| **Weber v Kalisky** |
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| 2020 NY Slip Op 34852(U) |
| June 29, 2020 |
| Supreme Court, Suffolk County |
| Docket Number: Index No. 614320/2016 |
| Judge: Carmen Victoria St. George |
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ORIGINAL

**SUPREME COURT – STATE OF NEW YORK**
**TRIAL TERM, PART 56 SUFFOLK COUNTY**

**PRESENT:**

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

x

**GINA WEBER,**

**Plaintiffs,**

**-against-**

**ALAN KALISKY,**

**Defendant.**

x

**Index No.**
**614320/2016**

**Motion Seq:**
**001 MG**
**Decision/Order**

The following electronically numbered papers were read upon this motion:

| | |
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| Notice of Motion/Order to Show Cause..... | 11-19 |
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| Defendant's/Respondent's..... | |

Defendant moves this Court for an Order dismissing the complaint on the basis that the plaintiff has not suffered a serious injury within the meaning of Insurance Law § 5102 (d). Plaintiff opposes the requested relief.

The motor vehicle accident giving rise to this action occurred on October 7, 2013. This action was commenced on September 12, 2016.

In her Bill of Particulars dated October 2, 2017, plaintiff claims that she has suffered injuries to her lumbar, cervical and thoracic spine areas, and to her sternum, resulting in, *inter alia*, decreased range of motion in her cervical, lumbar and thoracic spine areas, pain, stenosis, cervicalgia, bulging and herniated discs, weakness, and left side antalgic gait. Plaintiff also alleges that the injuries listed in her Bill of Particulars are permanent in nature, and that she has suffered injuries under the following categories of 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) 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).

In her opposition papers, plaintiff apparently concedes that she has not suffered a permanent loss of use of a body organ, member, function or system (Affirmation in Opposition, ¶ 52). 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]), and there is no evidence that plaintiff in this matter has suffered a total loss of use of any of her body parts, functions or systems.

Thus, the three categories of injury to be considered in the determination of the instant motion are 1) permanent consequential limitation of use of a body organ or member; 2) significant limitation of use of a body function or system, and 3) the 90/180 claim.

The Court recognizes 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 proponent of a summary judgment motion must tender sufficient evidence to demonstrate the absence any material issue of fact (***Winegrad v. New York University Medical Center***, 64 NY2d 851, 853 [1985]). "Failure to make such prima facie showing requires a denial of the motion, regardless of the sufficiency of the opposing papers" (***Id.***) "Once this showing has been made, however, the burden shifts to the party opposing the motion for summary judgment to produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact which require a trial of the action" (***Alvarez v. Prospect Hospital***, 68 NY2d 320, 324 [1986]). 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]).

The defendants 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]).

A defendant can satisfy the initial burden by relying on either the sworn statements of defendant's examining physician, or 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]). A defendant can 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]). Defendant's medical expert must specify the objective tests upon which the stated medical opinions are based and, when rendering an opinion with respect to plaintiff's range 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.

Here, defendant has made a *prima facie* showing that plaintiff did not sustain any serious injuries within the meaning of Insurance Law § 5102 (d) by submitting for the Court's consideration the pleadings, the affirmed reports of Edward A. Toriello, M.D. and Marc J. Katzman, M.D., and plaintiff's own deposition transcript.

At the outset, the Court notes that plaintiff's Bill of Particulars alleges that she suffered injuries to her lumbar spine, cervical spine, thoracic spine and sternum. Plaintiff does not claim injury to any other body parts, nor did she claim injury to any other body part during her deposition testimony. Furthermore, there is no evidence that plaintiff has served a Supplemental Bill of Particulars alleging injury to any additional body parts.

Dr. Toriello, defendant's examining orthopedic surgeon, examined plaintiff on January 7, 2019, more than five years after the occurrence of the subject accident. On the day of the independent medical examination (IME), plaintiff apparently advised Dr. Toriello that her present complaints consisted of numbness in the upper portion of her arms at night from her shoulders to her elbows. This complaint was not asserted in her Bill of Particulars, nor did plaintiff testify to this complaint at her deposition. In any event, Dr.Toriello examined plaintiff's cervical spine, right and left shoulders, bilateral elbows, bilateral hands and wrists, plaintiff's chest/ribs, her thoracic spine, and her lumbosacral spine. Notably, plaintiff has never asserted any injury to her shoulders, elbows, hands, or wrists as a result of the subject accident.

Dr. Toriello sets forth the objective means by which he obtained range of motion measurements in the areas of plaintiff's body that he examined, in addition to identifying the treatises from which he derived and stated the normal ranges of motion for each body part.

Plaintiff's ranges of motion in her cervical, thoracic and lumbosacral spine areas were normal upon examination. According at his report, deep tendon reflexes in the upper and lower extremities were bilaterally symmetrical, and there were no motor or sensory deficits in the upper or lower extremities. Dr. Toriello did not observe any erythema, ecchymosis, swelling, or tenderness in plaintiff's thoracic spine, chest, elbows or shoulders. Plaintiff was observed to have a normal heel and toe gait and no paralumbar muscle spasm was present in her lumbosacral spine area. Straight leg raising test was also bilaterally full and pain free.

Dr. Toriello noted wrote that there "was no paracervical muscle spasm or atrophy" in plaintiff's cervical spine area. Bilateral bending and rotation of plaintiff's cervical spine yielded normal range of motion results, as did flexion and extension of the cervical spine. Plaintiff was able to achieve full flexion (50 degrees) and extension (60 degrees), although Dr. Toriello noted that the plaintiff complained of pain in the parascapular region at the extremes of flexion and extension that she was able to achieve.

In addition to his physical examination of the plaintiff, he also reviewed a number of her medical records submitted to him, and he concluded that plaintiff's cervical, parascapular, thoracic and low back strains, as well as the sternal contusion, were causally related to the subject accident, but that they were all resolved and there is no objective evidence of continued disability. Dr. Toriello also noted in his affirmed report that the plaintiff's "subjective complaints are not consistent with objective findings."

Dr. Marc J. Katzman, M.D., defendant's radiological expert, performed an independent radiological interpretation of the March 22, 2014 MRI study of plaintiff's cervical spine. Dr. Katzman noted that there is partial straightening of the normal cervical lordosis, but there is no compression fracture, traumatic subluxation, or ligamentous injury. Dr. Katzman noted disc dehydration throughout the cervical spine, with degenerative disc height loss at C5-6 and C6-7, minimal degenerative disc bulges at C3-4 and C4-5, among other findings, leading Dr. Katzman to conclude that, "the MRI of the cervical spine performed on 03/22/2014 reveals mild to moderate chronic multilevel degenerative disc disease of the cervical spine without evidence of recent post-traumatic injury. The disc bulges at C3-4 and C4-5 and the disc osteophyte complexes at C5-6 and C6-7 are all by definition degenerative and non-traumatic. . .pre-existing, and unrelated to the accident on 10/07/2013."

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) regardless of the cervical spine MRI findings that are, in any case, found to be degenerative in nature by Dr. Katzman (***Little***, ***supra***).

Defendant has also established his *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 described that defendant's vehicle came out of a parking lot or driveway and the front of defendant's vehicle struck the driver's side of plaintiff's vehicle, between the driver's door and the passenger door. Although plaintiff described the contact as being "heavy, loud," her vehicle was not caused to move in any direction, nor did her vehicle strike any other objects or cars. Plaintiff was able to drive her car home after the accident.

Police were summoned to the accident scene, and the responding officer asked plaintiff if she wanted or needed an ambulance. The accident occurred at approximately 2:30 p.m. Plaintiff declined the offer of an ambulance at the scene, and she did not seek medical attention until later that evening when she was driven to the emergency department of St. Catherine's Hospital by her husband. At the hospital, she complained of pain in her back between her shoulder blades and pain in her neck. X-rays were taken, but apparently there were no fractures. Plaintiff was given a muscle relaxant and Motrin and told to follow up with her primary care physician. The plaintiff was not provided with any assistive devices and she returned home after being treated and released from the hospital. According to the plaintiff's own testimony, she did not suffer a

loss of consciousness; she did not bleed or bruise as a result of the accident, and the airbags in her vehicle did not deploy.

Plaintiff went to her primary care physician the next day. There, she made the same complaints of pain between her shoulder blades and in her neck. According to the plaintiff, her primary care physician told her that "everything felt tight," and the doctor referred plaintiff to a spine doctor, Dr. Basra.

Plaintiff treated with Dr. Basra a total of approximately three or four times. It is Dr. Basra who ordered the MRI of plaintiff's cervical spine that was ultimately performed on March 22, 2014, almost five months after the subject accident. Plaintiff testified that she was told that she has a bulging disc at C5-C6. Aside from the MRI, Dr. Basra initially prescribed physical therapy for plaintiff's neck and back. She attended physical therapy with Chris Prentiss, twice a week for approximately one month, amounting to a total of approximately five or six sessions. Plaintiff testified that she stopped attending physical therapy right at about the time she fell on the steps of a local school on November 6, 2013 and not necessarily because of this subsequent incident. Plaintiff denied that she hurt her neck or back in that subsequent incident.

According to her testimony, the plaintiff never returned to physical therapy with Chris Prentiss after the beginning of November 2013. Plaintiff did, however, testify that she attended physical therapy sessions at Team Rehab "sporadically," but she could not recall when she first went to Team Rehab. At the time of her deposition in November 2018, she testified that her last visit was in 2018, but she could not recall the month or months that she treated at Team Rehab, or how many times she visited the facility. Plaintiff stated that, if she has "a flare-up or have a lot of difficulty, I go in. I see them for two times a week for three weeks. And then I am okay for a little while. And then when I have another episode where I am having difficulty with turning my head or spasms in my back, I go back. It is just ongoing." Plaintiff was also unable to recall how many "flare-ups" or "episodes" she has had.

Further according to her testimony, she remained at home for only two days immediately following the accident. Plaintiff has not worked in her profession as a registered nurse since June 2011, when she was involved in another car accident where her vehicle was "t-boned" on the passenger side by another vehicle going at more than thirty miles per hour, causing her car to spin around 360 degrees and end up on an embankment. Plaintiff also underwent left shoulder surgery as a result of that car accident. Plaintiff denied that she hurt her neck or back in that prior accident.

During the two days that she remained home after the subject accident, she stated that she sat in a chair and walked around the house. Plaintiff's claim of confinement in her Bill of Particulars is also for two days immediately following this accident.

Plaintiff also acknowledged that prior to the subject accident on October 7, 2013, she has had pain in her neck, back and spine. She also went to Huntington Hospital in 2005 for lumbar back pain, but she could not recall who treated her, what the treatment consisted of, or what brought on the lumbar pain. She further acknowledged that she suffered a compression fracture to her thoracic spine in 2009. This fracture to the T-11 and T-12 vertebrae came to her attention

after a nursing shift when she felt pain in her back. In 2009, plaintiff was also diagnosed with osteopenia that, according to her testimony, means "the bones have less—they are more brittle, but it is before osteoporosis so it [is] the level before."

With respect to the subject accident, plaintiff additionally acknowledged that she did not receive any injections and that there was no fracture to her sternum. She and her family were able to take four annual vacations since the subject accident. They went to Turks and Caicos twice and to Italy twice. The Turks and Caicos vacations were about one week long and the trips to Italy were about twelve days each. The vacations involved flights and cruises.

The only activity that plaintiff testified that she no longer does since the accident is lifting weights to help with her osteopenia. She testified that she lifted three-pound weights a couple times per week prior to the accident, but that she experienced pain in her neck when she tried to lift the weights after the subject accident, so she stopped.

In terms of activities with which she has difficulty, plaintiff testified that she delegates some housework/cleaning to her adult children with whom she lives. She also stated that she experiences pain when vacuuming and cleaning the bathroom.

At the time of her deposition and within sixty days prior, plaintiff testified that she experiences pain between her shoulder blades when she turns her head in either direction, and that she also experiences neck pain, mostly at night that disturbs her sleep. When asked how often she experiences pain between her shoulder blades, she answered, "[s]ome days are harder than others. A lot of it I feel is weather related. It is difficulty sleeping." When the weather is humid or it is raining, she stated that she feels the pain more. The pain that plaintiff stated she feels in the base of her neck is felt mostly at night.

Plaintiff's own deposition testimony demonstrates that she was not 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. 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/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]). Accordingly, the defendant has demonstrated his *prima facie* entitlement to summary judgment as a matter of law with respect to all categories alleged in plaintiff's Bill of Particulars.

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 order to satisfy the statutory serious injury threshold, a plaintiff must have sustained an injury that is identifiable by objective proof; subjective complaints of pain do not qualify as serious injury within the meaning of Insurance Law §5102(d) (*see* ***Toure, supra; Scheer v Koubek***, 70 NY2d 678, 679 [1987]; ***Munoz v Hollingsworth***, 18 AD3d 278, 279 [1st Dept 2005]). Furthermore, a plaintiff cannot defeat a motion for summary judgment, and successfully rebut prima facie showing that she did not sustain a serious injury, merely by

relying on documented subjective complaints of pain (***Uddin v Cooper***, 32 AD3d 270, 271 [1st Dept 2006] *lv to appeal denied* 8 NY3d 808 [2001]).

In opposition, plaintiff submits an affirmed report of Ashish Kumar, D.O., medical records from Huntington Hospital, medical records from plaintiff's primary care physician (Cohen, Bergman, Klepper, M.D.'s, P.C.), Chris Prentiss Physical Therapy, and Team Rehab physical therapy. In sum, there is no evidence in any of the records submitted by plaintiff in opposition that raises a triable issue of fact as to any of her claimed injuries and the categories of injury alleged in her Bill of Particulars sufficient to defeat defendant's motion.

Dr. Kumar of Action Sports Medicine & Pain Management has authored an affirmed report dated December 2, 2019 (Exhibit A). Based upon plaintiff's own deposition testimony and the report itself, it does not appear that plaintiff ever treated with Dr. Kumar either before or after the subsequent accident up until the time of her deposition, but that the first time she encountered Dr. Kumar was on December 2, 2019, after the instant summary judgment motion was made by defendant.

When the plaintiff presented to Dr. Kumar, she complained of neck and midback pain, and that the neck pain radiated down her right shoulder and down the right upper extremity associated with numbness/tingling. As previously noted by this Court, numbness and tingling/radiating pain were never alleged in the Bill of particulars, nor did plaintiff testify about these specific complaints.

In any event, Dr. Kumar's report consists largely of plaintiff's subjective complaints of pain and a listing of the records he reviewed, including from the medical providers about which plaintiff testified at her deposition. Among those records is what Dr. Kumar refers to as "3/22/2014, MRI Cervical spine: Moderate degenerative changes most pronounced at C5-C6 and C6-C7," and Team Rehab physical therapy records he describes as "6/8/2016: Continue PT 2-3x/week, provide posture exercises, light weight routine and aquatic routine for osteoporosis. Educ. About imp. Of WB exercises, following up with her doctors, and strengthening/balance."

As noted above, plaintiff testified that she could no longer lift light weights for her osteopenia after the accident, but apparently, she was instructed to do so three years after the subject accident. Moreover, it appears from Dr. Kumar's note about the Team Rehab records that in 2016 plaintiff was receiving physical therapy for her osteoporosis, unrelated to the subject accident.

Dr. Kumar apparently examined only plaintiff's cervical spine range of motion. He did not note any examination of plaintiff's thoracic or lumbar spine areas, which areas were alleged to have been injured as per plaintiff's Bill of Particulars. Also, Dr. Kumar fails to state the objective means by which he obtained the range of motion measurements set forth in his report, nor did Dr. Kumar set forth the treatise or treatises upon which he relied for the normal values written in his report; accordingly, plaintiff has failed to establish an objective basis so that the respective qualitative assessments of plaintiff could readily be challenged by any of defendants' expert(s) during cross examination at trial and be weighed by the trier of fact *(see* ***Toure***, ***supra*** at 350 [2002]).

Moreover, Dr. Kumar noted that there was no erythema and no edema found in plaintiff's cervical spine area, and that three of the four orthopedic tests administered were negative. Only the Spurling's test was positive on the right. He also noted that, neurologically, plaintiff is intact, and her motor exam was normal in the upper extremities bilaterally. Dr. Kumar did not examine plaintiff's lower extremities.

Despite acknowledging that the MRI of plaintiff's cervical spine showed degenerative changes, and without addressing that issue, and without examining her thoracic spine, Dr. Kumar states in perfunctory fashion that, "[i]f the patient's history is correct, the patient's neck and mid back pain is caused by his [sic] motor vehicle accident on 10/7/13;" "She has disability with regards to her neck and midback." Dr. Kumar's conclusion concerning plaintiff's "disability with regards to her neck and midback" is rendered speculative and unsupported because of his failure to account for the established degenerative changes that even he acknowledges, his failure to examine plaintiff's thoracic spine, and his additional failure to provide an objective basis for his measurements.

As to the admissibility of the other medical records, the Court recognizes that a plaintiff may rely upon unsworn reports of medical examinations/procedures if the defendant presents the results of those reports in support of his or her summary judgment motion (***Irizarry v. Lindor***, 110 AD3d 846 [2d Dept 2013]; ***Zarate v. McDonald***, 31 AD3d 632 [2d Dept 2006]). In this case, Dr. Toriello set forth the results of MRI reports of plaintiff's cervical and thoracic spine, but not the results of the other records he reviewed at the time of the IME. Thus, the Court will not consider those records from Huntington Hospital, plaintiff's primary care physician (Cohen, Bergman, Klepper, M.D.'s, P.C.), Chris Prentiss Physical Therapy, and Team Rehab physical therapy as they are not in admissible form and their results were not presented as part of Dr. Toriello's IME report.

Even if this Court were to consider those records contained in Exhibits B through F, they fail to raise a triable issue of fact. Moreover, those records underscore plaintiff's significant pre-existing conditions in her neck and back area that Dr. Kumar failed to address in his report.

The Huntington Hospital records, aside from including records pertaining to body parts and medical conditions unaffected/unrelated by/to the subject accident, serve to demonstrate that, in 2009, plaintiff was already experiencing degenerative changes in her thoracic spine, significant disc height loss and disc herniation. Regarding the 2011 motor vehicle accident, plaintiff complained of left shoulder and neck pain. Three views of the plaintiff's cervical spine taken on June 22, 2011 showed degenerative changes in that area, which is more than two years before the subject accident. In December 2012, an MRI of plaintiff's lumbar spine revealed L4-5 degenerative disc disease with disc herniation and spinal canal stenosis. In April 2017, plaintiff presented to the hospital complaining of wheezing and chest pain. A CT scan of her chest including a finding concerning plaintiff's bones: "Bones: Degenerative changes." At that time in April 2017, plaintiff was also diagnosed with asthma after complaining of upper mid-back pain. She stated that she thought she had suffered another compression fracture, as she has a history of compression fracture. Nowhere in the records from April 2017 is the subject accident mentioned by plaintiff or by the health care provider as a source of the pain.

A collection of records from Cohen, Bergman, Klepper M.D.'s, P.C. (Exhibit C) consist of a number of laboratory reports and what appears to the report of her October 8, 2013 visit to her primary care physician. A note dated October 9, 2013 states that plaintiff's neck was supple with some paraspinal spasm and muscle spasm in her thoracic spine. The assessment states that she had a "muscle spasm/strain" related to the subject accident. No range of motion measurements were taken. The remainder of the records in Exhibit C are from 2014 through 2017, but they appear to relate to routine physicals or other unrelated complaints, and in any event, there are no orthopedic evaluations or orthopedic tests noted relative to plaintiff's neck and/or back. Notably, there is a thoracic spine MRI report from April 17, 2017 stating in relevant part that the "loss of disc space height and signal in the mid thoracic spine [is] compatible with degenerative disc disease." There is no causal relation to the subject accident noted in that report.

There are reports from Dr. Basra, included as Exhibit E. Notable among them is a report from January 4, 2013, which predates the subject accident by approximately nine months. Plaintiff went to the emergency department of Huntington Hospital with severe lumbar spasms. Plaintiff's primary care physician referred plaintiff to Dr. Basra for this episode. Dr. Basra's assessment was lumbar stenosis, disc displacement and degenerative disc disease. In a January 15, 2014 report, it is noted that the plaintiff complained of cervical spine pain and upper extremity numbness. This report, like his other reports included in the exhibit, is devoid of any objective means of measurement, actual range of motion values noted for the cervical spine, normal values and the source thereof; nonetheless, Dr. Basra's assessment of plaintiff's condition is "cervicalgia; degenerative disc disease—cervical." Nowhere does Dr. Basra attribute plaintiff's cervical spine complaints/conditions to the subject motor vehicle accident, nor does he restrict any of plaintiff's activities. Finally, the cervical spine MRI report for the March 22, 2014 study is included in Dr. Basra's records and the findings include multilevel disc degenerative disc desiccation, moderate degenerative changes most pronounced at C5-C6 and C6-C7. The MRI report does not causally relate any of the findings to trauma or to the subject accident.

The Chris Prentiss physical therapy reports (Exhibit D) consist mainly of billing sheets, and the examination reports that are included are devoid of the means of objective testing employed concerning ranges of motion noted therein. There are also no normal values noted for comparison, nor is there a source for normal values stated in those reports. Most importantly, there is no notation restricting plaintiff's usual and customary activities. In fact, there is a questionnaire included in Exhibit D that were apparently filled out by the plaintiff concerning how her back condition affected her everyday life. To the extent that the form is able to be read in the copy provided, plaintiff circled the following answers, for example: "The pain comes and goes and is moderate;" "I do not normally change my way of washing or dressing even though it causes some pain;" "Because of pain my normal sleep is reduced by less than 25%;" "I have some pain while walking but it doesn't increase with distance;" "I can sit in any chair as long as I like;" "I get some pain while traveling but it does not cause me to seek alternate forms of travel."

Like the other medical records submitted by plaintiff, the Team Rehab records are devoid of objective means of measurement of plaintiff's thoracic, lumbar and cervical spine areas,

normal values and the source thereof; they do not contain any notations restricting plaintiff's usual and daily activities, and there is no causal relation to the subject accident. In fact, there is a subjective patient history given on the first page of an August 8, 2016 Initial Evaluation stating that the "mechanism of injury" is as follows: "Insidious Pt reports thoracic pain that started without injury." Plaintiff apparently did not complain about her cervical spine at this initial visit, but only about her thoracic spine and left shoulder. As noted, plaintiff does not claim injury to her left shoulder as a result of the subject accident.

The records submitted by plaintiff not only fail to raise a question of fact as to whether she suffered a serious injury as a result of the October 7, 2013 accident, but, in a sense, they actually undermine her claims of injury and they fully reveal the purely speculative nature of Dr. Kumar's report that attempts to causally relate plaintiff's alleged injuries to the accident giving rise to this action while completely ignoring the substance of the medical records he purports to have reviewed.

In sum, none of the reports contain any recommendations/directives that plaintiff refrain from engaging in any activities of daily living; thus, the reports do not support plaintiff's 90/180 claim, nor do they raise a triable issue of fact regarding that category of injury. There is no evidence of permanent loss of use, and none of the cervical or thoracolumbar sprains/strains diagnosed constitute a significant or consequential injury (***Rabolt v. Park***, 50 AD3d 995 [2d Dept 2008]; ***Washington v. Cross***, 48 AD3d 457 [2d Dept 2008]).

For all the foregoing reasons, plaintiff has failed to raise a triable issue of fact sufficient to defeat defendant's motion as to any claimed category of injury under Insurance Law § 5102 (d).

Accordingly, defendant's motion is granted in its entirety and the complaint is dismissed.

The foregoing constitutes the Decision and Order of this Court.

Dated: June 29, 2020
Riverhead, NY

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

FINAL DISPOSITION [ X ] NON-FINAL DISPOSITION [ ]