Torrez-Ramirez v Sforza
2018 NY Slip Op 34339(U)
March 27, 2018
Supreme Court, Nassau County
Docket Number: Index No. 606955/2016
Judge: Karen V. Murphy
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Short Form Order

SUPREME COURT – STATE OF NEW YORK
TRIAL TERM, PART 8 NASSAU COUNTY

PRESENT:

Honorable Karen V. Murphy
Justice of the Supreme Court

x

YENNI TORREZ-RAMIREZ,

Plaintiff,

-against-

RUSSELL J. SFORZA, JR., CHRISTIAN LONDONO and D.C. VASQUEZ-GONZALEZ,

Defendants.

x

Index No. 606955/2016

Motion Submitted: 01/29/18
Motion Sequence: 001,002
MG, MG

The following papers read on this motion:

Notice of Motion/Order to Show Cause............	XX
Answering Papers..	XX
Reply..	XX
Briefs: Plaintiff's/Petitioner's........................	
Defendant's/Respondent's.................	X

The Londono and Vaszuez-Gonzalez defendants move this Court for an Order granting summary judgment in their favor, and dismissing the complaint on the ground that plaintiff has not sustained a serious injury as defined under Insurance Law § 5102 (d) (Motion Sequence 1).

Defendant Sforza cross-moves this Court for the same relief pursuant to Insurance Law § 5102 (d), relying upon the arguments and exhibits of the Londono/Vasquez-Gonzalez defendants (Motion Sequence 2).

Plaintiff opposes each of the defendants' motion sequences.

It is well recognized that summary judgment is a drastic remedy and as such should only be granted in the limited circumstances where there are no triable issues of fact. (***Andre v. Pomeroy,*** 35 NY2d 361 [1974]). Summary judgment should only be granted where the court finds as a matter of law that there is no genuine issue as to any

material fact. (***Cauthers v. Brite Ideas, LLC,*** 41 AD3d 755 [2d Dept 2007]). The Court's analysis of the evidence must be viewed in the light most favorable to the non-moving party, herein the plaintiff. (***Makaj v. Metropolitan Transportation Authority***, 18 AD3d 625 [2d Dept 2005]).

A party moving for summary judgment must make a *prima facie* showing of entitlement as a matter of law, offering sufficient evidence to demonstrate the absence of any material issues of fact. ***(Winegrad v. New York Univ. Med. Center,*** 64 NY2d 851 [1985]; ***Zuckerman v. City of New York,*** 49 NY2d 557 [1980]). Here, the defendants must demonstrate that the plaintiff did not sustain a serious injury within the meaning of Insurance Law Section 5102(d) as a result of this accident ***(Felix v. New York City Transit Auth.,*** 32 AD3d 527 [2d Dept 2006]).

The affirmed medical reports of defendants' physicians, as well as the plaintiff's deposition testimony can be sufficient to establish *prima facie* that the plaintiff did not sustain a serious injury in a motor vehicle collision within the meaning of Insurance Law § 5102(d) (*see* ***Park v. Orellana***, 49 AD3d 721 [2d Dept 2008]; ***Tarhan v. Kabashi***, 44 AD3d 847 [2d Dept 2007]).

The Court notes that, a tear in tendons, as well as a tear in a ligament or bulging disc is not evidence of a serious injury under the no-fault law in the absence of objective evidence of the extent of the alleged physical limitations resulting from injury and its duration (***Little v. Locoh***, 71 AD3d 837 [2d Dept 2010]). Thus, regardless of an interpretation of an MRI study, plaintiff must still exhibit physical limitations in order to sustain a claim of serious injury within the meaning of the Insurance Law.

In support of their motion, defendants submit, *inter alia*, the pleadings, the Bill of Particulars, the Supplemental Bill of Particulars, the affirmed report of Ronald A. Light, M.D., and plaintiff's deposition testimony.

The motor vehicle accident giving rise to this action occurred on July 14, 2015, at approximately 3:45 p.m. As a result of the accident, plaintiff claims to have suffered physical injuries, including to her cervical and lumbar spine areas, right shoulder, and right knee. As a result of these alleged injuries, plaintiff claims to suffer from, *inter alia*, cervical radiculopathy, pain, weakness, deformity and disability, difficulty with prolonged sitting, standing, walking, bending, climbing stairs, or carrying heavy objects, and limitation of motion in the aforementioned areas.

Specifically, plaintiff claims injuries under the following categories of injury as provided by Insurance Law § 5102 (d): 1) significant disfigurement; 2) permanent loss of use of a body organ, member, function or system; 3) permanent consequential limitation of use of a body organ or member; 4) significant limitation of use of a body function or system; and 5) a medically determined injury or impairment of a non-permanent nature

which prevented her from performing substantially all of the material acts which constituted her usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment (90/180 claim).

The Bill of Particulars states that the length of time that plaintiff was confined to home for a period of approximately four (4) months after the subject accident, and periodically thereafter, except when receiving medical aid and attention. Plaintiff states that she remains permanently partially disabled.

Defendants' examining orthopedic surgeon, Ronald A. Light, M.D., examined plaintiff on September 25, 2017. He obtained an oral history from plaintiff, and he reviewed a substantial amount of medical documentation, and the Bill of Particulars.

Plaintiff advised Dr. Light that she was not taking any medications at the time of the examination, and that she had not sustained any fractures or lacerations as a result of the accident. She also advised Dr. Light that her course of treatment consisted of physical therapy, acupuncture, and massage, and the treatment has been helpful to her. At the time of the Independent Medical Examination (IME), plaintiff stated that she was no longer undergoing treatment, and she was working on a full-time basis.

On the day of the IME, plaintiff complained of pain in her neck and her low back. Dr. Light tested plaintiff's ranges of motion in her cervical spine, thoracic spine, lumbar spine, right shoulder and right knee. Dr. Skolnick set forth the objective means by which he obtained those measurements, the measurements themselves, as well as the normal standard to which he compared his findings.

In sum, plaintiff exhibited normal range of motion throughout the areas examined, without tenderness upon palpation, and without muscle spasms. In addition, seventeen (17) separate tests, which are listed in the report, all produced negative results. Plaintiff's muscle strength and reflexes were all normal, as was her sensation to touch.

In Dr. Light's opinion, plaintiff's cervical, thoracic, and lumbar spine strains are resolved, as are her right shoulder and right knee sprains. Furthermore, Dr. Light found no orthopedic disability, no evidence of permanency, and no need for surgery, based upon his physical examination of the plaintiff.

A defendant may establish through presentation of a plaintiff's own deposition testimony that a plaintiff did not sustain a medically determined injury or impairment of a non-permanent nature which prevented plaintiff from performing substantially all of the material acts constituting plaintiff's usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence (90/180 claim)

(***Kuperberg v. Montalbano***, 72 AD3d 903 [2d Dept 2010]; ***Sanchez v. Williamsburg Volunteer of Hatzolah, Inc.***, 48 AD3d 664 [2d Dept 2008]).

Moreover, a plaintiff's allegation of curtailment of recreation and household activities and an inability to lift heavy packages is generally insufficient to demonstrate that he or she was prevented from performing substantially all of his or her customary daily activities for not less than 90 days during the 180 days immediately following the accident (***Omar v Goodman***, 295 AD2d 413 [2d Dept 2002]; ***Lauretta v County of Suffolk***, 273 AD2d 204 [2d Dept 2000]).

Plaintiff was deposed on July 31, 2017. Plaintiff testified that she was employed full-time at a factory at the time of the accident, and that afterward, she did not work full-time. In total, she worked for approximately only two weeks more, on a part-time basis, after the subject accident. Plaintiff cut patterns for dog beds and sewed the beds. According to her testimony, she did not go to work for a week after the accident. When she returned to work after the accident, she worked only six hours a day, for only two or three days per week.[1] Plaintiff acknowledged, however, that no doctor ever told her that she could not work after the subject accident. She testified that a doctor at "the therapy" told her only that she "should take it easier at work."

Plaintiff also worked as a dishwasher at a restaurant for approximately ten (10) months following the accident. She worked six days per week, for a total of thirty hours per week. Plaintiff claims that she told the restaurant owner that she could not stand for too long because of the accident, and she also testified that her husband would substitute for her on occasion. Plaintiff stated that she left the job at the restaurant because "they would not always allow him to take over for [her]."

Following the job at the restaurant, plaintiff testified that she was out of work for approximately five months, but gained employment at a party rental company, where she was working at the time of her deposition. At the party rental company, plaintiff packs table cloths into bags. She works from 8 a.m. to 4:30 p.m., Monday through Friday. She testified that if there is anything heavy to lift, "they don't ask us to do it, they call the men to do it."

Plaintiff admitted that, on the day of the accident, she was not a licensed driver of an automobile, and she had no driver's permit either. Plaintiff was giving a co-worker a ride, and she was on her way to a parkway when the accident occurred. Plaintiff was operating a Ford Explorer owned by her husband. According to her own testimony, she drove the vehicle whenever she could not take the bus, and she had been driving the vehicle intermittently for approximately one year before the accident. Plaintiff estimated

[1] Plaintiff's Supplemental Bill of Particulars states that plaintiff was unemployed at the time of the subject accident.

that she drove her husband's vehicle two to three times per week in the year preceding the accident.

Plaintiff was on Route 110 in Suffolk County, New York when the accident occurred. It was drizzling, and she had her windshield wipers and headlights on. Her co-worker was seated in the front passenger seat. Plaintiff's vehicle was in the right-most lane, stopped at a red traffic light when her vehicle was struck in the rear. There was a van stopped in front of plaintiff's car at the time of impact. A total of three vehicles were involved in the subject accident. Plaintiff described two impacts to the rear of her vehicle. Just prior to the first impact, plaintiff "only heard the screeching of the brakes and the car behind me." The first impact was "hard" and the second impact was "medium," but plaintiff's vehicle was not pushed into the car stopped in front of her.

According to plaintiff, her right knee came into contact with the console, and her right shoulder hit the seat when her body went backwards. Plaintiff also testified that she suffered a bruise to her right knee and part of her right ankle, but none of her clothes were ripped or torn. She also did not suffer any bleeding as a result of the accident. No airbags deployed as a result of the subject accident.

Police responded to the scene, and plaintiff received a ticket for being an unlicensed driver. Plaintiff had no pain while she was at the accident scene, and she was able to get out of the vehicle by herself after the accident. She did not request an ambulance. She also testified that she was permitted by police to drive the vehicle from the scene. Plaintiff eventually dropped her co-worker off and then went home.

According to her testimony, plaintiff started to feel "a very strong pain" in her right knee and throughout her body around 11 p.m. on the night of the accident; then she decided to go to Nassau University Medical Center at that time. The godfather of plaintiff's son drove plaintiff and her husband to the hospital because plaintiff's husband was also unlicensed.

At the hospital, plaintiff testified that she complained of pain in her neck, right arm, right shoulder, and her whole body. X-rays were taken at the hospital. She was treated and released, having been given a prescription for pain medication and nothing more.

Plaintiff sought therapy approximately one week after the accident, based upon the recommendation of her son's godfather. Plaintiff received massage and heat therapy for a period of seven months at a facility in Hempstead. She began attending five days per week, then four, three, and then two days. According to plaintiff, each of the sessions lasted forty minutes. She also testified that she was sent for MRI studies, and also to a place in Brooklyn for injections to her right shoulder and hip or lower back. The MRI studies were done on plaintiff's neck, right shoulder, and back.

According to plaintiff, the treatment/injections helped "a little," but after the injections, the pain returned. She did not tell the personnel at the Hempstead facility, and she did not have any further treatment after she received the injections. Plaintiff testified that she had an appointment with a doctor for her arm, but that she "lost" the appointment because she did not have any money to pay for it. Plaintiff did not have any private health insurance at the time of the accident, nor did she have any such insurance at the time of her deposition.

When asked how long she was confined to home after the accident, plaintiff testified that she "was not confined because [she] needed to go to work but [she] did not go anywhere because of the same problem that [she] had." Plaintiff explained that, aside from going to work, she did not go anywhere else. Later in her testimony, she stated that she was confined to her bed for one week immediately after the accident, and that she was confined to her home for "around three months," leaving only to go to work.

At the time of her deposition, plaintiff stated generally that she has "not recuperated to some of [her] activities." She testified that her right arm still bothers her, from her neck all the way down that arm, constantly. Also, her hip/lower back still bothers her when she stands or sits for too long. Specifically, she testified that she can stand for an hour before her hip/lower back/right knee bothers her, and she can sit for up to two hours. Plaintiff was never prescribed a brace for her knee, and she now takes Advil "almost every day."

She also testified that she cannot carry the laundry to the laundromat, and that he cannot play with her son as much. Her husband has to do mopping and vacuuming, but she is able to cook. She never attended a gym, even before the subject accident. Plaintiff was able to go on a trip to Pennsylvania approximately one month before her deposition, to visit family.

Plaintiff's deposition testimony is sufficient to underscore that defendants have established their *prima facie* entitlement to summary judgment as a matter of law as to the following categories of injury: 1) permanent loss of use of a body organ, member, function or system; 2) permanent consequential limitation of use of a body organ or member; 3) significant limitation of use of a body function or system, and 4) significant disfigurement.[2]

Plaintiff's deposition testimony is also sufficient herein to make a *prima facie* showing that the plaintiff did not sustain a serious injury within the meaning of Insurance Law § 5102(d), under the 90/180 category of injury (*see **Jackson v. Colvert***, 24 AD3d

[2] There is no evidence whatsoever concerning plaintiff's claim of significant disfigurement, not even in plaintiff's own deposition testimony.

420 [2d Dept 2005]; ***Batista v. Olivo***, 17 AD3d 494 [2d Dept 2005]) ***Paul v. Trerotola***, 11 AD3d 441 [2d Dept 2004]).

Plaintiff is now required to come forward with viable, valid objective evidence to verify her complaints of pain, permanent injury and incapacity (***Farozes v. Kamran***, 22 AD3d 458 [2d Dept 2005]).

In opposition, plaintiff submits the affirmation of Maxim Tyorkin, M.D., records from Nassau University Medical Center (NUMC), reports related to the injections plaintiff received, records from Hill Chiropractic, P.C., MRI reports related to plaintiff's right shoulder, lumbar spine, and cervical spine, the affirmed report of Dr. Light, plaintiff's affidavit sworn to on November 29, 2017, and plaintiff's deposition testimony.

The NUMC records, injection records from Cristy Perdue, M.D., SOAP notes, physical therapy notes, Hill Chiropractic records, Rehabilitation Medical & Diagnostic, P.C., and MRI reports were reviewed by defendants' expert, Dr. Light, as part of the IME. The Court will consider all reports submitted by plaintiff that were listed as being relied upon by defendant's expert, Dr. Light (*see* ***Williams v. Clark***, 54 AD.d 942 [2d Dept 2008]; ***Zarate v. McDonald***, 31 AD3d 632 [2d Dept 2006]).

The submitted MRI reports (Plaintiff's Exhibit E) do not contain any statements causally relating the findings therein to the subject accident; therefore, standing alone, they are insufficient to raise a triable issue of fact.

Plaintiff's affidavit will not be considered by the Court. Not only is it self-serving, amplifying her own deposition testimony in an attempt to create a feigned issue of fact, but it is written completely in the English language. At deposition, plaintiff required the services of a Spanish-language translator, and the NUMC records, for example, indicate that plaintiff's preferred spoken language is Spanish. Reports from Rehab Medical & Diagnostic, P.C state that plaintiff's speech is "spontaneous and fluent in Spanish." Plaintiff's "affidavit" is not accompanied by a translator's affidavit, which is required of foreign language witnesses. The lack of a translator's affidavit renders her English affidavit facially defective and inadmissible (CPLR § 2101 [b]; ***Saavedra v. 64 Annfield Court Corp.***, 137 AD3d 771 [2d Dept 2016]; ***Raza v. Gunik***, 129 AD3d 700 [2d Dept 2015]; ***Eustaquio v. 860 Cortlandt Holdings, Inc.***, 95 AD3d 548 [1st Dept 2012]; ***Reyes v. Arco Wentworth Management Corporation***, 83 AD3d 47 [2d Dept 2011]; *see also* ***Ramos v. Bartis***, 112 AD3d 804 [2d Dept 2013]). Plaintiff's defective and inadmissible affidavit is insufficient to raise a triable issue of fact.

The affirmed reports from Metropolitan Medical and Surgical/Cristy Perdue, M.D. (Plaintiff's Exhibit C) establish that plaintiff received lumbar epidural steroid injections on July 29, 2016 and September 2, 2016. The two operative reports detail the procedure, but they do not causally relate plaintiff's alleged injuries to the subject accident. The July

29, 2016 evaluation reports plaintiff's history as related by plaintiff, including plaintiff's reports of pain. As far as the "objective" findings in that report, Dr. Perdue noted only "restricted ROM" in plaintiff's back and cervical spine; however, there are no objective measurements noted. Although a positive Spurling test and straight leg raise test is reported, along with some tenderness to palpation, the doctor noted, "Musculoskeletal: Normal symmetry, tone, strength and ROM. No effusions, instability or tenderness to palpation." This report also fails to specifically relate any of the findings to the subject accident. The September 2, 2016 operative and evaluation reports suffer from the same defect.

The records from NUMC (Plaintiff's Exhibit B) establish that plaintiff was seen in the emergency department on July 15, 2015, at approximately 12:06 a.m. complaining of upper leg pain, back pain, and limping on ambulation. She was discharged at approximately 3:10 a.m. The diagnosis was "musculoskeletal strain, sprain of knee," and plaintiff was provided ibuprofen. Full range of motion of plaintiff's upper and lower extremities was noted, without joint tenderness or swelling. The x-rays taken of plaintiff's right knee, thoracic spine, and lumbosacral spine did not show any evidence of subluxation or acute fracture. In terms of her discharge instructions, it is written "resume normal activity."

The Hill Chiropractic, P.C. records (Plaintiff's Exhibit D) do document some positive results of various orthopedic tests performed on plaintiff's cervical and lumbar spine areas, as well as on plaintiff's right shoulder as of July 30, 2015, as well as evidence of left C6 radiculopathy in plaintiff's cervical spine area.[3] Despite these findings, however, there are no recommendations that plaintiff refrain from working, or engaging in any particular physical activities aside from plaintiff's own general statement that she has "not be[en] able to perform normal daily activities at this time because of the pain, weakness and stress." Notably, the July 30, 2015 report found no evidence of lumbrosacral radiculopathy or peripheral neuropathy in the lumbar spine and lower extremities following nerve testing.

Three reports from Rehab Medical & Diagnostic, P.C. were also submitted within Exhibit D. The reports are dated July 30, 2015, September 3, 2015, and November 17, 2015, thereby covering the 90/180-day claim period. Although these reports note positive results for certain orthopedic and neurological tests (Valsalva, Kemp's, Spurling), there are no notations restricting plaintiff from any activities. In fact, plaintiff variously reported that she was working in a factory assembling dog supplies, and then at a restaurant. Also, none of the range of motion values reported therein will be considered by the Court because the objective means of measurement is not noted, and there is no source for the normal values to which the findings were compared.

[3] The range of motion testing documented in that report fails to set forth the objective standard used for normal range of motion; therefore, those findings will not be considered by the Court.

The April 14, 2016 Hills Chiropractic, P.C. report discharges plaintiff as "permanently disabled at present time," her injuries being "directly related to the automobile accident on 07/14/2015," and her condition characterized as "non abating." The report also states that plaintiff has reached maximum medical improvement as the result of chiropractic management, acupuncture, and physical therapy. The report summarizes the MRI findings, in addition to the nerve study that revealed evidence of left C6 radiculopathy, and positive orthopedic and neurological test results (Spurling's, spinouts, Soto Hall, Kemp's, Valsalva).[4] Also noted in that report are muscle spasms and tenderness in plaintiff's cervical, thoracic and lumbar spine areas.

Dr. Tyrkin's affirmation is of little value in that it summarizes the reports already discussed herein. Moreover, his summaries of examinations of plaintiff that are recounted in the passive voice are not competent because the Court is not able to discern whose observations he recounts. The summary of the examination that he states he performed on August 3, 2016, as well as his summaries of other individuals' examinations fail to state the objective standard for the normal values cited therein. Annexed to his affirmation, however, are three follow-up orthopedic reports dated September 14, 2016, August 3, 2016, and November 3, 2017, each of which is affirmed by him.

The September 14, 2016 report apparently relates only to plaintiff's right shoulder and right knee. There is no statement as to the source of the normal values for range of motion cited therein; therefore, this is not competent evidence. Even if the Court were to consider the range of motion deficits noted therein, they represent 8% deficits, which is not a significant loss within the meaning of the Insurance Law, nor under the circumstances of this case (*see* ***Licari v. Elliott***, 57 NY2d 230 [1982]; ***Bandoian v. Bernstein***, 254 AD2d 205 [1st Dept 1998]; ***Waldman v. Chang***, 175 Ad2d 204 [2d Dept 1991]).

The August 3, 2016 affirmed report from Dr. Tyorkin addresses plaintiff's right shoulder and right knee. This report states the objective source for the normal range of motion values cited therein, but the deficits noted fall between 7% and 8%, which is not significant, although Dr. Tyorkin causally relates his findings to the subject accident.

The final report dated November 3, 2017 addresses plaintiff's cervical spine, right shoulder, right knee, and lumbar spine. Once again, Dr. Tyorkin fails to state the source of the normal range of motion values cited therein; thus the Court will not consider the

[4] The range of motion testing documented in that report fails to set forth the objective standard used for normal range of motion; therefore, those findings will not be considered by the Court.

range of motion findings. In any event, the losses recorded range from 6% to 8%, which are not significant.

The only findings of significance in this November 3, 2017 report are positive results of the straight leg raise test, on plaintiff's right side, performed in both the seated and supine positions. The straight leg test was performed in connection with the doctor's examination of plaintiff's lumbar spine. The doctor also noted that plaintiff was not able to walk on her heels or toes. "Our case law has consistently treated straight-leg raising tests as objective evidence of serious injury" (***Kim v. Cohen***, 208 AD2d 807 [2d Dept 1994]); accordingly, the affirmed report of Dr. Tyorkin, and also considering the Hills Chiriopractic, P.C. report dated April 14, 2016, together raise a triable issue of fact sufficient to defeat defendants' summary judgment motion as to the following categories of injury: 1) permanent consequential limitation of use of a body organ or member; 2) significant limitation of use of a body function or system.

The Court finds that plaintiff has failed to raise a triable issue of fact as to the following categories of injury: 1) significant disfigurement; 2) permanent loss of use of a body organ, member, function or system; and 3) a medically determined injury or impairment of a non-permanent nature which prevented her from performing substantially all of the material acts which constituted her usual and customary daily activities for not less than 90 days during the 180 days immediately following the occurrence of the injury or impairment (90/180 claim). Accordingly, summary judgment is granted to the defendants as to these categories of injury.

The foregoing constitutes the Order of this Court.

Dated: March 27, 2018
Mineola, NY

J. S. C.

ENTERED
MAR 30 2018
NASSAU COUNTY
COUNTY CLERK'S OFFICE