Eason v Blacker
2016 NY Slip Op 32843(U)
May 18, 2016
Supreme Court, Sullivan County
Docket Number: 2666-2013
Judge: Mark M. Meddaugh

At a term of the Supreme Court of the
State of New York, held in and for the
County of Sullivan, at Monticello,
New York, on February 12, 2016

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SULLIVAN

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MICHAEL EASON,

Plaintiff

-against-

APRIL NEUMAN BLACKER and
ALISON MARY MILLER,

Defendants.

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DECISION/ORDER

Index #2666-2013
RJI No. 52-35049-2014

Present: Hon. Mark M. Meddaugh,
Acting Justice, Supreme Court

Appearances:

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MEDDAUGH, J.:

The Defendant, Alison Mary Miller, has moved for an Order pursuant to CPLR 3212 granting her summary judgment dismissing the complaint on the grounds that the Plaintiff has failed to

establish as a matter of law that he suffered a "serious injury" as defined in Section 5102(d) of the Insurance Law. The motion was joined in by the Defendant, April Neuman Blacker, who requests that the complaint be dismissed against both Defendants.

This action arises out of a motor vehicle accident that occurred on January 10, 2013 in Westchester County. Counsel for Defendant Miller indicates that the accident occurred when Miller attempted to move from the right lane to the left lane of a four lane divided highway[1]. The Miller vehicle was struck by the co-Defendant, April Neuman Blacker, on the back left, driver's side of the vehicle. The Plaintiff, Michael Eason (DOB 4/8/82, age 30 at the time of the accident) testified that he was a passenger in the front seat of Miller's vehicle, and he was wearing a seat belt. Eason also testified that as a result of the impact, his body jerked forward and he struck his right knee on the dashboard.

It is asserted that the back seat passenger in Miller's car, Deanna Yeneic, was transported by ambulance to Westchester Medical Center, and Eason and Miller followed Yeneic to the hospital in Miller's car. It is also asserted that, despite the fact that Eason said that he complained to the police at the scene of the accident of back and knee pain, he was not offered medical attention, nor did he seek any care at Westchester Medical Center while he was waiting in the Emergency Room for Ms. Yeneic.

Mr. Eason testified that he went to Urgent Care the day after the accident, complaining of neck and back pain. He was referred back to his primary physician, but ultimately, he was treated by physicians at Crystal Run for pain management and for orthopedic care.

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[1]The Police Report is consistent with this statement, however Mr. Eason's deposition testimony indicates that the Ms. Miller was moving from the left lane to the right lane. This discrepancy is not determinative of the issues presented on this motion.

At the time of the accident, the Plaintiff had been receiving Social Security Disability, reportedly as the result of a learning disability, and he worked part-time for ARC, three days a week from 4:00 p.m. to 10:00 p.m., as part of an ARC mobile cleaning crew. Eason testified that he worked for less than two weeks after the accident, but that his doctor "took him out of work" because of the knee surgery.

Eason testified that he was incarcerated at the Sullivan County Jail from November to December in 2014, and then was re-incarcerated in January of 2015, where he remained as of the date of the affirmation of James R. McCarl, Esq., which was submitted in support of the instant motion.

Miller's counsel indicates that Eason asserted in his Bill of Particulars that he sustained a right knee anterior cruciate ligament tear requiring arthroscopic surgery, as well as injuries to his thoracic and cervical spine. Eason claimed that, as a result of these injuries, he sustained permanent or consequential limitation of use of a body organ or member; significant disfigurement; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevented him from performing substantially all of the material acts which constituted his 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.

Reports of Eason's medical treatment since the accident revealed the following:

Middletown Medical Urgent Care and Followup Primary care:

At Urgent Care on January 11, 2013, Eason came in complaining of lower back and neck pain. Miller's attorney points out that, despite the Plaintiff's testimony at deposition that he did not have any prior injuries to his knee, back or neck, the physician's report from Middletown Medical,

dated January 11, 2013, indicates that the Plaintiff had a prior history of back pain which had been aggravated by the accident. The report contained a diagnosis of "cervicalgia and paraspinal muscle spasm." An x-ray of the cervical spine on January 11, 2013, was found to be "unremarkable," and an x-ray of the lumbar spine revealed "mild degenerative changes."

Eason was next treated on January 31, 2013 with a complaint of headaches. A physical examination revealed neck and spine pain on palpation, but the "Assessment and Plan" only addressed his diagnosis of chronic migraine.

On February 11, 2013, the Plaintiff had an appointment, which was listed as a followup to a visit to the hospital ER on 2/3/13 for abdominal pain. The Plaintiff had been diagnosed with acute cystitis (inflamation of the bladder), which was resolved by this doctor's appointment.

On July 24, 2013, he was again treated for abdominal pain, and a CT scan of the abdomen and pelvis was performed "status post-cholecystectomy (removal of gallbladder), which was "unremarkable" of the abdomen and pelvis.

He returned to Urgent Care on August 28, 2013 for abdominal pain, and was advised to followup with his surgeon or to return to Urgent Care if symptoms continue.

The Defendant points to notations in the records of Middletown Medical, dated July 24, 2013 and August 28, 2013, which indicate that the Plaintiff had a full range of motion in his neck.

Defendant Miller's counsel argues that, with the exception of the first visit to Middletown Medical, the Plaintiff did not present with complaints of neck, back or knee pain, and the x-ray of his neck on that date was unremarkable. The x-ray of his back showed only mild degenerative changes. It is asserted that there is no indication in the records of any complaints of knee pain.

Crystal Run Healthcare Pain Office:

The Plaintiff treated on February 4, 2103 for chronic low back, neck and abdominal pain. The report made no mention of knee pain. There was no mention of the motor vehicle accident in this report.

The Report also indicated that the Plaintiff had received trigger point injections on four occasions between 9/5/12 and 12/3/ 2012 (all before the accident at issue), as well as "bilateral sciatic NBI (nerve block injections)" on three occasions during the same time period, and right occipital NBI on December 2012. His right knee was x-rayed on May 23, 2012, and the notation in the report of the 2/4/2013 visit reportedly that the x-ray showed no abnormalities. A Ct scan of the Cervical spine on April 14, 2012, reportedly showed no evidence of acute fracture or subluxation, with "clinical suspicion for cord injury and/or underlying myelopathy." An MRI of the Lumbar spine on May 23, 2012, was "grossly unremarkable" without disc herniation, central canal stenosis or neural foraminal narrowing." The report also noted a 12/7/12 Assessment plan by Dr. Husain relative to a diagnosis of Sciatica (L-S Radiculopathy).

On February 8, 2013, the Plaintiff returned for a followup of his "chronic pain syndrome with intractable pain of the low back." He has a continued diagnosis of Sciatica (L-S Radiculopathy) and was scheduled for nerve blocks. There was no discussion in the report of the motor vehicle accident, or that it was claimed that his symptoms were aggravated by the accident

There were followup visits on March 4, 2013 for chronic pain and he was given pain medication. There was no mention of knee pain, nor of the accident.

On March 13, 2013, he returned with complaints of abdominal pain, and he was seen by a surgeon regarding gall bladder surgery, which was scheduled for March 21, 2013. A physician's

statement dated March 26, 2013, indicated that he could return to work on April 21, 2013, with no lifting more than 25 pounds until April 21, 2013.

On April 3, 2013, he was treated at the pain office for low back pain and neck pain, with no complaints of knee pain. On May 8, 2013, he appeared with complaints of chronic pain. His pain management medication was reviewed and an x-ray was ordered of his knee, with a recommendation of trigger point injections and physical therapy. While there was a notation of right knee pain, there was no reference to the motor vehicle accident.

A letter from his physician, dated May 8, 2013, indicated that an x-ray of his knee revealed no acute findings, and a letter dated June 17, 2013, indicated that an MRI of his thoracic spine showed degenerative changes.

On July 5, 2013, he presented with knee, neck and sciatica (low back) pain. He also has mid back pain, for which there was a note of "degenerative disc disease and spodylosis." There was also a note with regard to the knee pain that the Plaintiff reported that he had fallen on blacktop when he was younger, but there was no reference to the motor vehicle accident.

On August 21, 2013, his physician wrote a letter indicating that an MRI of his right knee showed a chronic partial ligamentous tear, with a referral to an orthopedic surgeon.

Crystal Run Orthopedic:

On August 21, 2013, the Plaintiff met with a surgeon, and for the first time, there is a mention of the motor vehicle accident. The Impression was for "chronic partial anterior cruciate ligament tear." It was recommended that he wear a brace and attend physical therapy, before considering surgery.

On November 21, 2013, he again presented with complaints of knee pain and instability, although he had a negative Lachman test for instability. Arthroscopic surgery was recommended and right knee arthroscopy with synovial debridement was performed on December 6, 2013, which showed "patellofemoral osteoarthritis" and "a medium to large size plica on the medical femoral condyle."

The Plaintiff returned on August 27, 2014, with complaints of right knee pain. An MRI was obtained which showed no meniscal or ligamentous tear, the cartilage appeared normal and there were no arthritis changes. The doctor notes that the MRI was unremarkable and the physical examination was benign, The doctor state that he indicated he was "perplexed as to the source." The doctor also noted that the Plaintiff was taking "high dose pain meds" which the doctor advised him he could come down from. No followup was recommended.

ChiroCare Chiropractic:

The Plaintiff's initial intake was on August 12, 2013, which indicated that he was seeking treatment for injuries sustained in the January 10, 2013 accident. The Defendant denied taking any medications, despite a long list of medications in the reports from Middletown Medical and Crystal Run Health Care, including opiate pain medications. The report also indicated that the only medical history he reported was for asthma and his gallbladder surgery. He was diagnosed with Cervical, Thoracic and Lumbar Subluxation. He was scheduled to receive chiropractic care three days at week for six weeks. No further chiropractic records were submitted by the Defendants.

Mid Hudson Acupuncture:

An initial intake examination was performed on August 20, 2013, with complaints of neck, mid back and low back pain, and there was a reference to the subject motor vehicle accident. No other records regarding any acupuncture treatment were provided.

Middletown Physical Therapy:

There was an appointment on August 13, 2013, which referenced the subject motor vehicle accident, at which the Plaintiff claimed of neck, low back, and right knee pain. He was recommended to undergo physical therapy three times a week for six weeks. No other records from physical therapy were presented in connection with the motion.

In addition to the Plaintiff's medical records, the defense counsel provided a review of the Plaintiff's medical records, which was performed by Robert Hendler, MD, in lieu of an IME, due to the Plaintiff's incarceration, with no anticipated date for his release. Dr. Hendler states that the medical records reveal a pre-existing history of degenerative change in the thoracic spine with mild thoracic scoliosis. Dr. Hendler indicates that the Plaintiff's medical records reveal a significant amount of subjective complaints, but no objective diagnostic tests indicative of a herniated disc or radiculopathy in any portion of his spine. He concludes that the Plaintiff may have suffered a mild cervical and thoracolumbar sprain, with temporary exacerbation of prior spinal problems. Dr. Hendler also indicated that any exacerbation of his prior spinal problems caused by such sprains would be temporary and would not continue beyond the 6-10 week post-accident phase.

Dr. Hendler also concluded that it does not appear from the Plaintiff's medical records that he suffered any injury to his right knee at the time of the accident. He asserted that, if the Plaintiff had suffered an anterior cruciate injury in the accident, his knee would have been quite painful immediately after the accident, and he would have sought treatment well before the first documented complaint and treatment.

The Plaintiff has been incarcerated since January of 2015 and has reportedly not received any medical treatment since that time.

The attorney for Defendant Miller argues that there is no proof that the Plaintiff suffered a serious injury as a result of the accident at issue. With regard to the claim that the Plaintiff suffered a significant limitation of use of a body function or system, the Defendant argues that the Plaintiff is claiming injuries to his neck, midback and right knee, but there is no proof that any of these conditions were related to the accident. The Defendant has a prior history of neck and low back pain and was treating for these conditions in the months prior to the accident. An MRI, dated May 8, 2013, showed degenerative changes in the thoracic spine, but there was not much treatment of the thoracic spine in his post-accident medical care, as most of the Defendant's complaints concerned his lumbar spine.

It is also argued that the Plaintiff did not make any complaints about knee pain for four months after the accident, and it was not until seven months after the accident that his knee appeared to be swollen. The doctor who reviewed the Plaintiff's medical records for the defense opined that if the Plaintiff had suffered an anterior cruciate knee injury in the accident, it would have been painful and he would have sought medical care shortly after the accident.

It is also argued that, with regard to the 90/180 category of serious injury, there is no medical evidence that Plaintiff was unable to perform his daily activities for the requisite period. Although the Plaintiff claimed that his doctor took him out of work shortly after the accident because of his knee surgery, the Plaintiff did not have surgery until eleven months after the accident, and he only first met with the orthopedic surgeon in November of 2013, ten months after the accident. The only proof that he was medically restricted from working was after his gall bladder surgery in March of 2013, which was a period of four weeks.

It is also argued that there is no proof of any significant disfigurement.

In opposition, the Plaintiff's attorney argues that the Defendant failed to meet its burden on the 90/180 claim, since the defense expert failed to relate his findings to this category of serious injury. It is also claimed that the Plaintiff's Bill of Particulars demonstrated that he was unable to work for more than 90 days following the accident. The Plaintiff's counsel also points to a May 8, 2013 notation in the Crystal Run Healthcare's records which indicates that the Plaintiff was out of work because he had difficulty lifting anything, even a vacuum cleaner.

It is further argued that the Defendant's expert, Robert Hendler, MD, did not perform an examination of the Plaintiff, and that as a result, his report may not be used to meet the Defendant's prima facie burden. It is acknowledged that the Plaintiff has been incarcerated in the Sullivan County Jail since January of 2015, but it is argued that the Defendant could have sought a Court order to address the procedure by which an examination could have been conducted.

On the significant limitation of use of a body function or system category of serious injury, it is argued that the Plaintiff sustained a cervical spine injury and a right knee injury requiring surgery. It is claimed that the Plaintiff continues to suffer from knee pain and instability, and that his neck and back injuries cause daily pain. The Plaintiff provided a report from an Orthopedic surgeon who also performed a review of the Plaintiff's medical records, which concluded that the Plaintiff's neck and back symptoms were significantly exacerbated by the accident. The expert also opined that the accident was causative of the right knee internal derangement, resulting in the right knee diagnostic and operative arthroscopy.

It is also argued that, the gap in treatment between the accident and the first notation in the medical records reporting knee pain, as well as the gap between the end of the chiropractic treatment

and the Plaintiff's incarceration, are not dispositive, but only goes to the weight of the evidence and creates a question for the jury.

The Plaintiff further argues that the chiropractic records demonstrate significant limitations in the Plaintiff's range of motion, as well as positive tests for spasm, straight leg rasing, distraction and compression.

The Court points out that the Orthopedic surgeon, Charles Episalla, MD, noted in an affirmed report, dated January 22, 2016, that the Plaintiff had a prior slip and fall on ice in November of 2012, resulting in an injury to his neck and back, as well as treatment prior to November 2012 for his lumbar and cervical spine. It appears, however, that neither the attorneys nor the experts were provided with the nerve conduction tests, the MRI of his cervical spine on 6/18/12, and of his lumbar spine on 5/23/12, EMG testing of the lower extremities on 6/1/12, and of his upper extremities on 7/19/12, a CT scan of the cervical spine on 5/23/12. Dr. Episalla also indicated that he reviewed three IME reports dated 8/24/14, 10/1/13 and 10/2/13, but there were no other references to these IMEs in any of the papers submitted in connection with the instant motion, nor were the IME reports submitted in connection with his application.

In reply, the Defendant concedes, for the purposes of the motion that the opinion of the Defendant's expert has no bearing on the 90/180 category of serious injury. It is argued, however, that Defendant has met her burden of demonstrating the absence of a serious injury under this category, based upon the Plaintiff's medical records, EBT testimony and Bill of Particulars. It is argued that there is no medical proof that Plaintiff was restricted from performing his usual and customary activities as the result of any injuries sustained in the accident.

The Defendant also argues, with regard to whether the Plaintiff's alleged cervical spine and right knee injuries constitute a significant loss of use of a major body function or system, that there is no qualitative evidence of restrictions imposed by such injuries that were contemporaneous with the accident.

With regard to the knee injury, the Plaintiff did not make any complaints of knee pain until May 8, 2013 and, at that time, there was no reference about the subject accident. There was also the reference to an x-ray of the Plaintiff's right knee on May 23, 2012, and a reference to a prior fall on the blacktop.[2]

The Defendants' expert, Dr. Hendler opined that, if the Plaintiff had in fact suffered an anterior cruciate injury in the accident, his knee would have been quite painful and he would have sought medical treatment well before May 8, 2013 (4 months post accident). It is asserted that the records of the arthroscopic surgery indicate that it consisted of a synovial debridement, but there was no instability, and the meniscus and cruciate ligaments were found to be intact.

Finally, it is argued that, in the month preceding the accident, the Plaintiff was actively treating for chronic problems relating to his back and neck. At the visit to Crystal Run Healthcare on February 4, 2013, the report indicates that his neck pain had improved. The Defendants also rely on Dr. Hendler's conclusion that there are no findings indicative of a herniated disc or radiculopathy and, therefore, any injuries that the Plaintiff suffered were temporary and would resolve in 6-10 weeks. The Defendants further point to notations in the records of Middletown Medical, dated July

[2]The Plaintiff's expert, Charles W. Episalla, MD. indicated in an affirmed report, dated January 22, 2016, that the Plaintiff had a prior slip and fall on ice in November of 2012, resulting in an injury to his neck and back, as well as treatment prior to November 2012 for his lumbar spine, and his cervical spine.

24, 2013 and August 28, 2013, which indicate that the Plaintiff had a full range of motion in his neck.

Conclusions of Law

It has been recognized that the legislative intent underlying the No-Fault Law was to weed out frivolous claims and limit recovery to significant injuries, and as a result, the Courts have required objective proof of a plaintiff's injury in order to satisfy the statutory serious injury threshold; subjective complaints alone are not sufficient (*Toure v Avis Rent A Car Sys., Inc.*, 98 NY2d 345, 350, 746 N.Y.S.2d 865 [2002]). It has also been held that a minor, mild or slight limitation of use is classified as insignificant within the meaning of the no-fault statute (*Gaddy v Eyler*, 79 NY2d 955, 957, 582 N.Y.S.2d 990 [1992]).

The Plaintiff in this case is claiming that he suffered injuries to his right knee and to his cervical and thoracic spine in the accident. Although he testified at deposition that he had never treated for neck and back pain, or for a knee injury, prior to the subject accident, it is clear that he had a significant history of prior treatment for neck and back pain, and that an x-ray of his right knee was performed in May of 2012, prior to the accident, the need for which was unexplained.

The Plaintiff was incarcerated while this action was pending, complicating the Defendants' ability to have an IME conducted of the Plaintiff. A physical examination of the Plaintiff is not required, however, and the Defendants' expert may opine that the Plaintiff's injuries were preexisting or degenerative based upon a review of his medical records (*D'Auria v Kent*, 80 AD3d 956, 915 N.Y.S.2d 680 [3d Dept 2011]; *DeJesus v Paulino*, 61 AD3d 605, 607, 878 N.Y.S.2d 29 [1st Dept 2009].

With regard to the Plaintiff's knee injury, the Defendants' expert reviewed the Plaintiff's medical records, including the MRI performed on August 14, 2013, which showed a chronic right partial anterior cruciate ligament tear. He also reviewed the operative report of the arthroscopic

surgery performed on December 6, 2013, which found no meniscal or ligamentous injury, and also found that the knee was completely stable under anesthesia. The operative report revealed that the surgery consisted of a synovial debridement, and evidence of patellofemoral osteoarthritis and a medium to large size plica on medial femoral condyle.

The Defendants' expert indicated that, if the Plaintiff had sustained an anterior cruciate injury as a result of the accident, it would have been quite painful, and he would have sought treatment prior to his first complaint of knee pain, four months after the accident. It was not until August of 2013, approximately seven months after the accident that he had an MRI of his knee and he was seen by an orthopedist in connection with those complaints.

Based upon the reports prepared by the Plaintiff's treating physicians (see, *Franchini v Palmieri*, 1 NY3d 536, 775 N.Y.S.2d 232 [2003]), the Defendant's expert opined that the Plaintiff did not sustain an injury to his right knee at the time of the subject accident.

The Court finds, with regard to the claimed knee injury, that the Defendants have made a prima facie showing by establishing the absence of a material issue of fact with regard to whether the Plaintiff suffered a causally related serious injury to his right knee, which resulted in either a permanent or consequential limitation of use of a body organ or member, or a significant limitation of use of a body function or system.

The Court also notes that the Plaintiff had claimed that he suffered a significant disfigurement as a result of the scars from his arthroscopic surgery. The Defendants have argued that there is no reference in any of the medical records about any scarring, and the Plaintiff did not attempt to offer any proof in response.

In response to the Defendants' showing on the issue of knee pain, the Plaintiff failed to submit medical proof that the injury to his knee was causally related to the accident. The Plaintiff's expert has failed to address the gap in Plaintiff receiving any treatment for the claimed knee injury

following the accident, and his expert's conclusion that the knee injury was causally related to the accident was speculative and conclusory (*see, Franchini v Palmieri, supra.*; *Vaughan v Baez*, 305 AD2d 101, 758 N.Y.S.2d 648 [1st Dept 2003]).

With regard to the Plaintiff's claim that he suffered an injury to his cervical and thoracic spine, the Court notes that, although the medical evidence submitted by the Defendant does indicate that the Plaintiff was diagnosed with cervicalgia and paraspinal muscle spasm the day after the accident, x-rays taken on that day revealed no evidence of acute fracture, subluxation, or dislocation in his cervical spine, and an x-ray was only taken of his lumbar spine, which revealed only mild degenerative changes.

There were also notations in the records of his treating physicians at Middletown Medical, on July 24, 2013 and August 28, 2013 which indicated that the Plaintiff had a full range of motion in his neck.

The Plaintiff presented with a significant history of prior treatment and testing of the cervical and lumbar spine, in the four months prior to the subject accident, including a history of trigger point injections, and a bilateral sciatic nerve block.

The Defendant's expert noted that the Plaintiff made a significant amount of subjective complaints, but there were no objective diagnostic tests indicative of a herniated disc or radiculopathy in any portion of the spine. The only MRI performed post accident was of the Plaintiff's thoracic spine, and it reportedly showed only degenerative changes. The expert concluded that the Plaintiff had an obvious history of degenerative changes in his thoracic spine, and that he may have suffered a mild cervical and thoracolumbar sprain, with a temporary exacerbation of prior spinal problems. He stated that these possible sprains are self-limiting conditions which usually resolve in 6-10 weeks. Therefore, he concluded that the Plaintiff did not

suffer any significant injury to his neck or lower back at the time of the subject accident that would have caused any permanent findings of disability beyond the 6-10 week range.

The Court finds that the Defendants have satisfied their burden of demonstrating prima facie that the Defendant's back and neck problems resulted from his preexisting condition and were not causally related to the accident, and that any exacerbation of the injury was neither significant nor permanent (*D'Auria v Kent*, 80 AD3d 956, 957-58, 915 N.Y.S.2d 680 [3d Dept 2011]).

The Plaintiff attempts to rely on chiropractic records to demonstrate limitations to the Plaintiff's range of motion. The Chiropractic records were unsworn, but the Plaintiff argues that their expert could rely on them if they were submitted by the Defendant, or relied upon by the Defendant's expert in his report. The chiropractic records provided by the Plaintiff were dated between October 28, 2013 and July 29, 2014, whereas the Defendants' expert only had records from August 12, 2013 to October 21, 2013. The only chiropractic records submitted by the Defendant in suppport of the motion was the Plaintiff's initial chiropractic consultation on August 12, 2013. Therefore, the unsworn Chiropractic records which the Plaintiff attempted to introduce in opposition to the Defendant's motion are inadmissible and are insufficient to raise a triable issue of fact to defeat summary judgment (CPLR 2106; *Sanchez v Romano*, 292 AD2d 202, 739 N.Y.S.2d 368 [1st Dept 2002], *Barry v. Arias*, 94 A.D.3d 499, 500, 942 N.Y.S.2d 57 [1st Dept.2012]).

Therefore, the Court finds that the Plaintiff failed to offer any objective medical evidence to establish that the accident resulted in significant physical limitations, nor did he refute the Defendant's evidence of a pre-existing degenerative condition (*Pommells v Perez*, 4 NY3d 566, 797 N.Y.S.2d 380 [2005]; *Thomas v Ku*, 112 AD3d 1200, 977 N.Y.S.2d 481 [3d Dept 2013]).

With regard to the 90/180 category of serious injury, the medical records submitted by the Defendants revealed in the 180 days following the accident there were no restrictions placed on the

Plaintiff's activities as the result of his claimed injuries[3] and, in the Plaintiff's deposition testimony, he claimed that he did not return to work following the accident because of his knee surgery, but that did not occur until December of 2013, more than eleven months after the accident. The Plaintiff's medical records also indicated that he did not have an MRI of his knee or see an orthopedist until August 2013, more than six months after the accident.

There was only a single reference in the Plaintiff's medical records that he was unable to lift a vacuum without pain, but there was no evidence that the Plaintiff was unable to perform his usual and customary activities during the statutory period.

Therefore, the Court finds that the Defendants have made a prima facie showing that the Plaintiff did not suffer a 90/180 serious injury, and the burden shifted to the Plaintiff to raise a triable issue of fact.

In opposition, there were only the Plaintiff's generalized subjective complaints of pain, unsupported by any medical restrictions imposed upon him, which are insufficient to raise a triable issue of fact under this category of serious injury (*Crawford-Reese v Woodard*, 95 AD3d 1418, 944 N.Y.S.2d 333 [3d Dept 2012]). A plaintiff's self-serving claim that he was unable to perform substantially his usual and customary activities during the applicable period is insufficient to withstand a defendant's summary judgment motion, in the absence of a physician's affidavit substantiating that the plaintiff's alleged impairment was attributable to a medically determined injury (*Sherlock v Smith*, 273 AD2d 95, 709 N.Y.S.2d 176 [1st Dept 2000]). The affirmed report of Charles Episalla, MD, which does not set forth any objective tests on which his conclusions are base is insufficient (*Sainte-Aime v Ho*, 274 AD2d 569, 712 N.Y.S.2d 133 [2d Dept 2000]).

[3]The Plaintiff was restricted from working and lifting more than 25 pounds, following his gall bladder surgery in March of 2013, but there is no claim that the surgery was related to the accident.

Therefore, the Court finds that the Defendants are entitled to summary judgment on the grounds that there are no triable issue of fact with regard to whether the Plaintiff has suffered a "serious injury" as defined in Section 5102(d) of the Insurance Law.

WHEREFORE, in light of the foregoing, it is:

ORDERED that summary judgment is granted to the Defendants herein, and the Plaintiff's complaint is dismissed in its entirety.

This memorandum shall constitute the Decision and Order of this Court. The original Decision and Order, together with the motion papers have been forwarded to the Sullivan County Clerk's office for filing. The signing and filing of this Order by the Court shall not constitute entry under CPLR 2220. The filing of this Order does not relieve counsel from the obligation to serve a copy of this order, together with notice of entry, pursuant to CPLR § 5513(a).

Dated: May 18, 2016
Monticello, New York

E N T E R

Mark M Meddaugh

HON. MARK M. MEDDAUGH
Acting Supreme Court Justice

Papers Considered:

1. Notice of Motion dated December 7, 2015
2. Affirmation of James R. McCarl, Esq., dated December 7, 2015
3. Affirmation in Support of Edward P. Souto, Esq., dated December 14, 2015
4. Affirmation in Opposition of Mark P. Cambareri, Esq., dated February 5, 2016
5. Reply Affirmation of Andrea Durgin Pawliczek, Esq., dated February 10, 2015 (sic, should read "2016")