Silvester v Karimy
2019 NY Slip Op 34475(U)
June 11, 2019
Supreme Court, Suffolk County
Docket Number: Index No. 605357/17
Judge: Carmen Victoria St. George
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SUPREME COURT – STATE OF NEW YORK
TRIAL TERM, PART 56 SUFFOLK COUNTY

PRESENT:

Hon. Carmen Victoria St. George
Justice of the Supreme Court

x

DORN SILVESTER,

Plaintiff,

-against-

MIRWAIS KARIMY and ABDUL M. AKBARYAR,

Defendants.

x

Index No. 605357/17

Motion Seq: 001
Mot D
Decision/Order

The following numbered papers were read upon this motion:

Notice of Motion/Order to Show Cause...........	10-20
Answering Papers....................................	25-29
Reply..	31
Briefs: Plaintiff's/Petitioner's......................	
Defendant's/Respondent's.................	

Defendants Karimy and Akbaryar move for summary judgment dismissal of the complaint pursuant to CPLR 3212 because they contend that plaintiff has not suffered a serious injury within the meaning of Insurance Law 5102 (d) as a result of the motor vehicle accident that occurred between the parties' vehicles on September 3, 2014. After review and consideration of the submitted papers, defendants' summary judgment motion concerning plaintiff's bodily injury claims is granted in part and denied in part.

Plaintiff claims to have suffered injuries to her cervical, thoracic and lumbar spine areas, including exacerbation of asymptomatic conditions in those areas, sprains and strains, restricted motion, pain, radiculopathy and denervation of her extremities. Plaintiff specifically claims that she sustained a serious injury as defined in Insurance Law 5102 (d), under the following statutory categories of injury: 1) fracture; 2) permanent loss of use of a body organ, member, function or system; 3) permanent consequential limitation 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 plaintiff from performing substantially all of the material acts which constituted plaintiff's

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).

As a proponent of the summary judgment motion, the defendants herein have the initial burden of establishing that plaintiff did not sustain a causally related serious injury under the categories of injury claimed in the Bill of Particulars (*see* ***Toure v Avis Rent a Car Sys.***, 98 NY2d 345, 352 [2002]). 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]).

Defendants can satisfy the initial burden by relying on the sworn statements of defendants' examining physicians and plaintiff's sworn testimony, or by the affirmed reports of plaintiff's own examining physicians (***Pagano v Kingsbury***, 182 AD2d 268, 270 [2d Dept 1992]). Defendants can also demonstrate that plaintiff's own medical evidence does not indicate that plaintiff suffered a serious injury and that the alleged injuries were not, in any event, causally related to the accident (***Franchini v Palmieri***, 1 NY3d 536, 537 [2003]). Defendants' medical experts must specify the objective tests upon which the stated medical opinions are based and, when rendering an opinion with respect to plaintiff's ranges of motion, must compare any findings to those ranges of motion considered normal for the particular body part (***Browdame v. Candura***, 25 AD3d 747, 748 [2d Dept 2006]).

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 the injury and its duration (***Little v. Locoh***, 71 AD3d 837 [2d Dept 2010]; ***Furrs v. Griffith***, 43 AD3d 389 [2d Dept 2007]; ***Mejia v. DeRose***, 35 AD3d 407 [2d Dept 2006]). Thus, regardless of an interpretation of an MRI study, plaintiff must still exhibit physical limitations to sustain a claim of serious injury within the meaning of the Insurance Law. Furthermore, to qualify as a serious injury within the meaning of the statute, "permanent loss of use" must be total (***Oberly v. Bangs Ambulance Inc.***, 96 NY2d 295, 299, [2001]).

In support of their motion, defendants submit, *inter alia*, the Bill of Particulars, the affirmed reports of their examining/reviewing physicians, and the transcript of plaintiff's deposition testimony. Based upon these submissions, defendants have made a *prima facie* showing that plaintiff did not sustain 1) the permanent loss of use of a body organ, member, function or system, 2) a permanent consequential limitation of a body organ or member, 3) a significant limitation of use of a body function or system, or 4) an injury establishing her 90/180 claim.

Defendants' expert trauma physician, Jay M. Walshon, M.D., reviewed plaintiff's emergency department records from a Stony Brook University Medical Center visit on September 6, 2014, a police accident report, and the Bill of Particulars.[1] The actual hospital records are not annexed to Dr. Walshon's report, and he apparently did not review the medical records from Brookhaven Medical

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[1] The police report that is submitted as part of defendants' Exhibit E is not certified, nor does it contain the key code; therefore, it is not in admissible form and is incomplete. It will not be considered in the determination of the instant motion.

Center where plaintiff presented herself the day after the subject accident. There is no explanation in Dr. Walshon's report as to why he did not also review the earlier Brookhaven Medical Center records. According to Dr. Walshon, the records he did review indicate that plaintiff presented to Stony Brook University Medical Center's emergency department complaining of back pain and stated that she came to the hospital for "films." Her past history was noted for residual right-sided weakness due to a previous cerebral infarction/stroke, as well as diabetes and hypertension. According to Dr. Walshon, the plaintiff was discharged to her home in an ambulatory state, with a diagnosis of back sprain and musculoskeletal strain. X-rays of her thoracic and lumbar spine showed no evidence of fracture or other acute significant injury. Degenerative disease was seen in plaintiff's thoracic spine and marked atherosclerotic disease of her abdominal aorta was incidentally found. According to Dr. Walshon, the injuries claimed in the Bill of Particulars are inconsistent with the presentation to Stony Brook University Medical Center records from September 6, 2014. The Court recognizes that Dr. Walshon has apparently not reviewed the totality of plaintiff's medical records, and Dr. Walshon has not performed a physical examination of plaintiff; therefore, while his assessment of the September 6, 2014 hospital visit is some evidence in support of defendants' motion, it does not, standing alone, satisfy defendants' prima facie burden.

Dr. Edward M. Weiland, M.D, defendants' examining neurologist, conducted an independent medical examination of plaintiff on September 14, 2018, little more than four years after the occurrence of the subject accident. According to Dr. Weiland's affirmed report, he reviewed the Bill of Particulars. He states in his affirmed report that there were "no legally authenticated medical records available for review." The Court notes that defendants' other experts (Jay M. Walshon, M.D. and Michael Setton, D.O.) apparently reviewed the emergency department records from Stony Brook University Medical Center and the MRI reports of studies performed on plaintiff's cervical, lumbar and thoracic spine areas prior to the time that Dr. Weiland authored his report; therefore, it is unknown why Dr. Weiland did not at least review these records.[2] In any event, Dr. Weiland notes in his report that plaintiff told him that she is currently receiving monthly treatment from a pain management specialist and that she underwent a course of multi-modality rehabilitation treatments, including physical therapy and chiropractic spine care, for two-and-one-half (2 ½) years after the subject accident.

Despite Dr. Weiland's having not reviewed plaintiff's medical records, his examination of plaintiff cannot be ignored. It clearly reveals that plaintiff does not suffer from a total loss of use of any organ, member, function or system. All ranges of motion measured by Dr. Weiland utilizing a goniometer were compared to normal values set forth in the American Medical Association Guides to Evaluation of Permanent Impairment, Fifth Edition, revealing full range of motion in plaintiff's cervical, thoracic and lumbar spine areas. The results of fourteen (14) additional tests performed upon plaintiff also revealed negative results. Dr. Weiland noted that there were no spasms and no pain upon palpation of the thoracic spine. Although there were "subjective complaints of pain with light palpation throughout the posterior aspect of the spine," Dr. Weiland observed that there were "no signs of active tissue inflammation or soft tissue swelling." Dr. Weiland concluded that the alleged injuries to

[2] The Court notes that the hospital records submitted in opposition to the instant motion are not properly certified, and the records from other providers also submitted in opposition bear certifications from 2019, which is well after Dr. Weiland authored his examination report.

plaintiff's cervical, thoracic and lumbar spine are resolved, and that she can perform her activities of daily living.

Dr. Weiland also noted that plaintiff's past medical history is significant for a cerebrovascular accident in 1996 that caused a right hemiparesis. Dr. Weiland stated that there are "neuromuscular abnormalities consistent with an old cerebrovascular injury reported to have been sustained by Ms. Silvester in 1996," but he "can find no evidence of any lateralizing neurological deficits at this time that can be explained on the basis of any traumatic injury reported to have been sustained by Ms. Silvester on 09/03/14."

Since plaintiff did not exhibit any physical limitations during the independent orthopedic examination, there is no evidence of a serious injury in the categories of permanent loss of use, permanent consequential limitation of use, or significant limitation of use provided for by Insurance Law § 5102 (d).

Defendants have also established their *prima facie* entitlement to summary judgment as to plaintiff's 90/180 claim by submitting plaintiff's deposition testimony (***Kuperberg v. Montalbano***, 72 AD3d 903 [2d Dept 2010]; ***Sanchez v. Williamsburg Volunteer of Hatzolah, Inc.***, 48 AD3d 664 [2d Dept 2008]).

Plaintiff testified that she was operating her vehicle on York Avenue in Manhattan, in the right lane of the roadway, when a taxi pulled quickly away from the curb and impacted the passenger side of plaintiff's vehicle. Plaintiff testified that she jammed on her brakes and that the impact between the vehicles was "heavy." When the police responded to the accident scene, plaintiff did not tell police that she was injured or that she was in pain. Later that same day, plaintiff began to experience pain on the entire right side of her body. The day after the accident, on September 4, 2014, plaintiff presented herself to Brookhaven Hospital's emergency department complaining of neck, back, and right hip pain. Plaintiff testified that she underwent testing, but that she was released from the hospital on the same day, without any medication having been given to her. Plaintiff stated that hospital personnel told her to see her regular doctor. Plaintiff did not recall when she saw her primary doctor, Dr. O'Connell, but she did see him after the subject accident.

According to plaintiff, she was confined to her home for one month immediately after the accident. Plaintiff is retired. Plaintiff further testified that she underwent a course of physical therapy after the accident, commencing approximately one month after the occurrence of the subject accident. She has also been using a walker since December 2014 because a doctor at Ortho Med prescribed it for her. Plaintiff stopped treating in December 2015 because her daughter needed her help, and she testified that she "had had enough of the treatments."

Further according to plaintiff, she has had balance problems since the subject accident, and she treated with a neurologist five or six times over the course of approximately one year after the accident. After those five or six visits, she testified that she was discharged from the neurologist's care. Plaintiff explained that she treated for two to three years following her 1996 stroke, and that her remaining disability is to her right side and right hand, but that the stroke and its sequalae did not affect her ability to drive. She also stated that she did not have balance problems since she recovered from her prior stroke.

At the time of her deposition on August 1, 2018, she testified that her neck, back and right hip still hurt and that she sees a pain management physician approximately once per month. According to her testimony, plaintiff's normal daily activities have changed since the accident in that she cannot stand and do dishes for very long, that she cannot dust or vacuum, walk her dog, change her bedding, cook, or bake. Despite this testimony, there is no evidence that plaintiff had to hire any household help, or that she received any help from anyone in relation to these household activities.

Plaintiff's own deposition testimony is insufficient to demonstrate that she was prevented from performing substantially all of her customary daily activities for not less than 90 days during the 180 days immediately following the subject accident (***Omar v. Goodman***, 295 AD2d 413 [2d Dept 2002]; ***Lauretta v. County of Suffolk***, 273 AD2d 204 [2d Dept 2000]). Furthermore, her deposition transcript corroborates Dr. Weiland's findings because there is no evidence in her testimony supporting claims that she suffered a permanent loss of use of a body organ, member, function or system, a permanent consequential limitation of a body organ or member, or a significant limitation of use of a body function or system.

Michael Setton, D.O., defendants' expert radiologist, reviewed the October 21, 2014 MRI studies performed on plaintiff's cervical, thoracic and lumbar spine areas, and he authored three separate affirmed reports based upon his reviews. According to Dr. Setton, there is no acute fracture or malalignment in the cervical spine, and no osseous or soft tissue injury resulting from the subject accident. Principally, plaintiff's cervical spine MRI revealed mild to moderate multi-level degenerative disc disease and multi-level hypertrophic facet joint degeneration, some disc bulges, but no herniation. Multi-level degenerative disc disease and facet joint degeneration were also found in plaintiff's lumbar spine, along with mild disc bulging but no evidence of disc herniation. No evidence of acute fracture or malalignment in the lumbar spine was observed, or any osseous or soft tissue injury which may have resulted from the subject accident.

With respect to plaintiff's thoracic spine, however, in addition to degenerative changes that were noted, Dr. Setton wrote that the MRI "reveals evidence of a mild subacute compression fracture deformity involving the superior endplate of the T1 vertebral body anteriorly. This could have resulted from some type of recent hyperflexion injury such as a rapid deceleration. Alternatively, considering the patient's age and sex, this could also represent an insufficiency fracture relating to underlying metabolic bone disease such as osteoporosis. While there is no associated paraspinal soft tissue edema to suggest a traumatic injury, the two entities can be difficult to distinguish with a single MRI."[3] Based upon this conclusion reached by Dr. Setton, defendants have failed to sustain their prima facie entitlement to summary judgment as a matter of law for the category of injury alleging that plaintiff sustained a fracture as a result of the subject accident.

Plaintiff is now required to come forward with viable, valid objective evidence to verify her complaints of pain, permanent injury and incapacity as to the categories of injury for which the defendants have established their prima facie entitlement to summary judgement (***Farozes v. Kamran***, 22 AD3d 458 [2d Dept 2005]).

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[3] Dr. Setton also noted that "this mild compression injury will typically heal spontaneously without any long term sequelae and without any need for surgical intervention."

In opposition, plaintiff submits plaintiff's medical records from Stony Brook University Medical Center for the following dates: September 6, 2014, September 20-23, 2014 and October 24, 2014; medical records from Brookhaven Memorial Hospital; treatment records from Orthomed Care, P.C., and medical treatment records from South Shore Neurologic Associates, P.C.

Plaintiff's opposition papers are insufficient to raise a triable issue of fact regarding the 1) permanent loss of use of a body organ, member, function or system, 2) permanent consequential limitation of a body organ or member, 3) significant limitation of use of a body function or system, and 4) 90/180 categories of injury claimed to have been suffered by plaintiff principally because there is no evidence of a recent physical examination of plaintiff evidencing any such injuries (*see* ***Tudisco v. James***, 28 AD3d 536 [2d Dept 2006]; ***Hernandez v. DIVA Cab Corp***., 22 AD3d 722 [2d Dept 2005]), no explanation of any kind for the gap in treatment from March 2016 to the present (*see* ***Pommels v. Perez***, 4 NY3d 566 574 [2005]), and no evidence whatsoever submitted in opposition to the undisputed findings of degenerative disc disease unrelated to the subject accident (***Singh v. City of New York***, 71 AD3d 1121 [2d Dept 2011]).

Also, none of the submitted hospital records are certified; therefore, except for the September 6, 2014 Stony Brook University Medical Center records reviewed by defendants' expert Dr. Walshon, the remainder are not in admissible form and will not be considered by this Court (*see* ***Williams v. Clark***, 54 AD3d 942 [2d Dept 2008]; ***Barry v. Valerio***, 72 AD3d 996 [2d Dept 2010]).[4]

As to the September 6, 2014 records, there is nothing contained therein undermining Dr. Walshon's opinions expressed in his report. The hospital records state that plaintiff presented herself complaining of back pain and that she had been in a motor vehicle accident "on Wed." Noted therein is "right sided weakness due to residual of previous CVA." The record also indicates that this is the first time she presented to Stony Brook University Medical Center and that she was there "for 'films.'" Upon discharge later that same day, she was diagnosed as having a back sprain and musculoskeletal strain. Her musculoskeletal examination is noted as revealing "full range of motion 4 extremities at shoulders/elbows/wrists/hips and knees with no pain." The nursing note from 17:35 hours states that plaintiff was discharged "in no acute distress walked out of ER with steady gait." None of the radiology reports from September 6, 2014 included in the hospital records reveal any fractures or subluxation in plaintiff's thoracic or lumbosacral spine areas.

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[4] The Court notes, however, that if the Court were to consider such records, the October 24, 2014 records reveal that plaintiff presented to Stony Brook University Medical Center at approximately 10:52 a.m. complaining of a right finger and hand injury "from walking her cock spaniel last night." Notably, this information contradicts plaintiff's testimony that she can no longer walk her dog since the subject accident. A notation made by Christen Doughty during the Stony Brook discharge planning session held on September 23, 2014 at 12:07 states that plaintiff "denies having any home care services. [Plaintiff] has rolling walker that she does not use. No discharge needs identified." This note appears to contravene plaintiff's testimony that she was prescribed a walker in December 2014. Brookhaven Hospital records contain MRI reports dated from February 2015 through March 2015 concerning plaintiff's lumbar, lumbosacral, and cervical spine areas showing no spinal stenosis, herniation, fracture or dislocation in the lumbar/lumbosacral spine, but mild degenerative changes in the lumbar spine. The cervical spine MRI revealed significant osteoarthritic hypertrophy and osteoarthritis in this area. Also, an October 12, 2015 Brookhaven admission note states that plaintiff "was walking hewr (sic) dog and bent down to pick up the dog poop and was pulled forward onto ground by the dog." X-rays taken on October 12, 2015 also revealed degenerative changes in plaintiff's lumbosacral and cervical spine areas without fractures.

The Orthomed Care treatment records annexed to the opposition papers as plaintiff's Exhibit C range from October 2, 2014 to March 23, 2016. The billing records annexed to the end of the treatment records are not medical treatment records; therefore, they will not be considered. The treatment records are noteworthy in that there is no recommendation from the medical providers that plaintiff refrain from engaging in any activities. In fact, the activities of daily living that were allegedly affected are as reported by plaintiff, not determined by the provider. Furthermore, the doctors' reports either do not contain any range of motion measurements, or if they do, then there is no objective means of measurement stated, nor any source for the normal values cited therein.

Commencing with the January 5, 2015 Orthomed Care report through the July 14, 2015 report, the providers acknowledge that the MRI studies of plaintiff's cervical, thoracic and lumbar spine areas conducted on October 21, 2014 revealed degenerative disc disease; yet, there is nothing submitted in opposition to the instant motion differentiating plaintiff's injuries allegedly suffered because of the subject accident from her degenerative disc disease, or explaining any relationship between the alleged injuries and the degenerative conditions existing in her spine. Accordingly, the doctors' conclusory statements made in the reports that, "[i]f the events described above are correct then the symptoms described are causally related to the accident of September 3, 2014" are rendered speculative and without probative value (***Singh***, ***supra***).

The reports of David W. Rabinovici, M.D. (Orthomed neurologist) contained within the Orthomed Care records likewise fail to raise a triable issue of fact. None of the reports authored by Dr. Rabinovici contain any statement causally relating any findings to the subject accident (*see* ***Knox v. Lennihan***, 65 AD3d 615 [2d Dept 2009]; ***Munoz v. Koyfman***, 44 AD3d 914 [2d Dept 2007]; ***Collins v. Sheridan Stone***, 8 AD3d 321 [2d Dept 2004]). According to the records, Dr. Rabinovici first encountered plaintiff on October 29, 2014. He notes that approximately one year prior to the subject accident, plaintiff was diagnosed with a seizure disorder and periods of syncope (fainting) during the daytime hours. When she presented to Dr. Rabinovici, plaintiff had already fallen while walking her dog on September 23, 2014. Dr. Rabinovici did not measure any ranges of motion on October 29, 2014, but he noted that the MRI reports and the Brookhaven and Stony Brook hospital records revealed degenerative changes in plaintff's thoracic, cervical and lumbar spine areas. The only recommendation made to plaintiff refrain from "heavy lifting."

Dr. Rabinovici's November 26, 2014 report of the nerve conduction test that he ordered be performed revealed "moderately severe chronic denervation" of the right upper extremity and "mild chronic denervation of all the muscles tested." Dr. Rabinovici noted that plaintiff is a diabetic and also demonstrates atrophy in the right arm secondary to stroke. Importantly, Dr. Rabonovici does not attribute any of the findings of the nerve study to the subject accident.

The "Computerized Spinal Range of Motion Exam" pages contained within the Orthomed Care exhibit are not accompanied by any doctor's report specifically relating to the pages of computerized printouts; therefore, the Court will not speculate as to the interpretation of these pages.

The chiropractor's report dated September 19, 2014, which is also contained within the Orthomed Care records, does not set forth any range of motion values, the objective method of examination, or comparative normal values. The chiropractor simply states that cervical and lumbar

spine "[r]ange of motion was restricted in all planes with pain upon end range." In view of the totality of the records contained in the Orthomed Care exhibit, the chiropractor's conclusory and sweeping proclamation that there is a causal relationship between "the patient complaints and the injury the patient sustained on 9/3/14," as well as his statement that "[t]he patient is totally disabled" ring hollow and are utterly speculative.

Finally, the South Shore Neurologic Associates, P.C. records annexed to the opposition papers as Exhibit D fail to causally relate any of the findings contained therein to the subject accident.[5] In fact, nothing in this exhibit refers to the motor vehicle accident that gives rise to this action. The records range from January 13, 2016 through April 27, 2016. Based upon reading the reports of Edward Firouztale, D.O., it appears that plaintiff treated with South Shore Neurologic Associates because she fell on January 2, 2016, hitting her head and face. It further appears that her fall occurred in Manhattan because the doctor's report of January 13, 2016 states that plaintiff went to the Lenox Hill emergency room and had stitches and a CAT scan of her brain. There is no statement by any medical provider attributing her fall to the subject accident. Accordingly, no triable issue of fact is raised by this evidence.

Defendants' summary judgment motion is granted as to the following categories of injury claimed under Insurance Law 5102 (d): 1) permanent loss of use of a body organ, member, function or system, 2) permanent consequential limitation of a body organ or member, 3) significant limitation of use of a body function or system, and 4) the 90/180 claim, but it is denied as to the category of injury alleging a fracture.

The foregoing constitutes the Decision and Order of this Court.

Dated: June 11, 2019
Riverhead, NY

CARMEN VICTORIA ST. GEORGE, J.S.C.

FINAL DISPOSITION [ ] NON-FINAL ISPOSITION [X]

[5] These records also contain reports from Zwanger-Pesiri Radiology dated January 19, 2016 that are not separately sworn to or certified. Notwithstanding that these reports are not in admissible form, they also fail to relate any findings to the subject accident.