| **Ogle v Higgins** |
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| 2013 NY Slip Op 33828(U) |
| September 11, 2013 |
| Supreme Court, Kings County |
| Docket Number: 4852/11 |
| Judge: Debra Silber |
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SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: PART 9
---X

DEBORAH OGLE, a/k/a DEBRA OGLE,

Plaintiff,

-against-

PERLINE HIGGINS,

Defendant.
---X

DECISION/ORDER

Index No. 4852/11

Submitted 7/18/13

Mot. Seq. # 1

HON. DEBRA SILBER, A.J.S.C.:

Recitation, as required by CPLR 2219(a), of the papers considered in the review of defendant's motion for summary judgment dismissing the complaint.

| Papers | Numbered |
|---|---|
| Notice of Motion, Affirmation and Exhibits Annexed........................ | 1 |
| Affirmation in Opposition and Exhibits Annexed........................... | 2, 3 |
| Reply..................................................................................... | 4, 5 |

Upon the foregoing cited papers, the decision/order on this motion is as follows:

Defendant moves for summary judgment dismissing plaintiff's complaint on the grounds that she did not suffer a "serious injury" as defined by § 5102(d) of the NYS Insurance Law. Plaintiff oppose the motion.[1]

For the reasons set forth herein, the defendant's motion is granted and the complaint is dismissed.

Plaintiff claims she sustained personal injuries as a result of an automobile

[1]It is noted that this motion was submitted without argument, on consent, and that plaintiff submitted two affirmations in opposition and defendant submitted two reply affirmations.

accident on May 13, 2008, on Snyder Avenue near the intersection with Rogers Avenue, in Kings County. Plaintiff was the owner and operator of a vehicle which was hit from behind by a vehicle owned and operated by defendant. Examinations Before Trial and Independent Medical Examinations of the plaintiff have been conducted.

Plaintiff claims (Bill of Particulars) she has suffered numerous injuries, including injuries to her cervical and lumbar spine and to her left knee.

The plaintiff was 47 years old at the time of the accident. At the scene of the accident, plaintiff was taken by EMS to Kings County Hospital, treated and released. She later sought treatment from Dr. Stephen Wilson. The plaintiff subsequently commenced the within negligence action against the defendant.

Dr. Richard Weiss, an orthopedist, performed an Independent Medical Examination on July 31, 2012, to evaluate plaintiff's condition. See affirmation of Dr. Weiss, annexed to defendant's moving papers as Exhibit E.

Dr. Weiss states that plaintiff complained of pain to her lower back and left knee. She did not complain of pain to her neck. Plaintiff informed Dr. Weiss that she was working full time, and missed two weeks of work after the accident. Dr. Weiss notes that her "gait was normal . . . no assistive devices were in use."

Examination of plaintiff's cervical spine revealed no abnormality in plaintiff's range of motion. He used a goniometer for his testing. There was no evidence of spasm. Range of motion testing of the plaintiff's cervical spine showed flexion 50 degrees (50 normal), extension 60 degrees (normal 60), lateral bending 45 degrees bilaterally (normal 45), bilateral rotation 80 degrees (normal 80). Spurling's test "failed to elicit any sign of radiculopathy." He also states "range of motion testing elicited no complaint of pain."

Examination of the plaintiff's lower back revealed no evidence of spasm. Range of motion testing of the plaintiff's lumbosacral spine showed flexion 60 degrees (60 normal), extension 25 degrees (normal 25), bilateral lateral bending 25 degrees (normal 25).

The straight leg raising test was negative bilaterally. Sensation and motor function were normal in the lower extremities, as were plaintiff's reflexes. Dr. Weiss states that "there was no tenderness to palpation," and "heel/toe walking as well as tandem walk was performed without difficulty. Minor's sign was absent."

As regards plaintiff's left knee, Dr. Weiss tested her range of motion and found it too was normal. He states "all ligaments were stable bilaterally. Valgus and varus deformities were negative. Lachman, drawer and pivot shift were all negative. McMurray's sign was negative."

Dr. Weiss' diagnosis is "resolved cervical and lumbar strain" and "resolved left knee contusion." Dr. Weiss states that plaintiff has "no objective evidence of any disability." He adds "the claimant's current complaints are unrelated to the motor vehicle accident."

On the issue of causation, Dr. Weiss further states: "as to causality, the findings noted on the MRIs are suggestive of mild degenerative disease which was likely asymptomatic prior to the motor vehicle accident. The claimant sustained no more than mild sprain/strain/contusion injuries at the time of the motor vehicle accident which resolved within weeks of the motor vehicle accident. The claimant's current complaints are unrelated to the motor vehicle accident. The claimant did report a work related injury that occurred in February of 2012. However, no information regarding this event and any resultant injuries was provided by the claimant."

Defendant also cites plaintiff's Bill of Particulars (Exhibit B), which alleges that plaintiff was confined to her bed for approximately one week after the accident and confined to her home for approximately one week. The defendant also cites her deposition testimony (Exhibit D), in which she states she missed two weeks of work after the accident (Page 47 Lines 13-14).

Where a motion for summary judgment is predicated on a determination of "serious injury," the moving party has the initial burden of submitting sufficient evidentiary proof in admissible form to warrant a finding that the plaintiff has not suffered a "serious injury." *Lowe v Bennett*, 122 AD2d 728 [1st Dept], affirmed 69 NY2d 701 [1986].

Defendants' evidence, consisting of one doctor's affirmation, and plaintiff's deposition testimony, supports the conclusion that plaintiff did not sustain a "serious" injury, and thus defendant has met her prima facie burden of proof.

The plaintiff then has the burden of overcoming the motion. *Grossman v Wright* 288 AD2d 79 [2nd Dept 2000]. Plaintiff opposes the motion.

Plaintiff fails to overcome the defendants' prima facie case for dismissal. First, the plaintiff has failed to proffer competent evidence that she sustained 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.

At her deposition, plaintiff acknowledged that she missed two weeks of work after the accident because of her injuries, and then returned to work full time. For

plaintiff to overcome the motion on this prong of the statute, her doctor would have had to inform her that she could not return to work - or to resume her normal activities -- for ninety days or more. That is the prerequisite for a medically determined injury. See *Sainte v Ho,* 274 AD2d 569 [2nd Dept 2000]; *Welcome v Diab,* 273 AD2d 377 [2nd Dept 2000]. The affirmations of her doctor is silent on this subject.

As such, plaintiff cannot claim a medically determined injury or impairment which prevented her from performing substantially all of the material acts which constituted her customary daily activities for not less than 90 days during the 180 days immediately following the accident. *Abrahamson v Premier Car Rental of Smithtown,* 261 AD2d 562 [2nd Dept 1999]; *Kaplan v Gak*, 259 AD2d 763 [2nd Dept 1999]. The important element in establishing injury under the 90/180 day category is that the injury is medically determined. *Abrahamson v Premier Car Rental of Smithtown,* 261 AD2d 562 [2nd Dept 1999]; *Kaplan v Gak*, 259 AD2d 763 [2nd Dept 1999]. Absent some objective proof of her inability to perform the activities of daily living for 90 out of 180 days following an accident, there is no showing of a serious injury from a mere allegation. *Rum v Pam Transport, Inc.,* 250 AD2d 751 [2nd Dept 1998]; *Harney v Tombstone Pizza Corp*, 279 AD2d 609 [2nd Dept 2001].

As regards the other two applicable categories of injury, plaintiff has also failed to raise a triable issue of fact as to whether she sustained a permanent consequential limitation of use of a body organ or member, or a significant limitation of use of a body function or system. Insurance Law 5102(d).

in her opposition plaintiff provides a number of unaffirmed and inadmissible medical records and medical reports from Kings County Hospital and from several practitioners, along with an affirmation from Dr. Stephen W. Lastig, defendant's

radiology expert pursuant to defendant's CPLR 3101(d) exchange, and an affirmation from Dr. Hal Gutstein, a board certified neurologist dated March 29, 2013. There is also an affidavit from plaintiff. Plaintiff's affidavit describes her accident and her seven or eight month-long course of treatment. It states she ceased treatment because it was a financial toll on her.

Defendant then provides an affirmation in reply, and plaintiff provides a second affirmation in opposition, in which counsel indicates he was unable to obtain the certified records of the MRI facility and the plaintiff's treating doctor's facility in time for the original submission. Defendant then provides a second affirmation in reply. Counsel for both sides agreed that all of the above should be submitted and considered by the court.

Addressing the admissible medical evidence in the order it was provided, the court first turns to the affirmations of defendant's radiologist (Exhibit D) submitted by plaintiff. Dr. Lastig reviewed the films of the plaintiff's cervical and knee MRIs. He makes no mention of the MRI of the lumbar spine. With regard to her cervical spine MRI, which was taken on July 12, 2008, he states that "there is multilevel degenerative disc disease and degenerative spondylosis with marginal vertebral end-plate bony spurring and bilateral foraminal narrowing at C4-C5 due to uncinate osteophyte formation." He continues "disc space narrowing and dessication are the hallmarks of degenerative disc disease. In my opinion, the . . . disc bulging at C3-C4 . . . and spondylitic changes at C4-C5 are degenerative in origin and therefore, unrelated to the accident of 5/13/08. The . . . osteophytes . . . indicate the presence of a long standing degenerative . . . process which, in my opinion, definitely pre-exist the accident, which occurred only two months prior to this imaging study." He also indicates that the films

show "a focal midline disc herniation at C5-C6 causing cord impingement. Clinical correlation is advised." He also notes an enlarged thyroid gland (goiter).

Thus, Dr. Lastig concludes that, other than the C5-C6 disc herniation, the other positive findings on the MRI were pre-existing and degenerative, and with regard to the C5-C6 disc herniation, he was not sure if it was symptomatic, thus noting that a doctor would need to actually examine plaintiff and not just her films to determine if the herniation was symptomatic.

With regard to the MRI of plaintiff's knee, Dr. Lastig finds a horizontal tear of the posterior horn of the medial meniscus. He also notes that "there is tri-compartment degenerative joint disease." There are other abnormal findings, including a "popliteal cyst" and "some extrusion of the medial meniscus," as well as "Grade IV chondromalacia is seen within the medial patellar facet." He concludes that, in his opinion, all of the positive findings are "most likely degenerative in origin and therefore unrelated to the accident of 5/13/08."

The affirmations of Dr. Lastig do not overcome the motion and raise a triable issue of fact as is alleged by plaintiff's counsel, as he concludes that none of the findings on the films were caused by the accident, but were pre-existing and caused by plaintiff's age and/or were growths not related to trauma or congenital defects.

Next to be considered is Dr. Gutstein's affirmation (Exhibit F). Dr. Gutstein was not a treating doctor, as he first examined plaintiff on December 7, 2012, several months after defendant's motion was served and more than four years after the accident. His summary of the plaintiff's medical records is inadmissible, as he did not rely on these records for his treatment of plaintiff, as he is an expert witness and not a treating doctor. Thus, the discussion of the medical records he reviewed are

inadmissible hearsay to the extent he attempts to put their content before the court without any personal knowledge on his part. In addition, his summary of the information he was given by the plaintiff is also hearsay. The only part of his affirmation that can be considered by the court is his own range of motion testing. He states that he did the testing with the use of a goniometer. He found considerable and significant restrictions in the range of motion of plaintiff's cervical and lumbar spine. He concludes that "it is my opinion to a reasonable degree of medical certainty that the foregoing significant limitations of cervical range of motion are causally related to the 5/13/08 accident, and . . . are significant and permanent in nature and the same have, unfortunately, affected and constrained the patient's life in an important and meaningful way." Dr. Gutstein makes the same averments with regards to plaintiff's lumbar range of motion. His response to defendant's claim that plaintiff's subsequent accident caused the injuries to her neck and back is that "this is belied by the history provided to me enumerated above," whatever that means. Dr. Gutstein makes no mention whatsoever of plaintiff's knee, as a knee is not within the province of a neurologist, except to say he "defers to orthopedics." It is also noted that his description of what plaintiff told him about the accident and what transpired at the emergency room makes no reference to her knee, nor is there any mention of her knee in the ambulance call report or her emergency room records. While the improperly certified hospital records are inadmissible, if they were properly certified, the plaintiff's failure to mention her knee at the time of the accident constitutes a prior inconsistent statement. *Berrios v TEG Management Corp.*, 35 AD3d 775 (2d Dept 2006).

To address Dr. Lastig's and Dr. Weiss' claims that the positive findings are degenerative and not traumatic in nature, Dr. Gutstein claims the accident aggravated

plaintiff's "pre-existing age related changes" (paragraph 14).

While Dr. Gutstein has addressed both the issue of whether the positive findings are degenerative or pre-existing, and the issue of whether the subsequent accident is the cause of her current injuries, in that he avers that the plaintiff's alleged injuries were indeed caused by the subject motor vehicle accident, his conclusions are not legally competent as legal precedent requires the court to conclude that the four year gap in time between his exam and the end of plaintiff's treatment "breaks the chain of causation," as is discussed further below.

In the plaintiff's supplemental opposition papers, counsel supplies a notarized certification from the custodian of the records for Damadian MRI in Canarsie, P.C., certifying the MRI reports of Dr. Qiang Sun, as he has left that facility. In addition, plaintiff supplies a notarized certification from the custodian of the records for Empire Physical Medicine and Rehabilitation, which certifies the treatment records for plaintiff for the period 5/23/08 to 1/14/09 and avers that they are a complete set of said records.

The report of Dr. Sun for the lumbar spine MRI, done 7/12/08 states that the films show "mild disc bulges with slight facet joint hypertrophy at L3 to S1, causing mild spinal stenosis and mild bilateral foraminal stenosis, with no evidence of nerve impingement." While there is no affirmation to further elaborate on these findings, the report does not describe any traumatic injury. The report for the cervical spine MRI, also done 7/12/08, states that the films show an enlarged mass that could be an enlarged thyroid, and an ultrasound or CT "may be considered" for further evaluation. It also reports multiple disc bulges and herniations, "causing mild to moderate spinal and bilateral foraminal stenosis and demonstrating uncovertebral joint hypertrophy." The report for the left knee MRI, done 7/19/08, states that the films show "degenerative

changes with small knee joint effusion, small Baker's cyst and medial meniscal tear" [to the posterior horn of the medial meniscus].

The records of Empire Physical Medicine and Rehabilitation P.C. include bills and notes which indicate the dates she went there for physical therapy, which confirms her claim that she went for about eight months of treatment, and two handwritten exam reports of Dr. Stephen A. Wilson, the first dated 5/23/08, which, in the "history" portion, contains an admission against plaintiff's interest and a prior inconsistent statement in that she indicates that she fell to the ground when she got out of her vehicle as she was light headed.[2] She complained to Dr. Wilson of pain in her neck, back, right hip, and left knee. Dr. Wilson recommended that she have physical therapy three times per week and have MRIs. He indicates that he tested her range of motion, and that it was not normal, but there are no quantitative findings. He also reports that she was in moderate pain. The second report is from a visit on July 16, 2008, which indicates that Dr. Wilson had received the MRIs of the neck and back and that plaintiff was referred to an endocrinologist concerning the thyroid gland and to a gynecologist with regard to the fibroid in plaintiff's uterus found on the lumbar MRI. She was told to continue with physical therapy. There are some other notes which are handwritten and hard to understand. There are no other notes for any other office visits. It would appear that she continued to see the physical therapist without any follow up visits with Dr. Wilson. She never went to see him after the knee MRI was done, as it was taken on July 19, 2008. It is noted that a check of the New York State website for physician licensing

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[2]A hearsay entry in a hospital record as to the happening of an injury is admissible at trial, even if not germane to diagnosis or treatment, if the entry is inconsistent with a position taken by a party at trial. However, there must be evidence connecting the party to the entry. *Coker v. Bakkal Foods, Inc.*, 52 A.D.3d 765, 766 (2d Dept 2008); see *Cuevas v Alexander's, Inc.*, 23 AD3d 428, 429, (2d Dept 2005).

indicates that Dr. Wilson moved his practice to Queens, and certainly could have been reached to provide an affirmation. Thus, it is inferred that such an affirmation would have not supported plaintiff's motion.

The court next referred to the plaintiff's EBT for further clarification. Plaintiff indicates therein that she injured her neck and back in February of 2012, when she had an accident while on the job. Her job is not exclusively a desk job, as she indicated she worked in the office 95% of the time, sometimes worked on weekends, and was not able to "divulge this information at this time" when she was asked what her duties are as an intelligence analyst at the U.S. Department of Justice (Page 11 Line 19). She stated she was treated and released at the emergency room at Lenox Hill Hospital. She was referred by a treating doctor whose name she could not remember for MRIs at a stand up MRI facility. Because she works for the federal government, she is not covered by workers' compensation, as the federal government has an alternative system for work-related injuries. The questions asked at the EBT failed to elicit any information about this accident, or whether she missed any work after it. She did indicate she made a claim against her employer for [workers' compensation equivalent] benefits. Defendant has not included any records concerning this accident in her papers.

The plaintiff has established, by the minimal records of Dr. Stephen A. Wilson, that she sustained some injuries after the subject motor vehicle accident. In *Perl v Meher* (18 NY3d 208 [2011]), the Court of Appeals substantially reduced what is required for a plaintiff on a threshold motion to overcome the motion, especially with regard to what needs to be done at an examination contemporaneous with the accident. The court did not eliminate the requirement that plaintiff demonstrate that the

injuries are causally related to the accident, but reduced the plaintiff's burden on this point. As the Court stated:

> "There is nothing obviously wrong or illogical about following the practice that Bleicher followed here — observing and recording a patient's symptoms in qualitative terms shortly after the accident, and later doing more specific, quantitative measurements in preparation for litigation. As the author of a recent article points out, a contemporaneous doctor's report is important to proof of *causation*; an examination by a doctor years later cannot reliably connect the symptoms with the accident. But where causation is proved, it is not unreasonable to measure the *severity* of the injuries at a later time (*see* Morrissey, "Threshold Law": Is a Contemporaneous Exam by Court of Appeals in Order? New York Law Journal, January 18, 2011). Injuries can become significantly more or less severe as time passes."

The next issue that must be overcome by plaintiff is that which concerns the gap in plaintiff's treatment, as is raised in paragraph 23 of the affirmation in support of the motion. Plaintiff is unable to do so. The court notes that plaintiff's affidavit states she was treated at Dr. Wilson's office by a Dr. Lezama who provided physical therapy for seven or eight months. Dr. Wilson's records confirm this. She says treatment was terminated when she decided, on her own, to stop. In the affidavit, she says it was the financial expense, although she doesn't say that no-fault stopped paying, nor does Dr. Wilson in his notes or bills, which indicate she was covered by her husband's insurance. At her EBT, she instead said that she stopped treatment because shortly after each of her twice a week sessions the pain returned. She says (page 63 line 5) that Dr. Wilson told her to continue with the therapy. But (page 63 line 16) "I didn't feel it was, you know, helping me." There is no ambiguity that she stopped treatment of her own volition and not on any doctor's recommendation or because no-fault stopped paying, or for any other reason recognized as sufficient by the courts in New York.

The case law in New York makes it clear that plaintiff's gap in treatment is considered a factor which interrupts the chain of causation between the accident and the claimed injury. *Pommells v Perez*, 4 NY3d 817 [2005]; *Rivera v Bushwick Ridgewood Props.*, 63 AD3d 712 (2d Dept 2009). Five years is a very long gap. The last doctor's visit recorded in the motion papers was in July of 2008, other than the expert report of Dr. Gutstein. She indicates in her EBT that she also has a primary care physician, Dr. Mimms, but provided no indication that he or she provided any treatment for the injuries she alleges were caused by this accident. When specifically asked, she acknowledges that she did not see any doctor or have any physical therapy for the injuries she alleges were caused by this accident after January 14, 2009. "[E]ven where there is objective medical proof [of a serious injury], when additional contributory factors interrupt the chain of causation between the accident and claimed injury—such as a gap in treatment, an intervening medical problem or a preexisting condition—summary dismissal of the complaint may be appropriate" *Kwitek v Seier*, 105 AD3d 1419, 1420 (4th Dept 2013).

As the First Department states clearly in an analogous case, *Merrick v Lopez-Garcia*, 100 AD3d 456, 456-457 (1st Dept 2012):

> [Plaintiff] failed to address the gap in treatment between April 2008, when he was last treated, and December 2011, when Dr. Sloan evaluated him for purposes of opposing defendants' motion. This "gap" is essentially a cessation of treatment (see *Pommells v Perez*, 4 NY3d 566, 574, 830 NE2d 278, 797 NYS2d 380 [2005]). Plaintiff claimed that he stopped treatment because he could not afford it after his no-fault benefits ended, but he also testified that he had private health insurance. He never explained why he was unable to continue with treatment through his insurance, and testified only that the particular physical therapist he had been treating with did not accept his plan (see *Ramkumar v Grand Style Transp. Enters. Inc.*, 94 AD3d 484, 941 NYS2d 610 [1st Dept 2012]). Dr. Sloan was not plaintiff's treating physician, and his evaluation of plaintiff took place more than 3½ years after plaintiff was last treated. Because

plaintiff did not adequately explain the gap in treatment, Dr. Sloan's opinion as to permanency, significance, and causation is speculative and seemingly tailored to meet the statutory definition of serious injury (see *Arjona v Calcano*, 7 AD3d 279, 280, 776 NYS2d 49 [1st Dept 2004]).

Further, the case law is also clear that positive findings on an MRI, even of herniated discs, is not enough, standing alone, to overcome a motion to dismiss on the grounds of serious injury. "The mere existence of a herniated disc is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the disc injury and its duration (see *LaFerlita v Seagull 2000, Inc.*, 54 AD3d 905, 864 NYS2d 535 [2008]; *Siegel v Sumaliyev*, 46 AD3d 666, 846 NYS2d 583 [2007]; *Yakubov v CG Trans Corp.*, 30 AD3d 509, 510, 817 NYS2d 353 [2006]; *Kearse v New York City Tr. Auth.*, 16 AD3d 45, 49, 789 NYS2d 281 [2005])." *Gastaldi v. Chen*, 56 AD3d 420, 421 (2d Dept 2008). Nor is a finding of a tear to a person's meniscus in a knee prima facie evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the tear and its duration. Further, where a tear was repaired after an accident by arthroscopic surgery, the courts have uniformly held that the mere fact that surgery was performed does not constitute prima facie proof that the plaintiff sustained a serious injury. See *Vasquez v Almanzar*, 107 AD3d 538 (1st Dept 2013).

In conclusion, the plaintiff's evidence is insufficient to raise a triable issue of fact as to whether she has suffered a serious injury as a result of this accident. *Byum v Waltuch*, 50 AD3d 939 [2nd Dept 2008]. Plaintiff has failed to adequately explain the lapse in time between the cessation of her medical treatment and the re-examination for the purposes of opposing the defendant's summary judgment motion. See *Gnahore v Gonzalez*, 73 AD3d 690 (2d Dept 2010) citing *Rivera v Bushwick Ridgewood*

*Props., Inc.*, 63 AD3d 712, 714, 880 NYS2d 149 [2009]; *Ponciano v Schaefer*, 59 AD3d 605, 606-607, 873 NYS2d 212 [2009]. In *Rivera v Bushwick Ridgewood Props., Inc.*, the plaintiff also had a gap in treatment and a subsequent accident. The Appellate Division states that the plaintiff's doctor's opinion that the plaintiff's injures were caused by the accident in an affirmation that did not adequately address the subsequent accident "rendered speculative" his conclusions. See also *Smyth v McDonald*, 101 AD3d 1789 (4th Dept 2012).

The motion to dismiss plaintiff's complaint for failure to meet the serious injury threshold in Insurance Law § 5102(d) is granted and the complaint is dismissed.

Dated: Brooklyn, New York
September 11, 2013

**Hon. Debra Silber, A.J.S.C.**

Hon. Debra Silber
Justice Supreme Court