, and thus do not raise an issue of fact as to a significant limitation of use or a permanent consequential limitation.

Additionally, the physical therapy notes are inadmissible (exhs E and J). Ms. Pagan, an office manager, cannot certify that the information contained in the records of Heights Medical Care, P.C. (exh E) is true and accurate.

Sheela Exito, PT submitted her progress notes from Ace Physical Therapy and Rehabilitation, PC (exh J), and certified them to be true and accurate. However, mere notes from sessions fail to raise an issue of fact, even if the notes are true and accurate; a narrative report or opinion is necessary. The Court is not in a position to interpret handwritten progress notes and arrive at a medical conclusion.

Dr. Solomon's affirmed cervical and lumbar MRI reports (exhs H and I) are admissible but do not raise an issue of fact. Dr. Solomon's 2011 reports merely state what he saw on the November 1, 2011 films (3 disc bulges and lumbar fascitis) without characterizing the origin as traumatic or degenerative; he did not causally relate any of the findings on the MRIs to the subject accident. Plaintiff did not submit any other doctor's report to contradict Dr. Setton's findings of degeneration. Moreover, bulges and herniations, in and of themselves, do not constitute proof of a serious injury. *See Levinson v Mollah*, 105 AD3d 644, 644, 963 NYS2d 653, 654 (1st Dept 2013).

Plaintiff also submits the affirmed report of Dr. St. Hill, a physical medicine physician; these reports, dated 11/1/11, 12/27/11 and 4/28/15 (exh K), are admissible. At the November 1, 2011 exam[2], 7½ months after the accident, Dr. St. Hill measured range of motion restrictions in plaintiff's cervical and lumbar spine. Dr. St. Hill next examined plaintiff on December 27, 2011 and noted continuing range of motion restrictions. Recently, at the April 28, 2015 exam, Dr. St. Hill measured restriction in plaintiff's lumbar spine flexion (80 degrees measure/90 degrees normal) and extension (20 degrees measured/30 degrees normal) which she stated are permanent and causally related to the accident. On all of the office records, Dr. St. Hill stated that plaintiff's diagnosis was traumatic cervical, myofascial and lumbar pain syndrome.

As stated by defendants in the reply, plaintiff's subjective complaints of pain cannot form the basis of serious injury. *See Arenas v Guaman,* 98 AD3d 461, 949 NYS2d 688 (1st Dept 2012). Additionally, Dr. St. Hill's opinion, that plaintiff's range of

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[2]Dr. St. Hill states that this visit is a follow-up visit; however no earlier exam notes were submitted.

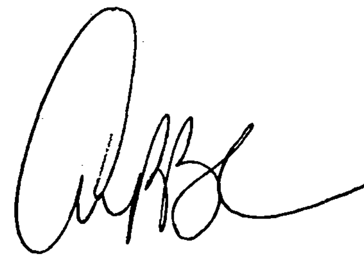
motion limitations were causally related to the subject accident, without addressing the detailed pre-existing degenerative conditions in plaintiff's cervical and lumbar spine found by defendants' radiologist, is conclusory and fails to raise an issue of fact sufficient to defeat summary judgment. *See Alvarez v NYLL Mgt. Ltd.,* 120 AD3d 1043 (1st Dept 2014), *affd* 24 NY3d 1191 (2015).

Finally, plaintiff has not raised any issue of fact regarding the 90/180 claim.

Accordingly, it is

ORDERED that the motions of defendants Malco-Espinal and ER Livery Service (Seq 01) and the motion of defendant David Little (Seq. 02) for summary judgment dismissing the complaint on the grounds that plaintiff has not demonstrated that her injuries meet the serious injury threshold pursuant to Insurance Law § 5102(d) are granted, and the action is dismissed.

This is the Decision and Order of the Court.



Dated: May 12, 2016
New York, New York

HON. ARLENE P. BLUTH, JSC