Short Form Order

SUPREME COURT - STATE OF NEW YORK
CIVIL TERM - IAS PART 34 - QUEENS COUNTY
25-10 COURT SQUARE, LONG ISLAND CITY, N.Y. 11101

P R E S E N T : **HON. ROBERT J. MCDONALD**
Justice

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MERRICK RICHARDS, Index No.: 10899/2014

Plaintiff, Motion Date: 12/1/17

- against - Motion No.: 126

CARLOS R. CRUZ and CARLOS JOSE CRUZ, Motion Seq No.: 3

Defendants.

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The following papers numbered 1 to 9 read on this motion by defendants for an order pursuant to CPLR 3212, granting defendants summary judgment and dismissing the complaint on the ground that plaintiff did not sustain a serious injury within the meaning of Insurance Law §§ 5104(a) and 5102(d):

	Papers Numbered
Notice of Motion-Affirmation-Exhibits.....EF	38 - 51
Affirmation in Opposition-Exhibits.....EF	53 - 58
Reply Affirmation.....EF	62

This is a personal injury action in which plaintiff seeks to recover damages for injuries allegedly sustained in a motor vehicle accident that occurred on October 16, 2013 at the intersection of Francis Lewis Boulevard and 23rd Avenue, in Queens County, New York. In the verified bill of particulars, plaintiff alleges that as a result of the accident he sustained serious injuries to his cervical spine, left shoulder, and lumbar spine.

Plaintiff commenced this action by filing a summons and complaint on July 15, 2014. Defendants joined issue by service of an answer dated August 18, 2014. Defendants now move for an order pursuant to CPLR 3212, dismissing the complaint on the ground that the injuries claimed fail to satisfy the serious injury threshold requirement of Section 5102(d) of the Insurance Law.

Plaintiff appeared for an examination before trial on October 22, 2015. He did not lose consciousness and was not bleeding. He did not have any bruises to any parts of his body on the day of the accident or in the days following. At the scene of the accident, he was experiencing pain in his lower back and neck. He told the police that he was not injured and did not need an ambulance, medical attention or first aid. He first sought care at Englinton Medical P.C. (Englinton Medical) on the same day of the accident. Range of motion studies were performed on his head and neck. No instruments were used. He treated at Englinton Medical two times a week. Treatment included massages, physical therapy, exercises, acupuncture, and chiropractic care. He was prescribed pain medication, but never took it. He continued treating at Englinton Medical for six months. He stopped treatment in April or May 2014. He discontinued treatment with Englinton Medical because his No-Fault insurance would no longer provide coverage for the treatment. He was referred by Englinton Medical to Dr. Perdue who gave him injections in his neck and back and performed an ambulatory procedure on his lower back. The last time he was examined by Dr. Perdue was in 2014. There are no activities that he did before the accident that he is completely unable to do now. Due to the accident, he is limited in lifting anything heavy and has reduced sexual relations with his wife. At no time following the accident was he confined to his home or bed or totally incapacitated for any period of time. At the time of the deposition, he no longer had any pain or discomfort in his neck or left shoulder and he only had lower back pain from time to time. He never missed any time from work. He never asked for assistance in performing his tasks at work, never requested any dispensation from performing any aspect of his job, never requested any courtesies or reduced hours, never avoided the performance of any assignments or job related tasks, and continued working the same days and hours. He did not recall being involved in any prior motor vehicle accidents. He did not sustain injuries to any parts of his body in any prior accidents.

David A. Fisher, M.D. reviewed plaintiff’s radiology films, including the MRIs of plaintiff’s cervical spine taken on November 20, 2013, lumbar spine taken on December 4, 2014, and left shoulder taken on November 8, 2013. Regarding the cervical spine MRI, Dr. Fisher notes degenerative changes throughout the cervical spine, most pronounced at the C5/6 and C6/7 levels; no disc herniations and no radiographic evidence of traumatic or causally related injury. Regarding the MRI of the lumbar spine, Dr. Fisher notes degenerative changes at the L4/5 and L5/S1 levels; no disc herniations; a mild disc bulge and small annular tear that are compatible with the amount of degenerative change

present; and no radiographic evidence of traumatic or causally related injury. Regarding the left shoulder MRI, Dr. Fisher notes no rotator cuff or labral tear and no radiographic evidence of traumatic or causally related injury.

Robert Y. Pick, M.D. performed an independent medical examination on plaintiff on March 31, 2017. Plaintiff denied sustaining any prior injuries. He reported current complaints of pain in his lower back and right shoulder. Dr. Pick identifies the records reviewed prior to rendering his report. He performed range of motion testing with a goniometer and found normal ranges of motion regarding plaintiff's lumbar spine and bilateral shoulders. All other objective tests were normal. Dr. Pick diagnosed plaintiff with lumbar spine sprain/strain/contusion, status post surgery and right shoulder sprain/strain contusion, resolved. Based on the records, physical examination, and plaintiff's denial of any prior accidents or injuries, Dr. Pick opines that the diagnoses are causally related to the subject accident. He concludes that he finds no orthopedic disability based on the physical examination and medical documentation. No ongoing physical therapy or orthopedic treatment would be reasonable or medically necessary for the subject accident.

Alan P. Wolf, M.D. performed a physical medicine and rehabilitation and acupuncture independent medical examination on plaintiff on February 17, 2014. Plaintiff denied previous and subsequent accidents, medical problems and surgeries. Plaintiff presented with current complaints of left shoulder pain and lower back pain. Dr. Wolf identifies the records reviewed prior to rendering his report. He performed range of motion testing with a goniometer, and found normal ranges of motion regarding plaintiff's cervical spine, thoracolumbar spine, and left shoulder. All other objective tests were normal. Dr. Wolf diagnosed plaintiff with resolved lumbar strain, resolved left shoulder contusion, and normal acupuncture examination with resolved Qi and blood stagnation. Based on his review of the medical records and plaintiff's examination, he opines that the injuries are causally related to the subject accident. Dr. Wolf further notes that prognosis is good, and there is no need for further treatment. Plaintiff may continue to work without restrictions and is independent in his activities of daily living.

Defendants contend that the evidence submitted is sufficient to establish, prima facie, that plaintiff has not sustained an injury which resulted in a fracture; significant disfigurement; permanent loss of use of a body organ, member or function; significant limitation of use of a body function or system;

permanent consequential limitation of use of a body organ or member; or a medically determined injury or impairment of a nonpermanent nature which prevented him for not less than 90 days during the immediate 180 days following the occurrence, from performing substantially all of his usual daily activities.

On a motion for summary judgment, where the issue is whether the plaintiff has sustained a serious injury under the no-fault law, the defendant bears the initial burden of presenting competent evidence that there is no cause of action (see Wadford v. Gruz, 35 AD3d 258 [1st Dept. 2006]). "A defendant can establish that plaintiff's injuries are not serious within the meaning of Insurance Law § 5102 (d) by submitting the affidavits or affirmations of medical experts who examined the plaintiff and conclude that no objective medical findings support the plaintiff's claim" (Grossman v Wright, 268 AD2d 79 [1st Dept. 2000]). Whether a plaintiff has sustained a serious injury is initially a question of law for the court (Licari v Elliott, 57 NY2d 230 [1982]). Where defendant's motion for summary judgment properly raises an issue as to whether a serious injury has been sustained, it is incumbent upon the plaintiff to produce evidentiary proof in admissible form in support of his or her allegations. The burden, in other words, shifts to the plaintiff to come forward with sufficient evidence to demonstrate the existence of an issue of fact as to whether he or she suffered a serious injury (see Gaddy v Eyler, 79 NY2d 955 [1992]; Zuckerman v City of New York, 49 NY2d 557 [1980]; Grossman v Wright, 268 AD2d 79 [2d Dept. 2000]).

Here, the competent proof submitted by defendants, including the reports of Drs. Fisher, Pick and Wolf and plaintiff's own testimony that at no time following the accident was he confined to his home, bed or totally incapacitated for any period of time, is sufficient to meet defendants' prima facie burden by demonstrating that plaintiff did not sustain a serious injury within the meaning of Insurance Law § 5102(d) as a result of the subject accident (see Toure v Avis Rent A Car Sys., 98 NY2d 345 [2002]; Gaddy v Eyler,79 NY2d 955 [1992]; Carballo v Pacheco, 85 AD3d 703 [2d Dept. 2011]; Ranford v Tim's Tree & Lawn Serv., Inc., 71 AD3d 973 [2d Dept. 2010]).

In opposition, plaintiff submits an affirmation from Arkadiy Shusterman, M.D. with certified records; certified records from Englinton Medical P.C.; certified MRI reports from Professional Health Radiology, P.C.; an affirmation form Mark Gladstein, M.D.; certified records from Metropolitan Medical and Surgical P.C.; and an affirmation from Ajendra Sohal, M.D.

Arkadiy Shusterman, M.D. submits an affirmation dated November 15, 2016. Dr. Shusterman notes the medical records reviewed prior to rendering the report. Dr. Shusterman affirms that on October 16, 2013, a physical examination of plaintiff was performed using a goniometer. Dr. Shusterman found restricted ranges of motion regarding plaintiff's lumbar spine, cervical spine, and left shoulder. On November 6, 2013, January 14, 2014, and February 25, 2014, Dr. Shusterman noted continued restrictions in range of motion in plaintiff's lumbar spine, cervical spine, and left shoulder. Dr. Shusterman opines that plaintiff has sustained a significant limitation of use to his cervical spine, lumbar spine, and left shoulder due to the subject accident. Dr. Shusterman further opines that due to the injuries, plaintiff had to refrain from all heavy lifting, sitting for prolonged periods of time, and was forced to take more frequent breaks at work. Dr. Shusterman states that plaintiff will suffer substantial pain on a permanent basis that will restrict his daily functions and activities and will interfere with his enjoyment of life. Dr. Shusterman concludes that plaintiff has sustained a permanent loss of use and significant limitation of use of his neck, back, left shoulder.

The certified records from Englinton Medical indicate that plaintiff was first evaluated by Englinton Medical on November 19, 2013. Objective inclinometry range of motion testing of plaintiff's lumbar spine, cervical spine, and bilateral shoulders revealed restricted ranges of motion. Plaintiff continued to treat at Englinton Medical through April 2014.

The certified records from Professional Health Radiology, P.C. reveal that on November 20, 2013, plaintiff underwent an MRI of his cervical spine which revealed muscle spasm, C5-C6 central disc herniation, and central disc bulges at C2-C3 and C6-C7 with posterior protrusion of disc material encroaching on the anterior thecal sac, and diffuse mild hypertrophic changes. On December 4, 2013, plaintiff had an MRI of his lumbar spine which revealed posterior bulge at L4-L5 with focal central disc herniation and broad-based posterior bulge at L5-S1. On December 12, 2013, Dr. Cohen performed an EMG/NCS test on plaintiff's upper and lower extremities, revealing an early acute C6 radiculopathy and early acute left L5-S1 radiculopathy.

Dr. Gladstein examined plaintiff in a pain management consultation. He identifies the medical records reviewed prior to rendering his report. Plaintiff first presented to Metropolitan Medical and Surgical P.C. on March 10, 2014. Based on the certified records from Metropolitan Medical and Surgical P.C. and Dr. Gladstein's affirmation, lumbar epidural steroid injections,

trigger point injections, and Epidurograms were performed on plaintiff on March 10, 2014, March 24, 2014, March 31, 2014 and April 7, 2014. On June 5, 2014, plaintiff underwent disc decompression and discectomy of L4/5. Plaintiff also received lumbar trigger point injections and a transforaminal steroid injection at the left L4/5 exiting nerve root. Dr. Gladstein opines that the injuries and disabilities in plaintiff's lumbar spine, cervical spine and left shoulder are causally related to the subject accident. Plaintiff has sustained a significant limitation of use to his cervical spine, lumbar spine and left shoulder due to the subject accident. Dr. Gladstein further opines that due to the injuries, plaintiff had to refrain from all heavy lifting, sitting for prolonged periods of time, and was forced to take more frequent breaks at work. Dr. Gladstein states that plaintiff will suffer substantial pain on a permanent basis that will restrict his daily functions and activities and will interfere with his enjoyment of life. Dr. Gladstein concludes that plaintiff has sustained a permanent loss of use and significant limitation of use of his neck, back, left shoulder.

Dr. Sohal performed an independent medical examination on plaintiff on July 2, 2014. Plaintiff presented with no major complaints. Dr. Sohal identifies the records reviewed prior to rendering the report. All ranges of motion in plaintiff's cervical spine and lumbar spine were normal. Dr. Sohal opines that plaintiff is capable of performing his daily activities without limitation. Dr. Sohal further opines that there is a cause/effect relationship between the subject accident and the injuries sustained by plaintiff.

Upon a review of the motion papers, opposition, and reply thereto, this Court finds that plaintiff failed to raise a triable issue of fact. Here, it appears that plaintiff's last evaluation was in June 2014. Thus, plaintiff failed to provide any recent examination demonstrating that his alleged injuries are permanent. Without a recent examination and medical report in admissible form indicating plaintiff's current physical condition, plaintiff's submissions are insufficient to raise a triable issue of fact as to whether the plaintiff sustained a serious injury (see Sham v. B&P Chimney Cleaning & Repair Co., Inc., 71 AD3d 978 [2d Dept. 2010] [finding that any projections of permanence have no probative value in the absence of a recent examination]; Cornelius v Cintas Corp., 50 AD3d 1085 [2d Dept. 2008]; Sullivan v Johnson, 40 AD3d 624 [2d Dept. 2007]; Barzey v Clarke, 27 AD3d 600 [2d Dept. 2006]; Farozes v Kamran, 22 AD3d 458 [2d Dept. 2005][finding that in order to raise a triable issue of fact the plaintiff was required to come forward with objective medical evidence, based upon a recent examination, to verify his subjective complaints of pain and limitation of motion]; Ali v Vasquez, 19 AD3d 520 [2d Dept. 2005]).

Regarding the 90/180 day category, plaintiff failed to submit competent medical evidence that the injuries allegedly sustained in the subject accident rendered him unable to perform substantially all of his usual and customary daily activities for not less than 90 days of the first 180 days following the subject accident (see Nieves v Michael, 73 AD3d 716 [2d Dept. 2010]; Sainte-Aime v Ho, 274 AD2d 569 [2d Dept. 2000]). Plaintiff himself testified that he was never confined to his bed or home and was never incapacitated due to the subject accident. He did not miss any time from work due to the subject accident. Additionally, plaintiff failed to submit medical evidence connecting the inability to perform daily activities with the alleged injuries (see Taylor v Jerusalem Air, 280 AD2d 466 [2d Dept. 2001]).

Accordingly, for the reasons set forth above, it is hereby,

ORDERED, that defendants CARLOS R. CRUZ and CARLOS JOSE CRUZ's summary judgment motion is granted, plaintiff's complaint is dismissed, and the Clerk of the Court shall enter judgment accordingly.

Dated: December 6, 2017
Long Island City, N.Y.

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ROBERT J. MCDONALD
J.S.C.