

Mats v Greuner

2025 NY Slip Op 33162(U)

August 20, 2025

Supreme Court, New York County

Docket Number: Index No. 805258/2023

Judge: John J. Kelley

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**SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY**

PRESENT: HON. JOHN J. KELLEY PART 56M

Justice

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ANNA MATS and VADIM MATS,
Plaintiffs,

INDEX NO. 805258/2023

MOTION DATE 08/18/2025

MOTION SEQ. NO. 002

- v -

DAVID GREUNER, M.D., VICTOR I. ROSENBERG, M.D.,
GLENYS HERNANDEZ, P.A., DAVID GREUNER, M.D.,
P.C., NYC SURGICAL ASSOCIATES, GREUNER
INPATIENT SURGICAL NY, P.C., GREUNER MEDICAL
P.C., CITY SURGICAL CARE OF NJ, and GREUNER
MEDICAL OF NJ, P.C.,

**DECISION + ORDER ON
MOTION**

Defendants.

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The following e-filed documents, listed by NYSCEF document number (Motion 002) 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 61

were read on this motion to/for RENEWAL/JUDGMENT-DEFAULT.

This is an action to recover damages for medical malpractice based on alleged departures from good and accepted practice, lack of informed consent, negligent hiring, training, supervision, and retention of health-care employees, gross negligence, fraud, and loss of spousal consortium. The plaintiffs move pursuant to CPLR 2221(e) for leave to renew those branches of their prior motion (MOT SEQ 001) which were pursuant to CPLR 3215 for leave to enter a default judgment on the issue of liability against the defendants David Greuner, M.D., David Greuner, M.D., P.C., Greuner Inpatient Surgical NY, P.C., and Greuner Medical, P.C. (collectively the Greuner defendants), on their medical malpractice cause of action, which had been denied without prejudice to renewal in an order dated July 14, 2025.¹ The Greuner defendants do not oppose the motion. The defendants Victor I. Rosenberg, M.D., and City

¹ The court notes that, in that order, it denied that branch of the plaintiffs' motion which sought leave to enter a default judgment on the issue of liability against the defendant Greuner Medical of NJ, P.C., since the plaintiffs never served process upon that defendant.

Surgical Care of NJ (together the Rosenberg defendants) partially oppose the motion. The motion is granted, the plaintiffs are granted leave to enter a default judgment on the issue of liability on their medical malpractice cause of action insofar as asserted against the Greuner defendants, and the matter is set down for an inquest on the issue the damages for which the Greunder defendants are liable, to be conducted simultaneously with the trial of the action against the remaining defendants. The court, however, agrees with the Rosenberg defendants that the opinions expressed by the plaintiffs' expert have been considered solely with respect to the issue of whether the plaintiffs have submitted sufficient proof of the facts underlying their medical malpractice claims against the Greuner defendants. The Rosenberg defendants are not precluded by the doctrines of law of the case or collateral estoppel from challenging any of the expert's facts and opinions at the appropriate juncture, since the plaintiffs' motion did not seek relief against them, and they had no basis on which to oppose the relief sought by the motion (see *Santiago v General Motors, LLC*, 232 AD3d 1173, 1174-1175 [3d Dept 2024] [party was not aggrieved for purposes of prosecuting appeal, where underlying motion was not addressed to it, but Supreme Court nonetheless made factual findings that the party believed were adverse to it; party did not have "a full and fair opportunity to litigate" the issue and, thus, the factual findings challenged by that party were not binding upon in it any future dispute]).

As explained in this court's July 14, 2025 order disposing of Motion Sequence 001, where a plaintiff moves for leave to enter a default judgment, he or she must submit proof of service of the summons and complaint upon the defaulting defendant, proof of the defendant's default, and proof of the facts constituting the claim (see CPLR 3215[f]; *Woodson v Mendon Leasing Corp.*, 100 NY2d 62, 70-71 [2003]; *Gray v Doyle*, 170 AD3d 969, 971 [2d Dept 2019]; *Rivera v Correction Officer L. Banks*, 135 AD3d 621 [1st Dept 2016]; *Atlantic Cas. Ins. Co. v RJNJ Services, Inc.* 89 AD3d 649 [2d Dept 2011]; *Allstate Ins. Co. v Austin*, 48 AD3d 720, 720 [2d Dept 2008]; see also *Manhattan Telecom. Corp. v H & A Locksmith, Inc.*, 21 NY3d 200 [2013]). As the court further determined in that order, the relevant affidavits of service

established that the Greuner defendants were properly served with process, and that the affirmation of the plaintiffs' attorney established that those defendants did not answer or move with respect to the complaint or appear in the action and, hence, were in default.

With respect to the proof of the facts constituting the claim,

“CPLR 3215 does not contemplate that default judgments are to be rubber-stamped once jurisdiction and a failure to appear have been shown. Some proof of liability is also required to satisfy the court as to the prima facie validity of the uncontested cause of action (see, 4 Weinstein-Korn-Miller, NY Civ Prac paras. 3215.22-3215.27). The standard of proof is not stringent, amounting only to some firsthand confirmation of the facts”

(*Joosten v Gale*, 129 AD2d 531, 535 [1st Dept 1987]; see *Martinez v Reiner*, 104 AD3d 477, 478 [1st Dept 2013]; *Beltre v Babu*, 32 AD3d 722, 723 [1st Dept 2006]). Stated another way, while the “quantum of proof necessary to support an application for a default judgment is not exacting . . . some firsthand confirmation of the facts forming the basis of the claim must be proffered” (*Guzetti v City of New York*, 32 AD3d 234, 236 [1st Dept 2006]). In other words, the proof submitted must establish a prima facie case (see *id.*; *Silberstein v Presbyterian Hosp.*, 95 AD2d 773 [2d Dept 1983]). “Where a valid cause of action is not stated, the party moving for judgment is not entitled to the requested relief, even on default” (*Green v Dolphy Constr. Co.*, 187 AD2d 635, 636 [2d Dept 1992]; see *Walley v Leatherstocking Healthcare, LLC*, 79 AD3d 1236, 1238 [3d Dept 2010]). In moving for leave to enter a default judgment, the plaintiff must “state a viable cause of action” (*Fappiano v City of New York*, 5 AD3d 627, 628 [2d Dept 2004]). In evaluating whether the plaintiff has fulfilled this obligation, the defendant, as the defaulting party, is “deemed to have admitted all factual allegations contained in the complaint and all reasonable inferences that flow from them” (*Woodson v Mendon Leasing Corp.*, 100 NY2d 62, 71 [2003]). The court, however, must still reach the legal conclusion that those factual allegations establish a prima facie case (see *Matter of Dyno v Rose*, 260 AD2d 694, 698 [3d Dept 1999]).

Proof that the plaintiff has submitted “enough facts to enable [the] court to determine that a viable” cause of action exists (*Woodson v Mendon Leasing Corp.*, 100 NY2d at 71; see *Gray v Doyle*, 170 AD3d at 971) may be established by an affidavit of a party or someone with knowledge, authenticated documentary proof, or by complaint verified by the plaintiff that sufficiently details the facts and the basis for the defendant’s liability (see CPLR 105[u]; *Woodson v Mendon Leasing Corp.*, 100 NY2d at 71; *Gray v Doyle*, 170 AD3d at 971; *Voelker v Bodum USA, Inc.*, 149 AD3d 587, 587 [1st Dept 2017]; *Al Fayed v Barak*, 39 AD3d 371, 371 [1st Dept 2007]; see also *Michael v Atlas Restoration Corp.*, 159 AD3d 980, 982 [2d Dept 2018]; *Zino v Joab Taxi, Inc.*, 20 AD3d 521, 522 [2d Dept 2005]; see generally *Mitrani Plasterers Co., Inc. v SCG Contr. Corp.*, 97 AD3d 552, 553 [2d Dept 2012]). As the court explained it in its prior order, in the context of a medical malpractice action, generally an affidavit or affirmation of merit from an expert is required to support a motion for leave to enter a default judgment, unless the matters alleged are within the ordinary experience and knowledge of a lay person (see *Fiore v Galang*, 64 NY2d 999, 1000-1001 [1985]; *Bollinger v Mark Mordechai Liechtung, DMD, P.C.*, 2023 NY Slip Op 31537[U], *5, 2023 NY Misc LEXIS 2231, *6 [Sup Ct, N.Y. County, May 5, 2023] [Kelley, J.]; *Checo v Mwando*, 2022 NY Slip Op 31223[U], *4, 2022 NY Misc LEXIS 1865, *5 [Sup Ct, N.Y. County, Apr. 7, 2022] [Kelley, J.]; *Garcia v Solomon*, 2020 NY Misc LEXIS 17635, *2 [Sup Ct, Bronx County, Jun. 19, 2020]; *Charles v Wolfson*, 62 Misc 3d 1224[A], 2019 NY Slip Op 50251[U], *1, 2019 NY Misc LEXIS 866, *3 [Sup Ct, Bronx County, Mar 6, 2019]).

On their prior motion, the plaintiffs did not submit an expert affirmation or affidavit. In connection with the instant motion, however, they have done so, thus rectifying the defect in their prior motion. Specifically, in support of the instant motion, the plaintiffs submitted not only a factual affidavit from the plaintiff Anna Mats (the patient), but also several sets of medical records generated by the Greuner defendants, and the expert affirmation of board-certified vascular surgeon Stephen Bauer, M.D.

“To sustain a cause of action for medical malpractice, a plaintiff must prove two essential elements: (1) a deviation or departure from accepted practice, and (2) evidence that such departure was a proximate cause of plaintiff’s injury” (*Frye v Montefiore Med. Ctr.*, 70 AD3d 15, 24 [1st Dept 2009]; see *Roques v Noble*, 73 AD3d 204, 206 [1st Dept 2010]; *Elias v Bash*, 54 AD3d 354, 357 [2d Dept 2008]; *DeFilippo v New York Downtown Hosp.*, 10 AD3d 521, 522 [1st Dept 2004]). The plaintiffs, by submitting Dr. Bauer’s affirmation, now have made the requisite prima facie showing necessary to support a motion pursuant to CPLR 3215(a).

As Dr. Bauer explained it, the patient’s medical records revealed that, on August 25, 2022, when she was 37 years old, she sought vascular medical care and treatment from Greuner and the other Greuner defendants, complaining of pelvic pressure, bloating, and distention. He stated that, on that date, Greuner performed a duplex ultrasound of the deep and superficial veins of the patient’s lower extremities, which reportedly was positive for pelvic congestion syndrome and deep venous reflux. According to Dr. Bauer, however, Greuner did not document that he examined the ovarian vein in the patient’s pelvis, which, in fact, was the source of the patient’s complaints, despite having ruled out what he characterized as “more common gynecological causes” of female pelvic pain, and despite his documentation of the patient’s history of sciatica, which he also did not explore as a possible source of the pain.

Dr. Bauer averred that, on September 14, 2022, the patient returned to Greuner for a follow-up meeting to discuss moving forward with procedures, upon which Greuner formulated a plan to perform a venogram to determine whether further intervention, including the placement of a stent and/or embolization, was warranted. He asserted that, on September 26, 2022, the patient returned to see Greuner for a diagnostic venogram, with further treatment dependent upon the results. As Dr. Bauer explained it, Greuner performed that procedure, which allegedly revealed that the patient was suffering from iliofemoral stenosis, deep venous reflux, pelvic pain and reflux, chronic venous insufficiency/chronic venous hypertension, hepatic hemangiomas, and iliac vein compression syndrome, which led him to diagnose her with pelvic congestion

syndrome and deep venous reflux. At that time, Greuner also performed an embolization of three benign hepatic hemangiomas, which Dr. Bauer concluded was unsupported by any medical documentation, since they were unrelated both to the patient's complaints and "pelvic congestion syndrome." Dr. Bauer further concluded that Greuner's qualifications to perform such a procedure was itself "suspect," since Greuner apparently had never received training in vascular surgery, and the certifications that he did have with respect to general and thoracic surgery had expired in 2021.

According to Dr. Bauer, on October 17, 2022, Greuner performed a duplex ultrasound upon the patient to ascertain the presence of abnormal vasculature or malformations, a scan that allegedly revealed abnormal vasculature in the left and right pelvis. He also tested her right common iliac vein, right external iliac vein, right femoral vein, and inferior vena cava under fluoroscopy, which allegedly revealed stenosis of the right external iliac vein, after which he performed two embolizations of her right external iliac vein, and inserted a stent-graft in that vein. Dr. Bauer asserted that the placement of a stent at this location had no medical purpose in aiding the pelvic organs that he allegedly was treating. As he interpreted the operative note for the procedures, Greuner placed the patient on an unidentified anticoagulant for at least 30 days. He further stated that, on November 2, 2022, Greuner tested the patient's left common iliac vein, left external iliac vein, left femoral vein, and inferior vena cava under fluoroscopy, which allegedly revealed stenosis of the left external iliac vein and multiple fistulas from the inguinal ligament to the hypogastric veins. Dr. Bauer averred that the patient's chart indicated that Greuner took the patient to the operating room, inserted a stent in her left external iliac vein, and diagnosed her with May-Thurner syndrome, which he described as a condition in which the right iliac artery compresses the left common iliac vein. Inasmuch as Dr. Bauer concluded that Greuner did not indicate where the stent had been placed, he concluded that it thus was "questionable" as to whether Greuner intended to write that the stent was placed in the left common iliac vein, rather than the left external iliac vein.

The relevant operative note recited that, after the November 2, 2022 appointment, Greuner first placed the patient on the anticoagulant Lovenox, and then switched her to the anticoagulant Xarelto, for a total of at least 30 days. Dr. Bauer, however, explained that Greuner then performed a postoperative stent duplex ultrasound, which allegedly revealed “no flow in the right common femoral vein status post stent,” which referred to the stent that he had placed on October 17, 2022, and that Greuner essentially diagnosed her with deep vein thrombosis (DVT). Dr. Bauer opined that Greuner departed from the applicable standard of care, which required Greuner to prescribe Xarelto for three months following the diagnosis of DVT, rather than the 30 days for which he did prescribed that drug.

On November 15, 2022, Greuner performed a duplex ultrasound on the patient to determine the presence of abnormal vasculature or malformations of her left pelvis and lower extremities bilaterally. As Dr. Bauer interpreted the patient’s chart, this examination allegedly revealed a DVT running from the patient’s right common femoral vein to the femoral vein stent, abnormal vasculature in the left lower extremity, with reflux in the left common femoral vein and external iliac vein stent and fistula in the left popliteal, and abnormal vasculature in the left pelvis. He further stated that a duplex ultrasound of the arteries of the patient’s left lower extremity also was performed, and allegedly revealed normal blood flow through the left common femoral artery. Greuner once again took the patient to the operating room, where the chart reflected that he embolized four malformations under fluoroscopy. Dr. Bauer opined that the performance of an embolization while the patient was suffering from a right lower extremity DVT was a “severe” deviation from the applicable standard of care that unnecessarily placed the patient’s life at risk. He explained that the operative note for the procedure indicated that Greuner began the patient on a regimen of the anti-hypertensive drugs Labetalol and Diltiazem, along with the anxiolytic drug Xanax.

On November 17, 2022, the patient returned to see Greuner, complaining of left lower extremity pain, muscular pain and tightness, and a rash that spread from her left thigh to her

foot. Dr. Bauer concluded that these symptoms likely were complications from the embolizations of the arterial branches that had been performed on November 15, 2022. Greuner reported in the patient's chart that his examination revealed spots appearing from her left thigh to her foot, and tenderness around the left calf muscle, as well as edema from the proximal left knee to the ankle. Greuner once again performed a duplex ultrasound of the arteries of the patient's left lower extremity, which allegedly showed normal blood flow through the common femoral artery, but reported that the patient still evinced arteriovenous malformations in the anterior and posterior calf, with triphasic flow. The chart indicated that Greuner sent the patient home and instructed her to take the beta blocker Lebetalol.

On November 22, 2022, the patient contacted Greuner by telephone, complaining of ankle and foot swelling, with areas of bruising, which Dr. Bauer concluded was likely the result of the embolization of the artery during her course of Xarelto, which she confirmed that she had not discontinued at least 48 hours prior to the planned November 17, 2022 arterial intervention. Greuner instructed the patient to apply an ACE bandage around the affected area, and to return to his clinic the next day for duplex ultrasound and further evaluation. Inasmuch as the patient determined that her calf looked slightly better by November 23, 2022, she cancelled her appointment for that day, even though her foot and ankle remained swollen. On November 30, 2022, Greuner again examined the patient and performed a duplex ultrasound to detect the presence of abnormal vasculature or malformations of her right upper extremity. As Dr. Bauer framed the issue, since the condition of the right upper extremity was unrelated to pelvic congestion syndrome, the purpose of this ultrasound procedure "cannot be explained." Nonetheless, he asserted that this ultrasound allegedly revealed abnormal vasculature in the right upper extremity, with nidus, that is, a site at which infectious bacteria had multiplied. Greuner wrote in his notes that he diagnosed the patient with several arteriovenous malformations in other parts of her body, and found the presence of high-flow vessels with varying waveforms that did not correspond to normal anatomy. Greuner further wrote that he

would like to “definitively rule out arteriovenous malformation of the brain, neck/carotid, and chest and abdomen/dissection for which a CT angiogram would offer more clarification of anatomy and determine surgical approach, if needed.”

On January 5, 2023, the patient met with Greuner’s partner, Rosenberg, for an evaluation of post-stent placement status. At this appointment, she complained of continuing pelvic discomfort and leg discomfort that had not improved subsequent to the procedure, as well as a tingling sensation in third, fourth, and fifth digits of her left foot. Rosenberg performed a postoperative stent duplex ultrasound, which allegedly revealed decreased blood flow throughout the right femoral stent, with turbulent, increased flow past the stent, and recommended a follow-up venogram and possible angioplasty, along with the recommencement of the anticoagulant Xarelto. On January 10, 2023, the patient returned to see Greuner for a follow-up venogram. Greuner once more performed a duplex ultrasound to evaluate the patient for the presence of abnormal vasculature or malformations of the pelvis bilaterally, which allegedly showed abnormal vasculature in the right uterus and the adnexa bilaterally. Greuner also performed a postoperative stent duplex ultrasound, which allegedly revealed that the plaintiff’s right profunda stent “precluded with no flow detected.” Greuner diagnosed the patient with possible arteriovenous malformation and pelvic congestion syndrome, and again took her to the operating room, where he performed an intravascular ultrasound of the right common iliac vein, right external iliac vein, right femoral vein, and inferior vena cava, which revealed two lesions. Greuner recommended that the patient undergo a transvaginal ultrasound to evaluate her for an arteriovenous malformation in the pelvis, he again diagnosed her with a DVT, and again started her on a regimen of Lovenox for 7 days and an increased dosage of Xarelto for 30 days. Greuner instructed her to return to see him in 30 to 60 days for reevaluation.

Dr. Bauer opined that Greuner departed from the applicable standard of vascular and surgical care by providing vascular medical and surgical care that was unrelated to the patient’s complaints of pelvic pressure, bloating, and distention, and unrelated to Greuner’s own

diagnosis of “pelvic congestion,” and that these departures proximately caused or substantially contributed to the injuries that she sustained. More specifically, he explained that the location of the stent placement, in the external iliac veins bilaterally, had nothing to do with pelvic congestion, and only were related to the patient’s legs. In other words, Dr. Bauer asserted that Greuner performed surgical procedures and testing upon the “wrong parts” of the patient’s anatomy, ostensibly to cure her of the complaints for which she sought medical care and treatment. Dr. Bauer further faulted Greuner for performing surgery and inserting stents into the patient’s external iliac veins bilaterally, which departure also caused or contributed to the patient’s injuries. He averred that none of the stents, inclusive of their placement, was related to pelvic congestion, nor could they relieve pelvic congestion if, in fact, the patient actually was suffering from that condition.

Dr. Bauer further asserted that Greuner should have referred the patient to an obstetrician/gynecologist (OB/GYN) to rule out other causes of her complaints prior to performing surgery, which failure was a departure from the applicable standard of care, and proximately caused the patient’s injuries. As he explained it, Greuner committed malpractice by operating upon the patient, without first having referred her for an OB/GYN examination and diagnosis that would have ruled in or ruled out whether her complaints of pelvic pain were related to ovarian issues, such as fibroids or ovarian vein reflux. Dr. Bauer further averred that this departure caused or contributed to the patient’s injuries. Along these lines, Dr. Bauer similarly concluded that Greuner unnecessarily performed embolizations of benign hepatic hemangiomas that were unrelated either to the symptoms of which the patient complained, or to the pelvic congestion or arteriovenous malformations that Greuner diagnosed, and that these departures also proximately caused the patient’s injuries.

In connection with the patient’s claimed injuries, Dr. Bauer opined that, as a result of the vascular medical and surgical care and treatment that Greuner provided to her, the patient must now take blood thinners for the remainder of her life to prevent the recurrence of DVT, which Dr.

Bauer concluded was caused by Greuner's surgical insertion of stents into her external iliac veins bilaterally. As he explained it, since the administration of blood thinners does not guarantee the elimination of clot formation, the patient remains at risk for clotting and DVT at the site of the stents, and the concomitant hospitalizations necessary to treat them. Moreover, Dr. Bauer contended that, due to the DVT, the patient will also face post-thrombotic syndrome, which he stated is characterized by swelling, pain, and discoloration of the ankle. Additionally, Dr. Bauer concluded that, despite the significant vascular, medical, and surgical treatment and testing, the conditions for which she sought treatment by the Greuner defendants, including pelvic pressure, bloating, and distention, have yet to be addressed, and have yet to be resolved. Moreover, Dr. Bauer opined that Greuner's misdiagnosis of the patient with pelvic congestion, a departure in and of itself, led Greuner to perform unnecessary and improper testing and surgical procedures that will have deleterious effects upon the patient's health.

Based on Dr. Bauer's affirmation and the affidavit of the plaintiff Anna Mats, the plaintiffs have now sufficiently set forth proof of the facts underlying their claims against the Greuner defendants, and, thus, they have satisfied that element, which is necessary for the entry of a default judgment against those defendants.

Accordingly, it is

ORDERED that the plaintiffs' motion to renew is granted, and, upon renewal, those branches of their motion seeking leave to enter a default judgment on the issue of liability as against the defendants David Greuner, M.D, David Greuner, M.D., P.C., Greuner Inpatient Surgical NY, P.C., and Greuner Medical, P.C., are granted, and the matter is set down for an inquest to assess damages against the defendants David Greuner, M.D, David Greuner, M.D., P.C., Greuner Inpatient Surgical NY, P.C., and Greuner Medical, P.C., to be conducted concurrently with the trial against the remaining defendants.

This constitutes the Decision and Order of the court.

8/20/2025
DATE



JOHN J. KELLEY, J.S.C.

CHECK ONE:

CASE DISPOSED

GRANTED

SETTLE ORDER

INCLUDES TRANSFER/REASSIGN

DENIED

NON-FINAL DISPOSITION

GRANTED IN PART

SUBMIT ORDER

FIDUCIARY APPOINTMENT

OTHER

REFERENCE

APPLICATION:

CHECK IF APPROPRIATE: