SHORT FORM ORDER

SUPREME COURT - STATE OF NEW YORK

Present:

HON. STEVEN M. JAEGER,
Acting Supreme Court Justice

JUSTIN FALCO,	TRIAL/IAS, PART 48 NASSAU COUNTY
Plaintiff,	INDEX NO.: 467-05
-against-	
DANIEL JACKSON,	MOTION SUBMISSION DATE: 5/8/06
Defendant.	MOTION SEQUENCE NO. 001

The following papers read on this motion:

Notice of Motion, Exhibits & Affirmation	X
Affirmation in Opposition	X

Defendant, Daniel Jackson (hereinafter "Jackson") moves for an order pursuant to CPLR §3212 for summary judgment and the dismissal of plaintiff Justin Falco's (hereinafter "Falco") Complaint on the grounds that the injury sustained does not constitute a "serious injury" under Insurance Law §5102.

This is an action for personal injuries in which plaintiff alleges that he was injured on December 29, 2002. At the time of his accident, plaintiff was a 19 year old driver in a vehicle which was struck by a vehicle driven by Jackson. The vehicle sustained moderate impact damage. Plaintiff did not complain of injuries at the scene and was not treated or taken by ambulance for emergency care.

This action was commenced by Summons and Complaint on July 21, 2004. Defendant appeared in this action by service of a Verified Answer on February 3, 2005.

The plaintiff alleges in his Bill of Particulars that he sustained various injuries including traumatically induced focal syrinx of the cervical spinal cord at C6/C7, severe cervical sprain with cervical radiculopathy, straightening of the lumbar lordosis, lumbosacral sprain, radiating pain, traumatic anxiety reaction, and loss of sleep. As a result, plaintiff alleges that he was unable to work for seven (7) days following the accident and confined to bed for one (1) day immediately following. Plaintiff claims permanent consequential or significant limitation of the use of the cervical and lumbar spine.

Plaintiff was not treated immediately following the accident on December 29, 2002. Upon experiencing pain in his head, neck, and back, plaintiff began treatment on December 30, 2002 with Dr. Raymond Bowles, D.C. (hereinafter "Bowles") of Massapequa Pain Management and Rehabilitation. Plaintiff continued treatment two-three times per week regularly through November of 2003 and intermittently thereafter.

In support of the motion, defendant submits an affirmed medical report of Dr. Joseph I. Lopez, an orthopedist, who examined plaintiff on behalf of the defendant on October 11, 2005. Dr. Lopez reviewed unsworn MRI reports, photographs of the vehicle involved in the accident, and plaintiff's Verified Bill of Particulars. Dr. Lopez alleges that plaintiff sustained a cervical strain and a lumbar strain. He states that there is no disability. He conducted range of motion testing on both the cervical and lumbar

spine. The cervical spine tests showed a normal range of motion, no tenderness, and no spasm. The lumbar spine tests showed a normal range of motion with some "tenderness in the paralumbar musculature" (see Defendant's Exhibit "H").

Defendant also submits an affirmed report of Naunihal Sachdev Singh, M.D., a neurologist who examined plaintiff on behalf of the defendant on November 11, 2005. Dr. Singh reviewed unsworn MRI reports, photographs of Falco's vehicle, and plaintiff's Verified Bill of Particulars. Dr. Singh alleges that plaintiff suffered a cervical spine strain and a lumbar spine strain, both of which had since resolved; likewise, he found that Falco did not sustain any permanent neurological defects. The doctor conducted range of motion testing on both the cervical and lumbar spine. The cervical spine tests showed no tenderness or spasm, but did not comment on cervical range of motion. The lumbar spine tests showed a normal range of motion, no tenderness, and "no paraspinal muscle tenderness or spasm on the right or left side". (See Defendant's Exhibit "G"). Plaintiff contends that this last finding is inconsistent with that submitted by Dr. Lopez.

Neither doctor contested a causal relationship between plaintiff's injuries and the December 29, 2002 accident.

In opposition to defendant's motion, plaintiff submits an attorney affirmation, affidavit of plaintiff, and affidavit of treating chiropractor, Raymond E. Bowles, D.C.

One (1) day after the accident, plaintiff was examined by Dr. Bowles. At that time, it was determined by use of a Goniometer in various flexion tests that plaintiff's cervical spine and lumbar spine showed a significant limitation of motion. Based upon this examination, Dr. Bowles' impression was that plaintiff suffered a cervical

sprain/strain, lumbosacral sprain/strain, facet syndrome, and myalgia/myositis. Dr. Bowles also found a causal relationship between plaintiff's injuries and the December 29, 2002 accident.

Plaintiff was placed on a course of chiropractic management and treatment from December 30, 2002 until approximately November 13, 2003 which consisted of specific adjustment to the cervical and lumbar spine, moist heat and high volt galvanism, spinal manipulation and soft tissue massage.

On March 9, 2006, Dr. Bowles re-examined plaintiff, who continued to complain of lower back pain. Based upon these findings, Bowles alleges that plaintiff continues to suffer an "acute, traumatic hyperflexion/hyperextention sprain/strain injury of the cervical spine, resulting in a hypocervical lordosis". (See Plaintiff's Exhibit "B"). It is also his opinion that there were extremes of joint motion with noncomitant stretching and tearing of supporting structures of the cervical and lumbar spine. Dr. Bowles states that plaintiff "will continue to experience difficulties with activities of daily living as well as activities that require prolonged posture". (See Plaintiff's Exhibit "B"). It is his further opinion that the injuries sustained constitute a significant limitation of those body parts and functions.

SUMMARY JUDGMENT PURSUANT TO CPLR 5102(d)

The proponent of a summary judgement motion must "make a prima facie showing of entitlement to judgment as a matter of law, tendering sufficient evidence to eliminate any material issues of fact from the case" (see *Winegrad v. N.Y. Univ. Med. Ctr. Corp.*, 64 NY2d 851, 853 [1985]). The court's role in a motion for summary

judgment is "issue-finding, rather that issue-determination" (see *Sillman v. Twentieth Century-Fox Film Corp.*, 3 NY2d 395 [1957]). Once the proponent of summary judgement has made a prima facie showing, the burden shifts to the party opposing the summary judgement motion , to "produce evidentiary proof in admissible form sufficient to establish the existence of material issues of fact..." (see *Alvarez v. Prospect Hosp.*, 68 NY2d 320, 324 [1986]). If the proponent of summary judgment fails to make a prima facie showing, then summary judgment is not appropriate. "...[S]ummary judgment is a drastic remedy and should not be granted if there is any doubt as to the existence of a triable issue of fact." *Moskowitz v. Garlock*, 23 AD2d 943, 944 (3rd Dept. 1965).

To establish a personal injury under the "no-fault" law requires the plaintiff to establish that a 'serious injury' has been sustained (*Licari v. Elliot*, 57 NY2d 230 [1982]). New York Insurance Law § 5102(d) defines 'serious injury' as:

"...a personal injury which results in death; dismemberment; significant disfigurement; a fracture; loss of a fetus; 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."

In the present action, the burden rests upon the movant-defendant to establish that the plaintiff has not suffered a 'serious injury' with the submission of evidentiary proof in admissible form. *Lowe v. Bennett*, 122 AD2d 728 (1st Dept. 1986). Once the defendant meets this burden, the burden shifts to the plaintiff to produce sufficient evidence in admissible form to establish that material issues of fact exist. *Alvarez v. Prospect Hosp., supra.*

To support its claim that the plaintiff has not sustained a 'serious injury', a defendant may rely either on the sworn statements of the defendant's examining physician or the unsworn reports of the plaintiff's examining physician. *Pagano v. Kingsbury*, 182 AD2d 268 (2d Dept. 1992). Generally, a medical affirmation or affidavit based upon a physician's personal examination and observations of the plaintiff is an acceptable method of proof to provide a doctor's opinion regarding the existence and extent of a plaintiff's serious injury. *Reid v. Wu*, 2003 NY Slip Op 50816 (Sup. Ct., Bronx Co.). However, a chiropractor is not one of the persons authorized under the CPLR to submit statements by affirmation; therefore, only an affidavit containing the requisite findings will suffice. CPLR §2106; *Picardo v. Blum*, 267 AD2d 441 (2d Dept. 1999).

Once the defendant has met its burden of establishing that the plaintiff has not suffered a 'serious injury' with the submission of evidentiary proof in admissible form, then the burden shifts to the plaintiff to produce prima facie evidence in admissible form to support its claim for serious injury. To do so, the affirmation or affidavit must contain objective medical findings, based upon the physician's own examinations, tests and

observations and review of the record, rather than merely manifesting the plaintiff's subjective complaints. *Toure v. Avis Rent A Car Sys.*, 98 NY2d 345, 350 (2002). However, unlike the defendant's proof, unsworn reports of the plaintiff's examining doctor are not sufficient to defeat a motion for summary judgment. *Grasso v. Angerami*, 79 NY2d 813 (1991). Objective proof of a plaintiff's injury is required in order to satisfy the statutory serious injury threshold. *Toure v. Avis Rent A Car Sys.*, *supra*.

Defendant has submitted two affirmed medical reports, one from New York State licensed neurologist, Dr. Nawnihawl Singh, and the other from New York State licensed orthopedist, Dr. Joseph Lopez. In Dr. Singh's report dated October 11, 2005, he evaluated the cervical spine, lumbar spine, and shoulder joints using flexion, extension, and lateral rotation tests which specify the plaintiff's degree of motion relative to the normal range. In evaluating the cervical spine, the range of neck movement showed flexion at 45° (45° normal), extension at 45° (45° normal), right and left lateral flexion at 45° (normal 45°) and right and left lateral rotation at 80° (80°normal). In the lumbar spine, the range of motion showed flexion at 90° (90° normal), extension at 30° (30° normal), right and left lateral flexion at 30° (30° normal) and right and left lateral rotation at 30° (30° normal). Supine straight leg testing was possible up to 90° on both sides (90° normal). Sitting straight leg-raising test was possible up to 90° on both sides (90° normal). Additionally, the report indicates functional muscle testing, finger-to-nose and heel-to-shin tests, and sensory examinations all within the normal range.

In Dr. Lopez's report dated October 11, 2005, he evaluated the cervical spine and lumbar spine with flexion, extension, and lateral rotation tests which again specify

the plaintiff's degree of motion relative to a normal range. In the cervical spine, the range of motion revealed 50 out of 50 degrees flexion, 50 out of 50 degrees extension, and 50 out of 50 degrees lateral bending and rotation. In the lumbar spine, he detected 70 out of 90 degrees of flexion, extension past neutral, and lateral bending and rotation in 20 out of 20 degrees.

Both physicians allege a cervical and lumbar strain which was causally related to the accident of December 29, 2002. Neither found any permanent disability.

In order to prove the extent or degree of physical limitation, an expert's qualitative assessment of a plaintiff's condition may suffice as long as the evaluation has an objective basis and compares the plaintiff's limitations to the normal function, purpose, and used of the affected body organ. See, *Dufel v. Green*, 84 NY2d 795 (1995). Here, it appears that both physicians used objective, medically accepted tests to conduct an evaluation of the plaintiff's injury using and found no permanent disability that would amount to a serious physical injury under Insurance Law §5102. These physicians found that plaintiff had full range of motion; their affirmed reports are a showing that plaintiff did not sustain serious injury. *Paul v. All Star Rentals, Inc.*, 22 AD3d 476 (2d Dept., 2005). Thus, defendant met his burden to establish a prima facie case for summary judgment.

Once defendant makes a prima facie showing that plaintiff's alleged injuries do not satisfy the serious injury requirement, the burden shifts to the plaintiff to submit admissible evidence to rebut defendant's claim. Two issues regarding the plaintiff's rebuttal of the summary judgment motion are presented: (1) whether the plaintiff has produced sufficient evidence in admissible form to overcome the summary judgment

motion, and (2) whether plaintiff has provided a reasonable explanation for his gap in treatment.

Plaintiff submitted an affidavit from his treating chiropractor Raymond E. Bowles D.C. In the affidavit dated May 2, 2006, Bowles states that, upon re-examination in March of 2006, the plaintiff's cervical spine showed a limitation of motion in all ranges. Using a Goniometer, it was determined that plaintiff was only able to flex to 50° (60° normal) and extend to 40° (50° normal). He was unable to rotate more than 70° to the right or the left (80° normal) or laterally flex more than 30° to the right or the left (40° normal). This amounted to a combined 60° loss of range of motion or approximately 17% loss of total range of motion. In the lumbar spine, it was determined that plaintiff was only able to flex to 60° (90° normal) and extend to 20° (30° normal). He was unable to rotate more than 20° to the right or the left (30° normal). This amounted to a combined 60° loss of range of motion or approximately 27% loss of total range of motion. Additionally, Bowles alleges moderate myospasm upon digital palpitation of the erector spine muscles. X-rays of the cervical spine showed flattening of the cervical lordosis and x-rays of the lumbar spine showed flatted lordosis and a right lateral convexity.

Based on his examination and review of the plaintiff's x-rays, Bowles opined that Falco continues to suffer from various cervical and lumbar conditions which will continue to infringe on his daily living activities. According to Bowles, he will suffer from permanent weakening of these regions which may subject him to frequent exacerbations of his symptom complex which constitute a significant limitation of those body parts and functions.

Generally, the affirmation of the plaintiff's examining physician is sufficient to raise a triable issue of fact when the physician has examined the plaintiff and, inter alia, identified and quantified specific limitations in movement which were significant in nature and substantially impaired the plaintiff's ability to perform his usual and customary work and daily living activities. *Panton v Spann*, 17 AD3d 429 (2d. Dept 2005). Likewise, it is well established that "conflicting medical opinions may not be resolved on motions for summary judgment". *Pittman v. Rickard*, 295 AD2d 1003, 1004 (4th Dept. 2002).

However, plaintiff's history revealed an interrupting factor–a cessation of treatment for nearly eighteen (18) months following the end of his treatment by Dr. Bowles in November of 2003. While cessation of treatment is not dispositive, the law also does not require a record of needless treatment in order to survive summary judgment. A plaintiff who terminates therapeutic measures following an accident, while claiming "serious injury", must offer some reasonable explanation for having done so. *Pommels v. Perez*, 4 NY3d 566 (2005). Even when there is objective medical proof of serious injury, an interruption of the chain of causation between the accident and claimed injury–such as a gap in treatment–may warrant summary dismissal of a complaint seeking no-fault benefits. *Pommels v. Perez, supra*.

This Court finds that the plaintiff has not provided a reasonable explanation for the 18-month gap in treatment. Plaintiff states in his affidavit that he ceased treatment when his insurance benefits lapsed. However, the record is devoid of any evidence in the form of a letter from the insurance carrier as to when and why the carrier

discontinued coverage. *Gomez v. Ford Motor Credit Co.*, 10 Misc.3d 900 (Sup. Ct., Bronx Co. 2005). Similarly, plaintiff has not provided any document from the Dr. Gerard Fusaro who he alleges treated him approximately ten (10) times during the gap in treatment from November of 2003 until May of 2005. Absent any admissible proof of these allegations, the reason proffered by plaintiff for discontinuing treatment remains "conclusory and non-probative". *Gomez v. Ford Motor Credit Co., supra*. Therefore, this gap in treatment is deemed a cessation of all treatment.

Plaintiff advances the argument that he falls within the '90 out of 180 day impairment' distinction of New York Insurance Law §5102. In such case, a gap or cessation in treatment would be irrelevant (see *Gomez v. Ford Motor Credit Co., supra.*). However, in order to establish a serious injury by this definition, plaintiff must show that he was prevented 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". New York Insurance Law §5102. By his own admission, plaintiff was bed-ridden for only one (1) day following the accident and out of work for approximately (7) days thereafter. He goes on to complain of interference of activities of daily living including standing, twisting, lifting, walking, kneeling, stooping, riding his jet ski every weekend rather than the once or twice a month he can tolerate after the accident, and operating box trucks rather than small vans at his place of employment. Vague and conclusory statements by plaintiff are insufficient to establish serious injury, given that plaintiff failed to submit any competent medical evidence that he was unable

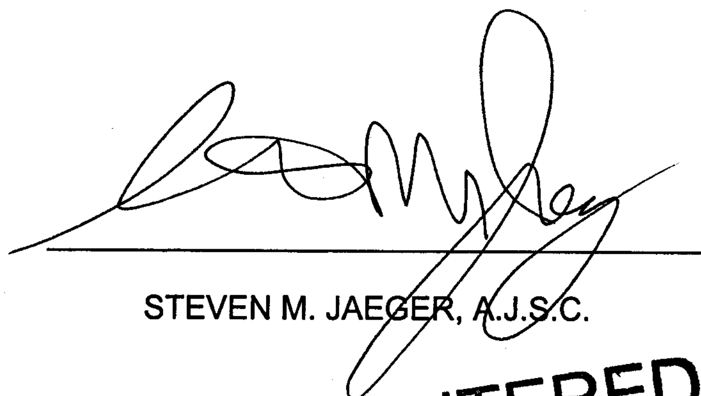
to perform the claimed activities. *Howell v. Reupke*, 16 AD3d 377 (2d Dept. 2005). Plaintiff has not explained the gap in treatment by establishing that his daily activities were substantially impaired for 90 of the first 180 days he was injured.

In sum, it is determined that plaintiff has failed to raise triable issues of fact with regard to the serious injury claim and the 90/180 day rule claim under New York Insurance Law §5102.

Accordingly, summary judgment is granted in favor of the defendant dismissing the Complaint.

This shall constitute the Decision and Order of the Court.

Dated: June 28, 2006



STEVEN M. JAEGER, A.J.S.C.

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