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

MOLLY MICHELS, Plaintiff(s) - against - DEBORAH A. MARTON, Defendant(s)	ORDER WITH NOTICE OF ENTRY Index #: 110644/11

COUNSELORS:

PLEASE TAKE NOTICE, that the annexed is a true copy of an Order duly entered in the office of the Clerk of the County of New York on the 3rd day of November, 2014.

Dated: Westbury, New York
November 11, 2014

Yours etc.

James Duggan,Esq.
KAY & GRAY
Attorneys for Defendant
Deborah Marton
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Our File No.:11R1653
Claim No.:0357665920101044 (J081)

To:

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FILED
NOV 17 2014
COUNTY CLERKS OFFICE
NEW YORK

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SUPREME COURT OF THE STATE OF NEW YORK
NEW YORK COUNTY

PRESENT: HON. ARLENE P. BLUTH
HON. ARLENE P. BLUTH
Justice

PART 22

Index Number : 110644/2011
MICHELS, MOLLY
vs.
MARTON, DEBORAH A.
SEQUENCE NUMBER : 001
SUMMARY JUDGMENT

INDEX NO. _____

MOTION DATE _____

MOTION SEQ. NO. _____

The following papers, numbered 1 to 3, were read on this motion to/for SJ - serious inj

Notice of Motion/Order to Show Cause — Affidavits — Exhibits _____ | No(s). 1

Answering Affidavits — Exhibits _____ | No(s). 2

Replying Affidavits _____ | No(s). 3

Upon the foregoing papers, it is ordered that this motion is

DECIDED IN ACCORDANCE WITH
ACCOMPANYING DECISION/ORDER

RECEIVED
NOV 03 2014
GENERAL CLERK'S OFFICE
NYS SUPREME COURT - CIVIL

FILED
NOV 03 2014
COUNTY CLERK'S OFFICE
NEW YORK

MOTION/CASE IS RESPECTFULLY REFERRED TO JUSTICE
FOR THE FOLLOWING REASON(S):

Dated: 10/30/14

HON. ARLENE P. BLUTH, J.S.C.

1. CHECK ONE: ..... ☒ CASE DISPOSED ☐ NON-FINAL DISPOSITION

2. CHECK AS APPROPRIATE: .....MOTION IS: ☒ GRANTED ☐ DENIED ☐ GRANTED IN PART ☐ OTHER

3. CHECK IF APPROPRIATE: ..... ☐ SETTLE ORDER ☐ SUBMIT ORDER

☐ DO NOT POST ☐ FIDUCIARY APPOINTMENT ☐ REFERENCE

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK: PART 22

----------X

MOLLY MICHELS,

Plaintiff,

-against-

Index № 110644/11

DEBORAH A. MARTON,

Motion Seq. 001

Defendant.

----------X

ARLENE P. BLUTH, J.:

In this personal injury action, defendant Deborah A. Marton (Marton) moves for an order, pursuant to CPLR 3212, granting summary judgment and dismissing the complaint on the ground that the plaintiff, Molly Michels (Michels), did not sustain a serious injury, as defined under section 5102 (d) of New York's Insurance Law, when she was struck by an automobile.

In this personal injury action, defendant moves for granting summary judgment dismissing the complaint on the ground that plaintiff did not sustain a serious injury, as defined under Insurance Law Section 5102(d), she was struck by a motor vehicle owned and operated by defendant.

To prevail on a motion for summary judgment, the defendant has the initial burden to present competent evidence showing that the plaintiff has not suffered a "serious injury" (*see Rodriguez v Goldstein*, 182 AD2d 396 [1992]). Such evidence includes "affidavits or affirmations of medical experts who examined the plaintiff and conclude that no objective medical findings support the plaintiff's claim" (*Shinn v Catanzaro*, 1 AD3d 195, 197 [1st Dept 2003], *quoting Grossman v Wright*, 268 AD2d 79, 84 [1st Dept 2000]). Where there is objective proof of injury, the defendant may meet his or her burden upon the submission of expert affidavits indicating that plaintiff's injury was caused by a pre-existing condition and not the accident (*Farrington v Go On Time Car Serv.*, 76 AD3d 818 [1st Dept 2010], *citing Pommells v*

Perez, 4 NY3d 566 [2005]). In order to establish prima facie entitlement to summary judgment under the 90/180 category of the statute, a defendant must provide medical evidence of the absence of injury precluding 90 days of normal activity during the first 180 days following the accident (*Elias v Mahlah*, 2009 NY Slip Op 43 [1st Dept]). However, a defendant can establish prima facie entitlement to summary judgment on this category without medical evidence by citing other evidence, such as the plaintiff's own deposition testimony or records demonstrating that plaintiff was not prevented from performing all of the substantial activities constituting customary daily activities for the prescribed period (*id.*).

Once the defendant meets his initial burden, the plaintiff must demonstrate a triable issue of fact as to whether he or she sustained a serious injury (*see Shinn*, 1 AD3d at 197). A plaintiff's expert may provide a qualitative assessment that has an objective basis and compares plaintiff's limitations with normal function in the context of the limb or body system's use and purpose, or a quantitative assessment that assigns a numeric percentage to plaintiff's loss of range of motion (*Toure v Avis Rent A Car Sys.*, 98 NY2d 345, 350-351 [2002]). Further, where the defendant has established a pre-existing condition, the plaintiff's expert must address causation (*see Valentin v Pomilla*, 59 AD3d 184 [1st Dept 2009]; *Style v Joseph*, 32 AD3d 212, 214 [1st Dept 2006]).

In the verified bill of particulars and supplemental bill, plaintiff claims bruising, swelling and soreness in her arms, shoulder and ribs, back and neck pain and sprain, aggravation of pre-existing degenerative changes in her cervical and lumbar spine, herniation at L5-S1, aggravation of right knee derangement with torn medial meniscus and post-traumatic stress reaction. She stated that she was not confined to bed after the accident and was confined to home for only one to two days.

Marton supports her motion with copies of the requisite pleadings, Michels's deposition transcript and two independent medical examination (IME) reports. The first IME was performed by Dr. Robert Israel, an orthopedic surgeon, and the second was performed by Dr. Jean-Robert Desrouleaux, a neurologist. It is Marton's contention that the objective findings contained in the IME reports establish that Michels does not suffer from a serious injury or a permanent consequential injury and/or disability as a result of the accident, and that her own testimony confirms that her injuries are not "serious," as defined by statute.

At her deposition, Michels explained that the accident occurred while she was walking with her friend Lois in a designated cross walk at the intersection of Cabrini Blvd and 186th Street in upper Manhattan. She recalled observing defendant's vehicle as it approached the intersection and thinking that the car was going to stop at the stop sign. Instead, defendant accelerated her vehicle through the intersection and without stopping, striking the two women. Michels testified that she was hit on the right side of her body, causing her to fall onto her left side, and on top of Lois. Marton exited her vehicle, apologized and called for help. Michels was then taken, by ambulance, to St. Luke's Roosevelt Hospital, where she was treated in the emergency room (Michels tr at 58-59).

Michels testified that she was in the emergency room for approximately three hours, during which time she underwent several examinations and x-rays for the pains emanating from her neck, the side of her head, her arm, ribs, thighs, knees and back. She recalled being told that she had bruising. She was not told that anything was broken. When she was released, Michels was provided with a cane, instructed to rest, take medication and to call her doctor if she continued to feel pain (*id.* at 59-61). Michels rested for the next few days and then saw her

internist, Dr. Seth Feltheimer, at Columbia Presbyterian[1] the following week. She complained to him of pain in her neck, shoulder, right side, knees and back. Dr. Feltheimer sent her to Dr. Kevin Sperber, also at Columbia Presbyterian, for pain management. Dr. Sperber prescribed Methocarbamol, OxyContin and physical therapy. According to Michels, she took the prescribed medication and attended physical therapy, and while some of the pain was reduced, it was not eliminated. Dr. Sperber then prescribed Lipoderm patches for her left buttock/lower back region. After two to three months, her right side started to improve (*id.* at 77), but the pain in her left hip and left side of her back grew progressively worse (*id.* at 80).

According to her testimony, Michels went for multiple sessions of physical therapy over the course of two years. During that time, she visited with several additional physicians affiliated with Columbia Presbyterian due to the pain she continued to experience. Michels saw an orthopedic surgeon named Dr. Howard Kiernan, complaining of back pain which was interfering with her life. She stated that Dr. Kiernan advised her to continue physical therapy and go for more pain management treatment. He also recommended that she see a neurosurgeon (*id.* at 81-83). She then saw neurosurgeons Dr. Michael Kaiser and Dr. Ogden of Columbia Presbyterian. Neither recommended surgery in her case, and both sent her for more physical therapy (*id.* at 85-87).

Michels testified that, after she treated with Dr. Sperber, Dr. Ogden and Dr. Paul McCormick (who works with Dr. Ogden) in or about 2010 and/or 2011, she was sent to see Dr.

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[1] Plaintiff and counsel refer to the hospital located on West 168th Street in upper Manhattan as "Columbia Presbyterian." That medical facility, more properly known as "New York-Presbyterian Hospital," will, for the sake of consistency, continue to be referred to as Columbia Presbyterian in the balance of this decision.

Christopher Viscuo, who was also at Columbia Presbyterian (*id.* at 101). She stated that Dr. Viscuo gave her two or three sessions of trigger point injections in her lower back, and that while the injections helped for a short period of time, like the treatment she received from Dr. Sperber, the pain kept returning. Dr. Viscuo referred her to Dr. Chantasi, a chiropractor affiliated with Columbia Presbyterian, to help her with her ongoing pain (*id.* at 107). Michels testified that she saw Dr. Chantasi five or six times, and that he treated her with back manipulations and trigger point injections. When it became evident that she was not making sufficient progress and was still in terrible pain, Dr. Chantasi recommended that she continue physical therapy and that she should wear a support brace when she needed to sit for a period of 30 minutes or longer.

Next, Michels saw Dr. Clark Smith at Columbia Presbyterian for pain management. She saw Dr. Smith three times and he treated her with epidural injections and recommended physical therapy. Following Dr. Smith, Michels saw Dr. David Bendola, another pain management specialist. According to Michels, Dr. Bendola spent a lot of time reviewing her prior treatment with her and the minimal improvement she obtained as a result. She stated that Dr. Bendola told her that he did not want to give her any more injections because she had probably received the maximum benefit from this type of treatment, and that he recommended that she continue her exercises and avoid weight gain (*id.* at 113).

Michels also testified about physical therapy and about a physical therapist named Brian, whom she found to be very helpful because he showed her how to sit down, how to get up, and how perform a few other basic movements with less pain (*id.* at 114). Michels stated that, on one occasion, she received counseling on how to deal with her pain from a psychologist/social worker named Tracy Stern, whom Dr. Sperber had recommended for her to see (*id.* at 116).

Michels was also questioned about medical treatment she received for her lower back prior to the accident. Evidently, Michels saw Dr. McCormick back in 2007, and had x-rays taken of her lower back because she was experiencing "some pain, general pain, across the back" (*id.* at 89). She described that pain as "gnawing" and thought it would be a good idea to have it "checked out" (*id.*). Dr. McCormick recommended exercise, and eventually that pain went completely away. Michels also acknowledged that, in the weeks just prior to the accident, she was under the care of Dr. Michael Weinberger, at Columbia Presbyterian, for pain management for an inflammation in the region of her buttocks and the upper parts of both of her legs (*id.* at 94-95). According to Michels, Dr. Weinberger treated her with an epidural injection and after a week to 10 days, her pain started to go away (*id.* at 98). Michels testified that she did not remember feeling pain from the inflammation after the accident had occurred, or at any time since (*id.* at 99).

When asked whether she was ever diagnosed with arthritis in her lower back or in any other part of her body, Michels responded "well," and "Dr. Kiernan may have said that I have some arthritis," but she denied taking any medication for it (*id.* at 105). When asked the following questions about what her physicians told her about the cause of her pain, she gave the following responses:

> "Q. Has any of your physicians that you mentioned told you what the cause of that pain is or the source of that pain is?
> A. Yes. Dr. Viscuo thinks it's as a result of the impact from the accident. Dr. Viscuo said that and Dr. Kiernan said that, that my alignment was thrown off.
> Q. Was anybody saying it's a specific dis[c] problem?
> A. No, they are not saying that, a specific, no"

(*id.* at 112-113).

Michels also acknowledged that, despite her discomfort, she was able to visit her sister in Florida two times during the winter months immediately following her accident, and resumed taking her approximately, one mile long walks in Fort Tryon Park about a year later (*id.* at 71-72, 78, 112). When asked to identify what things she could do before the accident that she could no longer do, Michels listed the following tasks: empty the lower level of the dishwasher; lift a heavy frying pan; bend; wash a floor; run a vacuum cleaner; wash a bathtub; pull things down from a closet; carry heavy packages or a heavy pocketbook; wear high heels; sit at a restaurant, a lecture, an opera or a movie for any length of time, and/or if she does go, she must arrive early enough to get an aisle seat so that she can leave early when necessary; ride in a car for more than 30 minutes or attend a social function without her support brace; and attend the Thanksgiving Day or other parades. Michels stated that her shopping and eating habits have changed in that she can no longer carry too many bottles and she now needs the doorman to bring her groceries and other heavy packages up to her apartment. Her involvement in local politics has also been affected in that she can no longer do the work of getting signatures on petitions and of handing out candidates' literature, and she now needs help in hosting political meet-and-greet coffees in her home (*id.* at 119-124).

Finally, Michels was asked to explain the difference between the pain she experienced in 2007, prior to the accident, and the pain she has experienced since the accident. Michels responded that she now has pain on her lower left side and that:

> "[the pain] occurs when I have to turn over in bed. The pain occurs when I have to stand up. I was taught how to stand up in a certain way, with my knees forward and my chest forward. I had trouble getting up from the toilet. I have two bathrooms in my apartment. I bought two comfort height toilets to make it easier on my knees in getting up after using the toilet. If I took the subway, I have pain

> if I had to get up quickly. You can't stand on the subway too long before your stop because you can get thrown over. So I was always very, very anxious getting up in the subway, the timing had to be like that, more or less. I had pain after I sit in a chair that's not comfortable. I cannot sit on the stool. I go to computer classes which they have, Apple, they only have stools, so I will sit for five minutes and I will do the rest of the lesson while I stand, because I have the pain. The pain is totally different. I never had this kind of the pain until after the accident"

(*id.* at 93-94).

Michels appeared for two IMEs at defendant's request, one with Dr. Israel, who examined Michels on May 16, 2012, and the other with Dr. Desrouleaux, who examined Michels several weeks later, on June 21, 2012. Marton submits a copy of the two IME reports and points out that neither physician noted in their reports any limitation of plaintiff's movement, or any disability occurring as a result of the accident.

According to Dr. Israel's report, Michels, who was 74 years old at the time of the orthopedic examination, was accompanied by her son Jeffrey Michels,[2] and complaining of pain from the injuries she sustained in the December 3, 2009 accident. She reportedly told Dr. Israel that the pain in her neck, upper back, right shoulder, rib, right wrist, right hand, right knee and right arm were getting better, while the pain in her lower back was getting worse, and that prior to the accident, she did not experience the type of pain she now endures. She provided a surgical history involving right carpal tunnel, an oophorectomy, and arthroscopies to her shoulder and knee. Dr. Israel noted in his report that Michels did not appear to be in acute distress or discomfort.

As part of the examination, Dr. Israel conducted range of motion (ROM) testing during the physical examination. He stated that, using goniometer and following AMA guidelines, he

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[2] Jeffrey Michels is also plaintiff's attorney of record in this action.

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made the following findings: cervical spine: normal lordosis; no tenderness or spasm to palpation; the cervical compression test, Soto Hall test, Valsalva test and Spurling test were all negative. The result of ROM flexion was to 50° (50° normal), extension to 60°(60° normal), right and left rotation to 80° (80° normal), and right and left lateral flexion to 45° (45°normal), and there was intact sensation to pin prick and light touch. Dr. Israel graded muscle strength at 5/5 in the biceps, triceps, wrist flexors and extensors bilaterally. He found her deep tendon brachioradialis, biceps and triceps reflexes to be symmetrical, her grasping power to be firm in both hands, and that there was no sign of atrophy, or pain with movement. Thoracic spine: normal kyphosis; flexion to 45° (45°normal) and lateral rotation is 45°to either side (normal 45°). He noted no tenderness or spasm to palpation over the spinous processes or paraspinal, he noted that her shoulder blades were symmetrical, her sensation to pinprick was intact, and that there was no pain with movement. Lumbar Spine: the lordotic curve was normal; no spasms or tenderness found on palpation; gait and toe heel was normal; straight leg raising was bilaterally negative to 75° (75°normal); and Bechterew's, Hoover's and the Babinski sign were all negative. ROM was forward flexion to 60°(60° normal), extension to 25° (25° being normal), right and left lateral flexion to 25° (25° normal), pinprick and light tough sensation were intact; muscle strength was 5/5 and there was no sign of atrophy. Dr. Israel noted that Michels's patella and Achilles' deep tendon reflexes were symmetrical. He found no clonus and that there was no pain with movement. Bilateral Shoulders: Dr. Israel noted no atrophy or tenderness on palpation. ROM was anterior flexion to 180° (180° normal), abduction to 180° (180° normal), adduction to 30° (30° normal), external rotation to 90° (90° normal), internal rotation to 80° (80° normal), and posterior extension to 40° (40° normal). He found the Hawkins test, the drop arm,

Yergason's, apprehension, Speed and O'Brien and clunk tests to be negative, and he noted no instability or pain with movement. Bilateral Elbows: ROM 0° to 150° (150° normal), pronation and supination of 80° (80° normal); Tinel's sign was negative, resisted extension was negative, muscle strength testing graded at 5/5, and no pain was found with movement. Bilateral Wrists: he found no evidence of swelling, tenderness or synovitis. ROM in pronation and supination was measured at 90° (90° normal), dorsiflexion and palmar to 60° (60° normal), ulnar deviation to 30° (30° normal), and radiation deviation to 20° (20° normal), and Phalen's, Tinel's and Finkelstein's tests were all negative. Bilateral hands: he found no evidence of swelling or tenderness. ROM of thumb showed radial adduction to 90° (90° normal), palmar abduction to 70° (70° normal), metacarpophalangeal joint flexion to 60° (60° normal), and interphalangeal joint to 80° (80° normal). Thumb/finger opposition was normal. ROM of metacarpophalangeal joint, proximal interphalangeal joint and distal interphalangeal joints of the remaining fingers at 90° (90° normal). Michels demonstrated firm grasping power and pinch, no finger locking or snapping, no thenar, hypothenar or interosseous atrophy. Her sensation was intact to pinprick and light touch, and she demonstrated no pain with movement. Bilateral Arms: he noted tenderness in her arms. ROM was full, the neurovascular status was intact, no atrophy present, her grip strength was normal, and no pain was found with movement. Bilateral Hips: normal gait, no tenderness, or shortening present. The Trendelenburg sign was negative and he found no sign of impingement. ROM was found to be normal with flexion to 100° (100° normal), extension to 30°(30° normal), adduction to 20° (20° normal), abduction to 40°(40° being normal), internal rotation to 40°(40° normal), and external rotation to 50° (50° normal). The Patrick's test was negative. She demonstrated no sensory loss to light touch or pinprick and no

pain with movement. Her muscle strength was graded as 5/5. Bilateral Knees: examination of plaintiff's knees reveals a normal gait, no tenderness or effusion, muscle strength graded at 5/5, in seven degrees of valgus and stable on valgus and varus stress, anterior stress at 30° and 90°, and the posterior drawer test was negative. ROM was 0 to 150°(0 to 150° normal), the McMurray test was negative, the patella-femoral compression test was negative, and there was no finding of patella-femoral crepitus, and no pain with movement. Bilateral Foot/Ankle: the examination of plaintiff's feet and ankles revealed a normal gait, no tenderness to palpation, and he was able to palpate pedal purses. He noted no color or temperature change. ROM dorsiflexion was 20° (20° normal), plantar flexion was 40° (40° being normal), inversion was 30° (30° normal), and eversion was 20° (20° normal). Muscle strength was rated 5/5 and "within normal limits," full ROM of the toes, no instability, no pain with movement, and no noted atrophy. Bilateral Legs: Examination of the legs revealed a normal gait, and examination of plaintiff's lower extremities revealed no redness, swelling, increased warmth or tenderness present. There was no atrophy or muscle wasting, her neurovascular status was intact, no instability was present, and there was a full range of motion and no pain with movement. Ribs: the rib regions were nontender, no deformity was noted.

Dr. Israel's stated impression was of a resolved sprain of her cervical spine, thoracic spine, lumbar spine, right shoulder, right elbow, right hip and right knee, and that, based on his "examination from an orthopedic point-of-view, the claimant has no disability as a result of the accident of record" (defendant's exhibit D).

Michels also appeared for an IME with the designated neurologist, Dr. Desrouleaux. Dr. Desrouleaux recorded her present complaints as pain relating to her neck, right shoulder, right

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rib, mid and lower back and her right knee, and he recorded her ROM degrees using a goniometer and "in accordance with AMA Guidelines." He reported that Michel's head was normocephalic and atraumatic. Her mental status was appeared to be "alert and oriented x3," and her "speech, language and attention were all intact." He reported cranial nerve findings: full visual fields, pupils equally round and reactive to light, extra-ocular movements intact, no facial asymmetry or sensory loss, hearing intact, her tongue was midline and her palate moved symmetrically. Deep Tendon Reflexes: 2+ throughout (2+ normal). The motor examination revealed normal bulk, tone, and strength throughout. He noted no atrophy, fasciculations (muscle twitches), or adventitious (unnatural) movements. The sensory examination yielded results that were intact to light touch in all extremities, her coordination examination revealed no dysmetria, ataxia, or nystagmus (involuntary eye movement), and he noted that her gait was normal, and that she was able to perform heel, toe, and tandem walking in a normal manner. Dr. Desrouleaux also reported that the results of the Phalen's, Tinels, Kernig's and Patrick's tests were negative. He found no tenderness of the cervical, thoracic and lumbar spine. No associated spasm was noted. Straight leg raising was possible up to 90° bilaterally in the sitting position (90°normal). ROM of Michels's cervical spine on flexion to 50° (50° normal), extension to 60° (60° normal), lateral bend to 45°(45° normal), right and left rotation to 80°(80° normal). Her shoulder blades were found to be symmetrical and no discomfort was noted. ROM with flexion 45° (45° being normal), extension 0° (0° normal), lateral bending 45° (45° normal) and rotation 30° (30° normal). Michels's ROM of her lumbar spine was: flexion: 60° (60° normal), extension: 25° (25° normal), and right and left lateral flexion: 25° degrees (25°normal). Dr. Desrouleaux diagnosed "status post cervical, thoracic and lumbar sprain/strain, resolved," and

opined that "there is no neurological disability due to the accident in question" (defendant's exhibit E).

As asserted by Marton, the above IME reports, together with her deposition testimony, constitute competent evidence that Michels, who suffers from a degenerative disc condition in her lumbar spine that predates the accident, did not sustain serious physical injuries, as defined under No-Fault, as a result of being struck by defendant's automobile. Prima facie entitlement to summary judgment has been established and the burden now shifts to Michels to demonstrate the existence of a triable issue of fact with respect to the severity of physical injuries caused by the accident (*Franchini v Palmieri*, 1 NY3d 536, 537 [2003]; *Giddy v Eyler*, 79 NY2d at 957).

To this end, Michels argues strenuously that the orthopedic IME report should be disregarded in its entirety because of a finding of misconduct made against Dr. Israel by the New York State Department of Health State Board for Professional Medical Conduct (BPMC). Claiming that Dr. Israel's medical license had been suspended due to his affirmance of IME reports between 2006 and 2008, which contained inaccurate and incomplete medical histories and examinations which he, Dr. Israel, later admitted that he did not perform, Michels asserts that the doctor's veracity and credibility are called into question, as is the validity of the orthopedic report he prepared with respect to her May 16, 2012 IME. Michels also seeks to discount the neurologic findings of Dr. Desrouleaux on the ground that he did not examine or make findings with respect to her right knee.

A review of the BPMC's Statement of Charges against Dr. Israel, Consent Agreement and Order, and Consent Order dated May 30, 2013, reveals that Dr. Israel's medical license was not suspended (*see* plaintiff's exhibit A). Rather, Dr. Israel consented, commencing March 2013,

and in relevant part, to: (1) being placed on probation for a period of three years, subject to specific terms and conditions, pursuant to NY Public Health Law § 230-a (9); and (2) limiting his license to practice medicine to exclude IMEs, pursuant to NY Public Health Law § 230-a (3). Contrary to plaintiff's assertion, not only was Dr. Israel's license to practice medicine not suspended, but at the time he performed Michels's IME, he was under no limitation, nor had he been found, upon consent or otherwise, to have committed professional misconduct. Also significant is the fact that Michels does not submit a sworn affidavit or any other probative evidence to establish that Dr. Israel failed to obtain a medical history, failed to perform the examination and tests referenced in his IME report, or in any other way, failed to perform a proper IME on Michels. Accordingly, this court finds no basis to reject Dr. Israel's IME report. Additionally, as Dr. Israel found full ROM with respect to Michels's right knee, the reported failure of the IME neurologist to either examine or to include findings with respect to Michels's right knee, is of little consequence.

The question, therefore, is whether the medical evidence offered by Michels raises a question of fact as to the severity of her claimed injuries, sufficient to forestall summary judgment.

In this regard, plaintiff submits the sworn affirmation of Dr. Leonard Harrison (plaintiff's exhibit 1). Dr. Harrison, who identifies himself as "a physician licensed to practice medicine in the State of New York," confirms his review of: Michel's deposition testimony; the records of Dr. Kiernan, Dr. Weinberger, Columbia Presbyterian dated December 8, 2009; and the pre- and post-accident lumbar MRI studies taken on November 13, 2009, and April 24, 2010, respectively. Dr. Harrison stated that, based on his comparison of the two studies, with the pre-

accident MRI revealing degenerative changes and disc bulges at the L2-L3, L4-L5 and L5-S1 locations, and the post-accident MRI revealing a frank herniation of her disc at L5-S1, he was able to determine that, at some point between those two dates, Michels sustained the frank herniation at L5-S1. He opined further, that the herniation of her disc was "superimposed over the pre-existing degenerative bulges, which could only be traumatically induced and causally related to the accident" (*id.*, ¶ 7).

With respect to her right knee, Dr. Harrison noted his reliance on an October 1, 2010 MRI, and the affirmed reports of radiologist Dr. Lisa Cimino-Gandolfo who diagnosed several soft-tissue injuries, Michels's physical therapy records, which contain her physical therapist's (unsworn) findings, and the ROM test results for her right knee contained in Dr. Kiernan's affirmation, which plaintiff submits as exhibit two. According to Dr. Keirnan, Michels's right knee ROM was 0-130° on December 30, 2009, and 0-130° on September 7, 2011. Dr. Harrison also reported the findings of his own ROM tests on Michels's right knee. He performed this test on June 5, 2012, and again on an unspecified date in November 2013. He states that, using a hand held goniometer, on June 5, 2012, Michels's right knee ROM was 0-128° (normal 0-150°), showing a 15% limitation, and approximately a year and a half later, in November 2103, the ROM for her right knee measured at 1-120° (normal 0-150°), showing a 5% increase to a 20% limitation.

Dr. Harrison also reports performing ROM tests on Michels's lumbar spine on the same dates. On June 5, 2012, he measured her lumbar flexion at 45° (90° normal), showing a 50% limitation; her extension was 10° (30° normal), showing a 66⅔% limitation; and her left and right lateral bending was at 15° (30° normal), a 50% limitation. He reported that when he re-

tested her in November 2013, her lumbar spine maintained the same ROM as he measured on June 5, 2012.

Dr. Harrison also reported performing digital palpation on areas where Michels complained of pain, and finding "swelling along the medial aspect of her right knee," as well as "deep and superficial 2+ spasms and trigger points in the right upper trapezius and splinting of the muscles of the right side of the thoracic back and scapula, and the lubosacral paraspinals." He stated that findings of "swelling, muscle spasms muscle spinting [sic] and trigger points are objective evidence of an orthopedic or neurological injury" (*id.*, ¶ 12). Based on the tests' results, Dr. Harrison opined "within a reasonable degree of medical certainty that these limitations of motion were permanent, medically significant and substantial in their effect on [Michels]" (*id.*, ¶ 14), that Michels sustained a traumatic exacerbation of pre-existing lumbar and cervical myofascial derangement with development of severe radicular symptoms, and a traumatic herniated disc at L5-S1, as well as traumatic tears of the body and posterior horn of the medial meniscus of her right knee (*id.*, ¶¶ 15, 16). He concluded that her injuries are permanent, and that the "injuries and limitations to her right knee and lower back are of great consequence in that they will limit any activities requiring any significant bending or flexing of her knees, such as climbing stairs or squatting, or of bending at the waist, such as tying her shoes or picking something up off the floor" (*id.*, ¶ 18).

Next, Michels submits copes of reports pertaining to the lumbrosacral spine MRIs performed on November 13, 2009, and April 26, 2010, and the right knee MRI preformed on October 1, 2010 (*see* plaintiff's exhibit 3). According to the report for the November 13, 2009 MRI, which was ordered by Dr. Weinberger ("reason: spinal stenosis and radiculitis") and

interpreted by Dr. Cimino-Gandolfo, Michels has a history of lower back problems, and the findings on November 13, 2009, were being compared to radiological results previously obtained on October 10, 2007 and October 11, 2006 (copies of which are not provided for court review). Dr. Cimino-Gandolfo's report, dated November 13, 2009, states, in relevant part:

> "again noted are varying degrees of dessication of multiple discs indicating degeneration of those intervertebral discs, most pronounced at L5/S1. There is increased narrowing of the L2-L3 and L5-S1 intervertebral disc spaces since previous study. New discongenic degenerative changes are seen at L5-S1.
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> * * *
>
> "At L4-L5, there is a mild diffuse disc bulge flattening the thecal sac and slightly narrowing bilateral neural formina. The size of the left paracentral disc protrusion has slightly increased since the prior study . . ..
> "Impression: Multilevel degenerative changes as described, with interval progression at L2-L3 and L5-S1 since 10/10/2007."

The report for the MRI performed approximately four and a half months after the accident, on April 26, 2010, prepared by a different radiologist, Dr. Frieda Feldman, states, in relevant part:

> "no compression fracture or malalignment . . . varying degrees of intervertebral disc desiccation representing disc degeneration. Intervertebral disc space narrowing is again noted at L5/S1 and L2/L3 with multilevel Schmorl notes. . . .
> At L2/L3, again seen is a diffuse disc bulge . . . these findings are without significant interval change since 11/13/2010.
> At L4/L5, there is a posterior disc bulge with an annular tear indenting the anterior thecal sac, without evidence of spinal canal stenosis. Mild bilateral neural foraminal narrowing is present.
> At L5/S1, and again noted is a central disk protrusion indenting the anterior thecal sac, without evidence of spinal canal stenosis or neural foraminal narrowing. . . .
> Impression: 1. No compression fracture or malalignment. 2. Multilevel this [sic] displacements, as described, without significant interval change since 11/13/2009."

The report for the October 1, 2010, right knee MRI study prepared by Dr. Cimino-

Gandolfo includes the following findings: medial collateral ligament bursitis; mild irregularity of the articular cartilage in the lateral compartment; and mild degenerative changes in the articular surface of the patellar facets. Dr. Cimino-Gandolfo's stated impression was: (1) tear of the body and posterior horn of the medial meniscus; (2) medial collateral ligament bursitis; (3) mild quadriceps tendinopathy; (4) a small synovial cyst versus a ganglion cyst in the soft tissues posterior to the knee; and (5) supra patellar fat pad edema, raising question of supra patellar impingement.

Plaintiff's fourth exhibit purports to be a copy of a hospital record dated December 8, 2009, and another radiologist's unsworn, unaffirmed report pertaining to her cervical spine. Annexed as exhibit five is, what purports to be, a one-page copy of Dr. Weinberger's notes dated November 2, 2009, and maintained at the Pain Management Center at Columbia Presbyterian. However, neither the hospital record, nor the radiological report, nor Dr. Weinberger's notes constitute competent evidence, as they are not certified or affirmed as required for consideration (*see Grasso v Angerami*, 79 NY2d 813, 814-815 [1991]).

It is well settled that the "legislative intent underlying the No-Fault Law was to weed out frivolous claims and limit recovery to significant injuries" (*Toure v Avis Rent A Car Sys.*, 98 NY2d 345, 350 [2002], quoting *Dufel v Greene*, 84 NY2d 795, 798 [1995]). In 1982, the Court of Appeals in *Licari v Elliott* (57 NY2d 230 [1982]) stated that:

> "the purpose of enacting an objective verbal definition of serious injury was to 'significantly reduce the number of automobile personal injury accident cases litigated in the courts, and thereby help contain the no-fault premium.'. . . While it is clear that the Legislature intended to allow plaintiffs to recover for non-economic injuries in appropriate cases, it had also intended that the court first determine whether or not a prima facie case of serious injury has been established which would permit a plaintiff to maintain a common-law cause of action in tort"

(57 NY2d at 236 - 237; Memorandum of State Executive Dept, 1977 McKinney's Session Laws of NY, at 2448). In 2005, the Court of Appeals in *Pommells v Perez* (4 NY3d 566 [2005]) reviewed the evidence necessary to determine whether a particular soft-tissue injury, which involves subjective complaints of pain, and is often difficult to observe and/or quantify, constitutes a serious injury within the meaning of the statute. "[W]hether there has been a '*significant*' limitation of use of a body function or system (the threshold statutory subcategory into which soft-tissue injury claims commonly fall) can itself be a complex, fact-laden determination" (*id.* at 571). To demonstrate serious injury, a plaintiff's submissions must include objective evidence of the existence of a soft-tissue injury, accompanied by objective evidence of the extent of the alleged physical limitations resulting from that injury (*id.* at 574; *Onishi v N & B Taxi, Inc.*, 51 AD3d 594, 595 [1st Dept 2008]; *Kearse v New York City Tr. Auth.*, 16 AD3d 45, 49-50 [2d Dept 2005]). Other factors to be considered in reviewing No-Fault threshold motions include a cessation or gap in treatment, an intervening medical condition interrupting the chain of causation, and one or more pre-existing conditions (*Pommells v Perez,* 4 NY3d at 572).

Here, in Michels's bill of particulars, she alleges that, as a result of defendant's negligence, she sustained an exacerbation of soft-tissue injuries to her lower back and new soft-tissue injuries to her lower back, right knee, head, neck, right arm, right shoulder, ribs, and thighs, plus numbness in her right palm, all of which are permanent in nature and cause her to experience pain and limitations of motion on a daily basis. However, Michels's evidentiary submissions in opposition to the motion pertain to her lumbar spine and right knee injuries only. The evidence she offers to rebut defendant's prima facie showing is inadequate to meet the No-

Fault threshold with respect to both her right knee and lumbar spine, requiring dismissal of her complaint.

An examination of her deposition transcript reveals that, after the first two to three months post-accident, Michels sought and received almost all of her medical care and treatment for the pain she was experiencing on the lower left side of her back. After detailing her many visits to physicians, physical therapists and other treaters, all of which involved Michels's attempts to alleviate her lower back pain, she was questioned at length about her post-accident physical limitations. In response, Michels identified various activities which caused pain and discomfort to her lower back, without any mention of her right knee or her neck, the side of her head, her right arm, right shoulder, right palm, ribs, or her thighs. In addition to acknowledging that she began driving again after several weeks and resumed her walks around Fort Tryon Park approximately a year after the accident, she testified that pain she experienced on the right side of her body had subsided two to three months after the accident (Michels tr at 77), and that she no longer experiences any numbness in her right palm (*id.* at 117). And noticeably absent from her testimony, is any complaint or indication that using her knees, neck, head, right arm, right shoulder, right palm, ribs, or her thighs caused her either pain or discomfort. In fact, Michels's lone reference to her injured knee was when she explained that, in order to do housework, she tries to "use her knees to avoid using [her] back" (*id.* at 119-120). Even when questioned by her own attorney towards the end of her deposition, Michels failed to mention any pain or discomfort related to her knee or to any other body part or member.

Additionally, the ROM findings in the affirmation prepared by Dr. Kiernan, referenced above, lacks evidentiary value. Dr. Kiernan omits information as to how he reached these results

(whether he used a goniometer, visual estimation, or otherwise), and he omits any information as to what extent his findings might show an abnormality or physical limitation, if any (*Pommells v Perez*, 4 NY3d at 574, *Onishi v N & B Taxi, Inc.*, 51 AD3d at 595).

This court also notes that, while Dr. Harrison presents objective findings for Michels's June 5, 2012 's ROM tests, neither Dr. Harrison nor plaintiff's counsel provides an explanation for the lack of a specific date for the retesting supposedly performed in November 2013. As a result, Dr. Harrison has provided no objective comparative base to support his conclusion that Michels's knee "injuries are permanent and will not improve further," rendering his opinion speculative. However, even if a specific date had been included, and accepting plaintiff's objective (MRI) evidence of torn menisci, the claims regarding her knee must, nevertheless, be dismissed because of her lack of evidence relating to any physical limitations resulting from, and relating directly to, the soft-tissue injuries to that knee (*id.*).

Michels also fails to adequately rebut defendant's evidence and raise a question of fact with respect to her back injury. Regarding Michels's objective MRI evidence of a post-accident herniation at L5-S1, with radiculopathy, which was not observed on the pre-accident MRI, it is well settled that "[a] herniated disc, by itself, is insufficient to constitute a 'serious injury'; rather, to constitute such an injury, a herniated disc must be accompanied by objective evidence of the extent of alleged physical limitations resulting from the herniated disc" (*Onishi v N & B Taxi, Inc.*, 51 AD2d at 595]; *Cortez v Manhattan Bible Church*, 14 AD3d 466, 466 [1st Dept 2005]).

Dr. Harrison's lumbar ROM measurements vary considerably from that of defendant's IME physicians, showing clear limitations on Michels's ability to move her lumbar spine. However, Dr. Harrison's findings of limited movement suffer from the same evidentiary lapse as

the knee ROM results, and they are not supported by plaintiff's treating physician, Dr. Kiernan. According to Michels's own testimony, she complained to Dr. Kiernan about her back pain and its interference with her life (Michels tr at 82, 83, 105). Accordingly, it is significant that Dr. Kiernan made no mention of her back issues in the affirmation he prepared on her behalf (*see* plaintiff's exhibit 2).

Also problematic, are the results of Dr. Harrison's digital palpation examination, as he omits information as to what is considered to be the normal function of each body part being examined so that a comparative determination can be made as to whether there are any medical problems, and if so, to what extent, and whether she experiences any physical limitations as a result (*see Dufel v Green*, 84 NY2d at 798; *Womack v Wilhelm*, 96 AD3d 1308, 1310 [3d Dept 2012]).

Moreover, where as here, there is undisputed evidence of pre-existing degenerative changes in her lumbar spine, including disc bulges at L2-L3, L4-L5 and L5-S1, Michels carries the additional burden of providing competent objective medical proof which quantitatively and qualitatively distinguishes her claimed injuries from her pre-existing condition (*Pommells v Perez*, 4 NY3d at 580). In this respect, Dr. Harrison's affirmation is inadequate as he fails to provide a medically "objective basis for concluding that [Michels's] present limitations and continuing pain are attributable to the subject accident rather than to [her] degenerative condition" (*see Valentin v Pomilla*, 59 AD3d 184, 186 [1st Dept 2009]). Because Dr. Harrison failed to explain how the accident, and not Michels's history of degenerative changes and disc bulges, was the cause of, or how it impacted, her current pain and movement limitations, his opinion is speculative (*id.*).

It is also well settled that the mere use or repetition of the word "permanent" in Dr. Harrison's affirmation is insufficient to establish serious injury (*Lopez v Senatore*, 65 NY2d 1017, 1019 [1985]), and as evident from the statute's language, the significant limitation category of Insurance Law § 5102 (d), requires plaintiff to provide evidence that her limitation or curtailment is actually significant, rather than minor, mild or slight (see *Licari v Elliott,* 57 NY2d at 236; *see also Oberly v Bangs Ambulance*, 271AD2d 135, 137-138 [3d Dept 2000], *affd* 96 NY2d 295 [2001]). And the inclusion of the words "substantially all" in the statute's provision means that plaintiff must be "curtailed from performing [her] usual activities to a great extent rather than some slight curtailment" to satisfy the statute (*Licari v Elliott*, 57 NY2d at 236), and the activities which Michels identified at her deposition, as those which she can no longer perform as a result of her claimed injuries, do not rise to that level. Additionally, Michels's own denials of pre-accident pain and movement limitations are neither objective nor adequate to meet her burden of proving the extent or degree of her alleged physical limitations resulting from her post-accident disc injury. It is relevant that she lacks objective proof that her claimed post-accident curtailment of activities: (1) differed from medically documented limitations associated with her pre-existing injuries (plaintiff offers no proof in this regard); and (2) were at the direction of a physician, and therefore, medically determined. This deficiency of evidence renders her claims that her injuries and limitations are significant, permanent, and will not improve, both subjective and tailored to meet the statutory requirements (*Lopez v Senatore*, 65 NY2d at 1019).

For the reasons set forth above, Michels has failed to raise an issue of fact sufficient to defeat summary judgment.

Accordingly, it is

ORDERED that defendant's motion for summary judgment is granted and the complaint is hereby dismissed.

This is the Decision and Order of the Court.

Dated: October 30, 2014
New York , NY

J.S.C.

HON. ARLENE P. BLUTH