Kancza v Dodge
2012 NY Slip Op 30312(U)
January 26, 2012
Supreme Court, Nassau County
Docket Number: 865/2010
Judge: Jr., R. Bruce Cozzens
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SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

PRESENT: HON. R. BRUCE COZZENS, JR.
Justice.

TRIAL/IAS PART 4
NASSAU COUNTY

SUSAN KANCZA,

Plaintiff(s),

-against-

JENNIFER DODGE and LINDA DODGE,

Defendant(s).

MOTION #001
INDEX # 865/2010
MOTION DATE:
October 27, 2011

The following papers read on this motion:

Notice of Motion..1
Affirmation in Opposition..1
Reply Affirmation...1

Motion in personal injury action by defendants, Jennifer Dodge and Linda Dodge, for an Order of this Court granting Summary Judgment pursuant to CPLR §3212, dismissing the complaint of the plaintiff, Susan Kancza, on the grounds that plaintiff has not sustained a serious injury within the meaning of the Insurance Law §5102(d). For the reasons that follow, defendant's motion is granted.

The instant motion arises from the underlying complaint sounding in negligence. Therein plaintiff alleges, inter alia, that defendant, Jennifer Dodge, was reckless, careless and negligent in the operation of the motor vehicle owned by defendant, Linda Dodge, and resultantly, caused plaintiff to sustain serious injuries pursuant to Insurance Law §5102(d).

Plaintiff alleges in her Bill of Particulars that she sustained, inter alia, the following injuries: central disc herniation at C4-C5; posterior disc bulging at C5-C6; reversal of the lordotic curve of the cervical spine; cervical vertebral subluxation complex; lumbar vertebral subluxation complex with resultant lumbar radicular syndrome; strain/sprain of cervical and lumbar spines; and post traumatic vertebrogenic headaches.

On February 2, 2009 at about 3:40 p.m., on Route 27A a.k.a. Montauk Highway, in the Town of Babylon, County of Suffolk, the vehicle operated by defendant, Jennifer Dodge, made contact with vehicle operated by the plaintiff. Plaintiff was removed from her vehicle by

emergency medical personnel who transported her to Good Samaritan Hospital. She was treated in the hospital's Emergency Room and released the same day. On that same day, plaintiff sought treatment with a chiropractor, David Slavin, D.C., C.C.S.P., who had previously treated her within the year before the subject accident.[1]

Plaintiff's chief complaints were of pains in the mid back, neck and muscle soreness. Dr. Slavin referred her for Magnetic Resonance Imaging ("MRI") testing, and recommended treatment in his office for a minimum of two times a week. Plaintiff underwent the recommenced treatment regiment for six months and decreased her treatment as her no-fault insurance did not approve the frequency of her appointments. Plaintiff then acquired different insurance and resumed weekly treatment with Dr. Slavin. Other than the MRI testing, she underwent treatment by a message therapist, who was on staff with Dr. Slavin's office, and a neurological consultation. She was still being treated by Dr. Slavin at the time of this motion.

Plaintiff, an "an unemployed "off and on" student attending "Old Westbury" college (see Notice of Motion, Exhibit E) and self-declared stay-at- home parent at the time of the accident, claimed that she was virtually bedridden from the time of the accident until the summer. She alleges that she was and is unable to participate in sports activities, and perform household chores which includes caring for her son, born in 2004. As plaintiff alleges that it was and is too painful for her to sit for long periods of time, she is not able to look for employment.

The defendants argue that: there is no evidence to support that plaintiff's injuries fall within any of the categories of serious injury set forth in Insurance Law §5102(d); the plaintiff has not submitted any medical documentation to support confinement to her home or bed pursuant to her claim under the 90/180-day period of disability under the statute; and any such confinement arises out of the plaintiff's own volition and her subjective complaints of pain. Further she testified that she does not claim missed time from college classes due to the subject accident.

Defendants' evidence includes, copies of the pleadings, a copy of the transcript of plaintiff's January 17, 2011 Examination Before Trial, and medical reports by Lawrence J. Robinson, M.D., Diplomate American Board of Neurology dated April 1, 2011, and Arnold M. Illman, M.D. F.A.A.O.S., F.A.C.S.

Plaintiff, in her Bill of Particulars, claims serious injury on the bases of permanent loss of use of a body organ, member, function, or system; permanent consequential limitation of use of body organ or member; significant limitation of a use of a body function or system; and a medically determined injury which prevents her from performing all of the material acts of her daily activities for more than 90 of the 180 days since the occurrence of the accident.

In addition to the same evidence already submitted by the defendant, plaintiff submits

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[1]It is noted that when plaintiff was asked, during her January 17, 2011 Examination Before Trial, about the reasons for prior treatment, she responded that she did not recall (see Notice of Motion, Exhibit D, p.65, ln. 12 -25.)

[* 3]

her sworn affidavit, a copy of the MRI report of the cervical spine dated August 4, 2009, Dr. Slavin's treatment ledger, and Dr. Slavin's affirmation, note of disability, and medical reports.

Dr. Robinson's review of plaintiff's treatment included: the Emergency Room records from Good Samaritan; Dr. Slavin's medical records; EMG/NCV report of the upper and lower extremities dated August 7, 2009; and x-ray reports of the cervical and thoracic spine. It is noted that plaintiff denied that she had been involved in a subsequent motor vehicle accident (see Notice of Motion, Exhibit D, p. 77, line 18-25); however, Dr. Robinson's review of the medical records uncovered that plaintiff was involved in an accident in July, 2009. The records also indicate that plaintiff has a history of a bipolar disorder.

Dr. Robinson's examination indicated the following ranges of motions: cervical flexion of 45 degrees (normal-45); cervical extension of 45 degrees (normal-45); cervical rotation of 70 degrees (normal - 70); lateral flexion of 40 degrees (normal-40); lumbar flexion of 90 degrees (normal-90); lumbar extension rotation, and lateral flexion at 30 degrees (normal-30). He also noted that there was no tenderness or spasm. His overall impression was that the exam did not reveal any neurological dysfunction or impairment and that there was no objective evidence to support her reports of pain, which he deemed as subjective.

Dr. Robinson averred that plaintiff's presentation was consistent with post cervical dorsolumbar strain. It is also noted that his review of the report from plaintiff's treating neurologist, uncovered that plaintiff's bi-polar condition may be impacting her recovery.

Dr. Illman's examination of the plaintiff, indicated that she has returned to her normal daily activities and that there was no evidence of a disability. Further, plaintiff has indicated a normal range of motion and there was no evidence of tenderness or spasm. Further, the cervical and lumbosacral sprain have been resolved.

Dr. Slavin 's February 2, 2009 examination of the plaintiff indicated the following range of motion of the lumbar spine: lumbar flexion of 40 degrees (normal-90); lumbar extension of 10 degrees (normal-30); and right and left lumbar lateral flexion of 20 degrees (normal-30). His May 4, 2009 range of motion of the cervical spine indicated the following: cervical flexion of 30 degrees (normal-45); cervical extension of 45 degrees (normal-55); right and left lateral flexion of 30 degrees (normal-40); and right and left rotation of 45 degrees (normal-70). Dr. Slavin's recent range of motion results, dated June 29, 2011, reported little or no change in plaintiff's condition.

Dr. Slavin opined that plaintiff's present condition is the direct result of the February, 2009 accident and that there will be a "permanent weakening" in the supporting structures of the cervical, thoracic and lumbar spines. He recommended treatment on an as needed basis as it has resulted in "both symptomatic and functional improvement in her overall condition, albeit temporary." He further contends that after two and half years following the accident, plaintiff continues to present with "active subjective symptomotology". As the objective examination results corroborate her symptoms, her condition is permanent and resultantly will interfere with her activities of daily living.

The MRI of the cervical spine, conducted by Senghao Fong, M.D., indicated findings of:

straightening and slight reversal of the lordotic curve of the cervical spine; 3 mm central disc herniation at C4-C5; and 3 mm posterior disc bulging at C5-C6. The report also indicated that the cervical spinal cord showed no evidence of cord compression or abnormal signal intensities, and that the paravertebral areas were unremarkable. In sum, the report concluded as follows: *slight* reversal of the lordotic curve, compatible with muscle spasm; *small* central disc herniation at C4-C5; and *mild* disc bulging at C5-C6.

In a personal injury action, a summary judgment motion seeking to dismiss requires that a defendant establish a prima facie case that the plaintiff did not sustain a serious injury within the meaning of Insurance Law § 5102(d) (*Gaddy v. Eyler,* 79 N.Y.2d 955 [1992]). Upon such a showing, it becomes incumbent on the plaintiff to come forward with sufficient evidence in admissible form to demonstrate the existence of a question of fact on the issue (*Gaddy v. Eyler, supra*). The court must then decide whether the plaintiff has established a prima facie case of sustaining serious injury (*Licari v. Elliot,* 57 N.Y.2d 230 [1983]).

It is now well settled that when a defendant moves for summary judgment dismissing the complaint based on the plaintiff's failure to establish "serious injury" and relies solely on findings of the defendant's own medical witnesses, those findings must be in admissible form, and not unsworn reports, in order to make a prima facie showing of entitlement to judgment as a matter of law (see, *Pagano v Kingsbury,* 182 AD2d 268 [2nd Dept 1992]; *see also, Miller v Metropolitan Suburban Bus Auth.,* 186 AD2d 116[2nd Dept 1992]).

Insurance Law §5102(d) defines serious injury, in relevant part, to mean a personal injury which results in: "... permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system; or a medically determined injury or impairment of a non-permanent nature which prevents the injured person from performing substantially all of the material acts which constitute such person's usual and customary daily activities for not less than ninety days during the one hundred eighty days immediately following the occurrence of the injury or impairment.['90/180 Claim']".

Regarding the claims of permanent loss of use of a body organ, member, function or system; permanent consequential limitation of use of a body organ or member; significant limitation of use of a body function or system, the defendant met their initial burden by submitting competent proof in admissible form showing that plaintiff's injuries did not fall within certain statutory definition of serious injury.

The defendant presented a medical report from an orthopedic specialist, who reported that the plaintiff's ranges of motion were all within normal ranges, and set forth his specific findings, and compared them accordingly. He also concluded that plaintiff did not present any disability (see *Staff v. Yshua*, 59 AD3d 614 [2nd Dept 2009]). The defendant also presented evidence from a neurologist who reviewed plaintiff's medical records and discovered that she had been in motor vehicle accident in July, 2009. His examination also indicated that plaintiff's range of motion was within normal limits, and that the plaintiff did not suffer from a

neurological disorder resulting from the subject accident.

As to the 90/180 days issue, the defendant relies on plaintiff's testimony and has submitted the same into evidence. Her own testimony indicates that the accident was not the cause of her missing classes or attending classes. Further, she was not working at the time of the accident (see Notice of Motion, Exhibit D, p. 11, ln. 10 - 22).

To prevail on a 90/180 Claim, a plaintiff must provide competent, objective medical evidence to support the alleged limitations on her daily activities. *(Monk v. Dupuis*, 287 AD2d 187, 191 [3rd Dept 2001]). When construing the statutory definition of a 90/180 claim, the words "substantially all" should be construed to mean that the person has been prevented from performing his usual activities to a great extent rather than some slight curtailment." (See *Sands v. Stark*, 299 AD2d 642 [2nd Dept 2002]). Generally, Courts have been unwilling to find a "serious injury" under the 90/180-day limitation where the plaintiffs' treating physician placed no restrictions on them or their activities (See *Gonzales v. Green*, 24 AD3d 939 [3rd Dept 2005]; *Clements v. Lasher* 15 AD3d 712 [3rd Dept 2005]).

It is noted that plaintiff's testimony does not evince a concentrated and/or concerted search for employment since her telemarketing employment ended in 2002, and she describes herself as an "on and off" college student. Further, plaintiff did not provide evidence, by way of testimony, that her treating physicians ordered her not to return to her school, search for employment, or perform household duties and/or duties associated with the care of her son. Moreover, the plaintiff did not submit any competent medical evidence to support her claim that she was unable to perform substantially all of her daily activities for not less than 90 of the 180 days immediately following the accident as a result of the subject accident (see *Sainte-Aime v. Ho,* 274 AD2d 569, *Jackson v. New York City Tr. Auth.,* 273 AD2d 200).

Accordingly, defendants met their initial burden that plaintiff did not sustain a serious injury within the meaning of Insurance Law § 5102(d). The burden now shifts to plaintiffs to offer proof in admissible form sufficient to create a material issue of fact (see *Powell v. Alade,* 31 AD3d 523 [2nd Dept 2006]).

As stated previously, the plaintiff has not submitted evidence to support a serious injury claim under the 90/180 criteria. Dr. Slavin's letter of disability, dated August 21, 2009, only directs that plaintiff "refrain from any strenuous activity including all forms of exercise". There is nothing in Dr. Slavin's report or in the record before this Court to support that plaintiff was restricted or confined to her residence and that she was unable to substantially perform her daily activities (see *Gonzales v. Green,* 24 AD3d 939 [3rd Dept 2005]).

Moreover, allegations of subjective complaints of occasional pain or recurrent pain fail to satisfy the statutory threshold showing of a serious injury. Additionally, plaintiff's self-serving comments concerning her inability to function and restriction to her bed for five months without more, are insufficient to defeat a motion for summary judgment (see *Phillips v. Costa*, 160 AD2d 855 [2nd Dept 1990], *Shvartsman v. Vildman,* 47 AD3d 700 [2nd Dept 2008]).

The plaintiff argues that her diagnosis of disc herniations, supports her claim of a serious

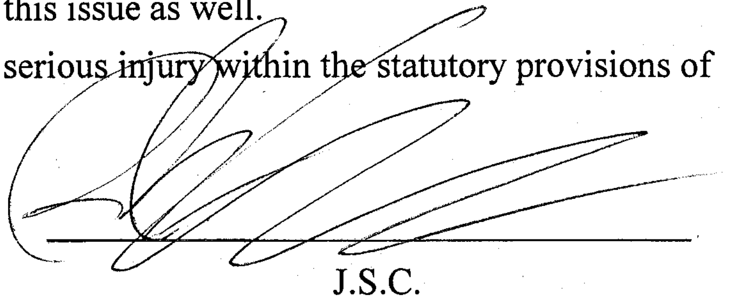
injury. However, it is settled that proof of a herniated disc, without additional objective medical evidence establishing that the accident resulted in significant physical limitations, is not alone sufficient to establish a serious injury (see *Pommells v. Perez,* 4 N.Y.3d 566, [2005]). The physician's assessment and evaluation must have an objective basis and compare the plaintiff's limitations to the normal function, purpose and use of the affected body organ, member, function or system (see *Toure v. Avis Rent A Car Sys.,* 98 N.Y.2d 345 [2002]).

In addition, the MRI reports, submitted into evidence by plaintiff, describe plaintiff's herniation at C4-C5 as "small ", with "mild" disc bulging at C5-C6 and no compression on the spinal cord. It appears that the evidence relied upon by plaintiff's treating physician in reaching the conclusion that her condition is permanent, is based on plaintiff's subjective complaints of pain (see *Gonzalez v Green*, 24 A.D3d 939 [3rd Dept 2005]).

Additionally, the mere use of the word "permanent" by the plaintiff's physician is also insufficient to defeat summary judgment. Regarding "permanent limitation" of a body organ, member or system the plaintiff must demonstrate that she has sustained such permanent limitation. The word "permanent" can be sustained only with proof that the limitation is not "minor mild, or slight" but rather "consequential". In order for the plaintiff to sustain proof of permanency, she must demonstrate the existence of such injury through objective medical tests which demonstrate the duration and extent of the injuries alleged (see *Orr v. Miner*, 220 AD2d 567 [2nd Dept 1995]).

Finally, the record contains evidence indicating that the plaintiff was involved in an automobile accident in July, 2009 (see Notice of Motion, Exhibit E). Plaintiff's failure to address this is fatal as it relates specifically to the issue of causation. Under the circumstances of this case, the plaintiff's evidence failed to demonstrate that the February 2009 accident constituted a proximate cause of the claimed serious injury (see *McCreesh v. Hoehn,* 307 AD2d 638 [3rd Dept 2003]). It is also noted that defendant's expert noted that the report from plaintiff's treating neurologist cited that her bipolar disorder has interfered with her recovery. The plaintiff failed to address and/or controvert this issue as well.

In sum, the plaintiff has not established a serious injury within the statutory provisions of Insurance Law, § 5102(d).



Dated: JAN 26 2012

J.S.C.

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