7. AUTOMOBILE LITIGATION: NO-FAULT LAW & BODILY INJURY CLAIMS IN LIGHT OF SERIOUS INJURY THRESHOLD REQUIREMENTS

NEW YORK STATE BAR ASSOCIATION

NO FAULT INSURANCE FUNDAMENTALS:

SERIOUS INJURY THRESHOLD
NO FAULT COVERAGE

Robert A. Glick, Esq.
Brand Glick & Brand, P.C.

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Top Twenty Drivers' Statements

20."A truck backed into my windshield and into my wife's face."

19. "The telephone pole was approaching, I was attempting to swerve out of its way when it struck the front end."

18. "The guy was all over the road. I had to swerve a number of times before I hit him."

17. "I pulled away from the side of the road glanced at my mother-in-law and headed off the embankment."

16. "I had been driving for 40 years when I fell asleep at the wheel and had an accident."

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Top Twenty Drivers' Statements

15. "The pedestrian had no idea which way to run, so I ran over him."

14. "I thought my window was down but found out it was up when I put my head through it."

13. "Coming home, I drove into the wrong house and collided with a tree I don't have."

12. "In an attempt to kill a fly, I drove into a telephone pole."

11. "I was on my way to the doctor with rear end trouble when my universal joint gave way causing me to have an accident."

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Top Twenty Drivers' Statements

10."I was driving in the wrong lane, but I was there first. The car that ran into me didn't show up until much later."

9. "I had been shopping for plants all day and was on my way home. As I reached an intersection, a hedge sprang up, obscuring my vision."

8. "I told the police that I was not injured, but on removing my hat, I found that I had a fractured skull."

7. "I saw a slow-moving, sad-faced old gentleman as he bounced off the hood of my car."

6. "My car was legally parked as it backed into the other vehicle."

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Top Twenty Drivers' Statements

5. "As I approached the intersection, a stop sign suddenly appeared in a place where no stop sign had ever appeared before. I was unable to stop in time to avoid the accident."

4. "A pedestrian hit me and went under my car."

3. "The indirect cause of the accident was a guy in small car with a big mouth."

2. "A bee flew in my window and forced me to hit the pedestrian."

1. "The gentleman behind me struck me on the backside. He then went to rest in the bush with just his rear end showing."

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THE SERIOUS INJURY THRESHOLD

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LICARI v. ELLIOT

While there is little doubt that the plaintiff suffered discomfort as a result of the accident, the court has no choice but to enforce the legislative mandate and dismiss the complaint when a plaintiff fails to meet the burden of proving the threshold requirement of establishing a prima facie case that he sustained a serious injury within the meaning of the statute . . .

***Licari v. Elliot*, 57 N.Y. 2d 230, 441 N.E. 2d 1088, 455 N.Y.S.2d 570 (1982).**

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STATUTORY INTENT

The legislative intent of the no-fault system was to eliminate frivolous claims, restrict recovery to major significant injuries.

A specific goal of the no-fault system is to prevent minor automobile personal injury cases from being litigated.

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NEW YORK INSURANCE LAW SECTION 5104(a):

…in any action by or on behalf of a covered person against another covered person for personal injuries arising out of negligence in the use or operation of a motor vehicle in this state, there should be no right of recovery for non-economic loss, except in the case of serious injury, or for basic economic loss.

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NEW YORK INSURANCE LAW SECTION 5102(d):

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

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

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A Personal injury which results in:

- **Death;**
- **Dismemberment;**
- **Significant disfigurement;**
- **Loss of fetus;**
- **Fracture;**
- **Permanent loss of a body organ, member, function or system;**

Oberly v. Bangs Ambulance, 96 N.Y.2d 295 (May, 2001)

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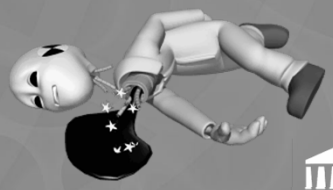
Oberly v. Bangs Ambulance, 96 N.Y.2d 295 (May, 2001)

For a permanent loss of use of a body organ, member, function or system to qualify as a "serious injury," the loss of use must be ***total.***



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A Personal injury which results in:

- **Death;**
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- **Significant disfigurement;**
- **Loss of fetus;**
- **Fracture;**
- **Permanent loss 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 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.

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Permanent or Consequential Limitation of a Body Organ or Member	Significant Limitation of Use of a Body Function or System
Significant Limitation of use	**Significant Limitation of use**
Limitation *must* be permanent *and* total	**Limitation *need not* be permanent**
Limitation must be to a *body organ or member*	**Limitation must be to a *body function or system***

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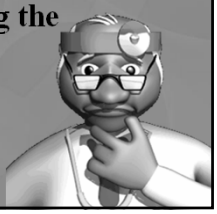
90/180 Day Rule

The inability to perform the required acts lasted for at least 90 days during the first 180 days following the accident;

Substantially all of his usual activities (material acts) were curtailed;

Competent medical evidence that he sustained an injury or impairment as a result of the accident; and

Competent medical evidence that the injury sustained was a cause of the alleged disability or impairment during the applicable period.



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SUMMARY JUDGMENT

Burden of Proof

Defendant's Burden

Initially the burden of proof is on the Defendant to present competent evidence that the plaintiff did not sustain a "serious injury" within the meaning of §5102(d).

Plaintiff's Burden

After the defendant meets his initial burden, ***the burden of proof shifts to the Plaintiff*** to prove that he has suffered a "serious injury."

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GRANTING SUMMARY JUDGMENT ON LIABILITY DOES NOT ESTABLISH SERIOUS INJURY

Granting of the plaintiff's motion for summary judgment as to liability does not automatically create a finding that the plaintiff sustained a serious injury, when the issue of serious injury was not raised in the motion.

Zeca v. Riccardelli
(May 8, 2002)

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PLAINTIFF MUST ESTABLISH *"OBJECTIVE"* PROOF

Toure v. Avis Rent-A-Car Systems

Manzano v. O'Neill

Nitti v. Clerrico

(July, 2002)

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TOURE, MANZANO & NITTI

"Expert Opinions not backed by objective proof will not be sufficient to establish a serious injury"

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SUMMARY JUDGMENT

Satisfying the Burden

- **Medical proof**
- **Subjective complaints are not sufficient**
- **Sworn medical statements are required**
- **Tracking the statutory language is not sufficient**
- **Conclusory statements are not sufficient**
- **Sworn medical opinions must be formed shortly after examining the plaintiff**
- **Include plaintiff's affidavit to establish plaintiff has been out of work or can't partake in daily activities**

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RECENT CASES

Pommells v. Perez

Brown v. Dunlap

Carrasco v. Mendez

(Decided April, 2005)

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Pommells/Brown/Carrasco

- Three cases consolidated for appeal purposes.
- Proof of a herniated disc, without additional objective medical evidence establishing significant physical limitations is in sufficient.
- Unexplained interruptions (gaps or terminations) in treatment may not satisfy plaintiff's burden.
- A plaintiff is not required to continue treatment that would be "palliative in nature" – but it must be explained.
- A Plaintiff's failure to refute preexisting conditions that caused the plaintiff's injuries will not survive summary judgment.

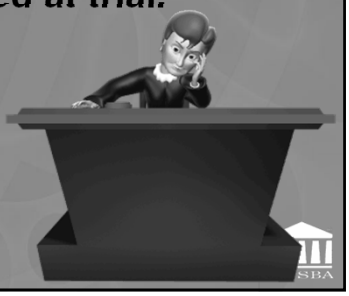
The Impact of Pommells/Brown/Carrasco

Where there are significant gaps in treatment and/or pre-existing injuries, plaintiffs can no longer escape dismissal of their claims by having a physician causally relate the injury to the accident.

Plaintiff must be able to explain these significant causation issues or provide a reasonable excuse.

TRIAL

If the plaintiff makes a threshold showing sufficient to defeat the defendant's motion for summary judgment, the issue of whether there has been a "serious injury" becomes a question of fact to be determined at trial.



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PRACTICAL CONSIDERATIONS

- **Initial case analysis: Does the plaintiff meet the threshold?**
- **Use the Threshold as a tactic during settlement discussions**
- **Obtain all medical records and review them carefully**
- **Does the plaintiff need to be examined to determine if he/she will meet the threshold?**
- **Remember, courts are not inclined to grant summary judgment**
- **Be sure the examining physician uses objective tests**
- **Be sure your proofs are submitted in proper form**

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NO FAULT LAW

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INTRODUCTION

What is a no-fault claim?

- A breach of contract claim.
- Six (6) year statute of limitations period based upon the failure of the insurer to reimburse for medical treatment tendered due to injuries sustained a motor vehicle accident.

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ARBITRATION vs. LITIGATION

Contrast and Comparison

Arbitration

- Inexpensive
- Two-step process:
  - Conciliation: Mediation phase where both parties exchange respective position, followed by Arbitration
- Relaxed rules of evidence (i.e. no requirement to authenticate documents)
- No discovery required
- Claimant customarily fails to provide all necessary documents to administer claim (failure to produce initial evaluation, treatment notes, or letter of medical necessity)
- For Claims under $2,000, appearance not required.

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ARBITRATION vs. LITIGATION

Contrast and Comparison

Litigation

- Slow moving (due to plaintiff inaction)
- Expensive (discovery i.e. written interrogatories, document production)
- Rules of evidence in force (i.e. IME physicians must testify as to IME cut-off)
- Courts unfavorably view no-fault claims

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APPEALS

Master Arbitration
Appellate Division

Same Results.
Unlikely to overturn prior decision.

GROUNDS TO VACATE ARBITRATION DECISION

- The rights of a party were prejudiced by:
  - Corruption, fraud or misconduct in procuring the award
  - Partiality of the arbitrator
  - The arbitrator exceeded his/her power.

INDEPENDENT MEDICAL EXAMINATION

- Scheduling letters:
  - If represented, sent to attorney of record;
  - May schedule any time. Generally one month after accident;
  - Letter must contain mandatory reimbursement for transportation and/or lost income;
  - All treatment before first IME no-show must be paid in full;
  - For fractures, bulges, and/or herniations, schedule orthopedist;
  - For soft tissue injuries, refer to neurologist;
  - If psych, chiropractor, or acupuncture, received, refer to IME physician in each discipline.

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PEER REVIEW(s)

- Situations when it should be considered:
  - Unnecessary and frivolous medical testing and treatment;
  - Availability of alterative low-cost treatment;
  - Unscientifically proven medical testing (CPT: Current perception threshold testing);
  - Who should perform peer reviews?
    - Doctors – Doctors - Doctors
      A treating physician's opinion will carry significantly more weight than a nurse practitioner second guessing his/her prognosis.

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FORM NF-1O

- Must include the following:
  - Signed and dated including dates of service billed and when they were received by insured;
  - Must include ***all bases*** upon which the claim is being denied;
  - If conducting SIU investigation and/or peer review, do not send NF-10 -- Send delay letter;
  - Unless you have a valid coverage defense (no policy), an untimely denial will be fatal.

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"DELAY" LETTERS

- What are their purpose?
  - To advise the claimant and/or medical provider of an on-going investigation or permit sufficient time outside the 30 days to verify the treatment tendered by requesting additional information or to conduct peer reviews.
- When do you send them?
  - Within 15 days of receipt of the first bill:
    - If claim is still pending, send another delay letter within 10 days;
    - If on-going, send one at least once a month;
    - When investigation completed, send NF-10. In NF-10, refer back to all dates of delay letters.

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OGC OPINIONS

For all questions not fully addressed in the NY PIP regulations, the NYS Insurance Department for the Office of General Counsel prepare opinion letters on written question presented.

NOTICE REQUIREMENTS

- The time for claimant to submit written notification of an accident is 30 days.
- Notice is satisfied by the insurer's receipt of an MV-104 or other accident report indicating injury, the applicant's submission of an NF-2 application for no-fault benefits, or by the insurer's receipt of a completed hospital facility form (NF-3).
- When an insured denies a claim based upon late notice, the denial must advise the applicant that late notice will be excused where the applicant can provide reasonable justification of the failure to give timely notice.

NOTICE REQUIREMENTS

(CONTINUED)

- What is clear and reasonable justification?
  - The OGC advised that "it would be difficult to create an encompassing list which would have uniform applicability, but the new proposal includes provisions that require insurers to establish reasonable objective standards for review of late notice of claim and late submission of proof of claim.
  - The regulation specifies that appropriate consideration must be given to pedestrians and non-related occupants of motor vehicles who may have difficulty ascertaining the insured.
  - Additionally, a denial for late submission should not be based upon a third-party's failure to provide the information necessary to establish the claim.

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PROOF OF CLAIM

- Failure by any medical provider to submit written proof of claim within 45 days from the date of service is required to ensure payment.
- An insurer may deny based upon a violation of the 45 day rule except in the instant where "there is a clear and reasonable justification" for the delay in forwarding the billing.

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	REGULATION 68-A	1ST AMENDMENT TO REG. 68-C	1ST AMENDMENT TO REG. 68-D
Policy Conditions			
Notice Requirement of Claim	30 Days	---	---
Medical	45 Days	---	---
Work Loss	90 Days	---	---
Other Necessary Expenses	90 Days	---	---
Relief for Failure to Comply	Demonstrate clear and reasonable justification for failure to comply. File for expedited arbitration.		
Claim Practice Procedures			
Acknowledgement of Claim	Section 65-3.4(b) Application within 5 business days. If claim sent to incorrect office, application must be forwarded within at least 10 business days.		
Procedures	Section 65-3.5(a) Send other forms with NF2. Speeds up process.	---	---
	Section 65-3.5(b) May request any information "to establish proof of claim."	---	---

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	REGULATION 68-A	1ST AMENDMENT TO REG. 68-C	1ST AMENDMENT TO REG. 68-D
Examination Under Oath	Section 65-3.5(3) Insurer must have objective standard for conducting examination under oath.	---	---
Late Notice	Section 65-3.5(l) Carrier must establish standards for review of late notice of claim and late proof of claim. Must have supervisory review of claims denied.	---	---
Electronic Data	Section 65-3.5(k) Carriers with more than 1,000 policies are required to establish procedures for receipt of claims, notices, and verification by fax or electronic transmittal.	---	---
Interest on Overdue Claims	Section 65-3.9 % simple interest	---	---
Attorney's Fees:	Section 65-3.10(a)	---	---
No Denial	Increases attorney fee prior to arbitration to 20% of amount overdue plus any interest subject to maximum of $60.00		
Denial Issues	Section 65-3.10(a) $80.00 attorney fee due when a claim is denied and settled prior to arbitration.		
Direct Payments	Section 65-3.11(a) Limits assignment to health care services as provided in Section 5102(a)(1) and Section 5102(a)(2) of Insurance Law.	--- Requires provider to submit properly executed assignment on NF-3 or NF-AOB.	---

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	REGULATION 68-A	1ST AMENDMENT TO REG. 68-C	1ST AMENDMENT TO REG. 68-D
Direct Payments (Cont'd)	---	Section 65-3.11(c) Insurer may request in writing original assignment.	---
Medical Benefits	Section 65-3.16(a)(12) Provider of health care benefits must meet State and local licensing requirements.	---	
Optional Arbitration Procedures			
Special Expedited Arbitration	Section 65-4.5(b) To resolve disputes that solely involve late notice of claim. Conciliation Center will walk claim through. Will be mailed to arbitrator within 1-2 days. Arbitrator has 10 days to issue decision. Rocket Docket.	---	Section 65-4.2(b)(3) Applicant to submit all supporting documents with arbitration request. Document submitted later will be marked "late" (except additional or on-going benefits). Carrier has 30 days to respond to arbitration notice from Conciliation Center otherwise marked "late." Insurer may, in writing, request additional 30 calendar days to respond.

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PRIMA FACIE CASE AND BURDEN OF PROOF

- If the denial is untimely, the insurer is precluded from raising any defenses to the applicant's claim for no-fault benefits
- Therefore, as long as the provider is able to establish that it performed the services billed, any challenge as to the medical necessity of such treatment is barred under the 30 day rule.

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THE EBB AND FLOW OF PIP FRAUD

- Medical no-fault (PIP) claim costs are rising faster in New York than anywhere else in the country.
- The sudden surge in claims costs is the result of greater frequency of claims as well as extraordinarily large increases in the average cost per claim.
- Medical no-fault claim frequency in New York is 30% above the median no-fault state while New York's average cost per claim is more than double the no-fault median.
- The rise in frequency and cost of medical no-fault claims cannot be explained by any economic factors such as increases in medical inflation.

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THE ANATOMY OF A FRAUD

- The more common crimes associated with auto insurance are staged accidents, stolen identities, fraudulent police reports, and "jump-ins."
- Owners and managers of medical clinics pay "runners" or recruiters to arrange minor auto accidents and send individuals supposedly injured in the accidents to the clinics for treatment.
- Although staged accidents are intended to cause no real injuries to the defendant driver or passengers, the accidents are reported to police so that a record can be created to support the fraudulent insurance claims.
- Medical bills often reach $10,000 to $20,000 per passenger and can go as high as $50,000 per passenger under the New York no-fault law. A single staged accident with multiple claimants generally results in billings for hundreds or even thousands of treatments.

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THE MANY FACES OF MEDICAL FRAUD

Flaws in New York's no-fault laws have permitted perpetrators of fraud to get away with a surprisingly wide array of abuses. Virtually all insurers have indicated significant fraud and abuse in the following areas:

- **Provider Billing**
- **Durable Medical Suppliers**
- **Transportation "Provider" Bills**
- **Lost Wages**
- **Household Help**

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THE MANY FACES OF MEDICAL FRAUD

(continued)

- **Exotic Medical Treatments:**
  - **Aromatherapy**
  - **Biofeedback**
  - **Acupuncture**
  - **Psychotherapy**
  - **Massages**
  - **Whirlpool Sessions**
  - **Electrical Stimulation**
  - **Thermography**
- **Treatment Frequency**

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OTHER TYPES OF FRAUD

- ***Identity Fraud***
- ***Bounced Checks***
- ***Garaging***

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GARAGING INVESTIGATION

- Circumstantial proof required to disclaim coverage *ab initio* (retroactive to the inception date of the policy)
  - All NF-2, NF-3 and police report record a NY address.
  - Initial reservations of rights letter.
  - Retention of NY investigator to obtain NYSDMV information and visit location of insured and secure insured recorded statement (if not represented).
  - Send SIU adjuster to alleged MA address listed on policy to ascertain whether its a valid address and/or whether the individual ever lived or principally garaged their vehicle at the location.
  - Trace report establishing insured residential history.
  - Registration and licensing of vehicle and insured.
  - Schedule EUO as last resort to bolster investigation.

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CASES OF INTEREST

- Payment priority
- Insurer must show lack of medical necessity.
- Establishing fraud requires clear and convincing evidence.

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CASES OF INTEREST
(CONTINUED)

- Blanket disclaimers do not eliminate insurer's obligation to pay or deny claims within 30 days.
- Verification requests sent within 25 days considered timely.
- Insurer's failure to timely disclaim coverage precludes it from denying claims

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CASES OF INTEREST
(CONTINUED)

- Insurer can request verification of medical necessity from medical supply company.
- Non-payment complaint against insurer dismissed for assignor's failure to appear at pre-claim exam.
- Court defines medical necessity.

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CASES OF INTEREST
(CONTINUED)

- Discovery motion denied for failure to include denial of claim or demand for verification forms.
- Insurer met burden to show accident was staged by using circumstantial evidence.

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NEW YORK STATE BAR ASSOCIATION

NO FAULT INSURANCE FUNDAMENTALS:

SERIOUS INJURY THRESHOLD
NO FAULT COVERAGE

Tuesday, May 16, 2006

Robert A. Glick, Esq.
Brand Glick & Brand, P.C.

NYSBA
NYSBACLE

NO-FAULT FUNDAMENTALS

SUBMITTED BY:

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I. No Fault Fundamentals

A. The Comprehensive Automobile Insurance Reparations Act, initially codified in 1973, and re-codified in 1984 as Article 51 of the Insurance Law of the State of New York.

1. Limited legislative comments can be found in the Governor's memorandum Approving L. 1973, ch. 12, 1973 N.Y. Legis. Ann., at 298.; and Report of the Joint Legislative Committee on Insurance (NY Legis doc, 1973, No. 18).

B. Part 65 (Regulation 68) of Title 11 of the New York Official compilation of Codes Rules and Regulations.

1. Cited as 11 NYCRR sec 65 et sec, these are the regulations implementing the No-Fault Law. They are promulgated by the Superintendent of Insurance and carry the force of law. So long as the regulations are consistent with Article 51 of the Insurance Law, the Insurance Department has "broad authority" to implement them.

2. The most recent version of the regulation, effective April 5, 2002, can be found at the New York State Insurance Department's website @ www.ins.state.ny.us.

3. State Administrative Procedure Act (SAPA) – The only published explanation of the Superintendent's intentions regarding proposed regulations.

C. Court and Arbitration Decisions

1. Many lower and Master Arbitration decisions are published in the "No-Fault SUM Reporter," which also includes articles and topics regarding no-fault coverage. Not all decisions are published, however; thus, decisions contrary to those in the SUM Reporter may exist.

2. Arbitration decisions may be confirmed in the Courts but otherwise carry no precedent.

3. Rulings in both a plenary action and arbitration are res judicata and collateral estoppel with respect to each other.

D. Advisory Opinions and Circular Letters

1. Anyone may seek the opinion of the General Counsel of the State Insurance Department. Such opinions do not carry the force of law but are to be given "deference" by the Courts. Many of these opinions are available through the Freedom of Information Law.

II. Statute

NY CLS Ins § 5106(a):

Payments of first party benefits and additional first party benefits shall be made as the loss is incurred. Such benefits are overdue if not paid within thirty days after the claimant supplies proof of the fact and amount of loss sustained. If proof is not supplied as to the entire claim, the amount which is supported by proof is overdue if not paid within thirty days after such proof is supplied. All overdue payments shall bear interest at the rate of two percent per month. If a valid claim or portion was overdue, the claimant shall also be entitled to recover his attorney's reasonable fee, for services necessarily performed in connection with securing payment of the overdue claim, subject to limitations promulgated by the superintendent in regulations.

III. Regulations

Four sections:

65-1 Prescribed policy endorsements
65-2 Rights and liabilities of Self-Insurers
65-3 Claims processing
65-4 Arbitration/Litigation

In 2002, the Secretary of the Insurance Department released regulations, based on Insurance Law §5106(a), which changed many of the procedural time limits governing first-party no-fault benefit claims. The old regulations apply to all claims brought on and

before 4/3/2002. But the new regulations apply for those claims filed on or after 4/4/2002.

A. Mandatory Personal Injury Protection 65-1.1

The company will pay first-party benefits to reimburse for basic economic loss sustained by an eligible injured person on account of personal injuries caused by an accident arising out of the use or operation of a motor vehicle or a motorcycle during the policy period and within the United States of America, its territories or possessions, or Canada.

First-party benefits, other than death benefits, are payments equal to basic economic loss, including medical expense, work loss, other expense and, when death occurs, a death benefit as herein provided.

An eligible injured person is any person who sustains a personal injury arising out of the use or operation of the insured motorcycle while not occupying the insured motorcycle, any other motorcycle or a motor vehicle.

1. **Notice**. **65-1.1 and 65-2.4**.

   a. A claimant's time frame for the submission of "written notice" of an accident is 30 days after the accident (old regulations 90 days). "Written notice" is defined as reasonably obtainable information regarding the time, place and circumstances of the accident.

   b. The most common way of providing written notice is by the submission of an Application for No-Fault Benefits (NF-2). However, sufficient notice can also be provided by submission of a police report, motor vehicle accident report (MV-104) or a letter. The insurance carrier, within a certain prescribed time frame, may request that a **completed** NF-2 be submitted. **65-3.5(f)**.

   c. Failure to submit "written notice" within 30 days may be excused if there is "clear and reasonable justification" for such failure. The burden lies with the claimant to demonstrate such an excuse, although the carrier must advise the claimant in its denial that such late notice will be excused if it can provide such.

   d. Where the insurer determines that "clear and reasonable justification" was not established, the regulations provide for a **special expedited arbitration** proceeding to resolve such disputes. **65 4.5 (b)(1)-(8)**.

   e. An applicant may request a special expedited arbitration within 30 calendar days after mailing of the denial of claim by the insurer.

The applicant is required to make a complete submission supporting his/her position, at the time of the request.

f. Applications for special expedited arbitration must be submitted to the conciliation center and are to comply with the requirements for initiation of arbitration contained in section **65-4.2(b)(1)**.

2. **Proof of Claim**. **65-1.1 and 65-2.4**.

a. The no-fault regulations require a claimant submit medical bills within 45 (old regulations 180 days) days after the date of service was rendered.

b. As with the "written notice" requirement, failure to submit "proof of claim" within 45 days may be excused "if there is a clear and reasonable justification."

In Central Bronx Medical, P.C., a/a/o Maria Gomez v. Countrywide Ins. Co., No. 47757/2005, (Civil Ct., County of Bronx, October 27, 2005), the Court determined that a denial, based upon late submission of proof of claim, is defective as a matter of law if it fails to comply with the statutory mandate of 11 NYCRR §65-3.3. The Court noted that the denial of claim form failed to contain the statutorily required language of 11 NYCRR §65-3.3(e), "which states that 'such denial must advise the applicant that **late notice will be excused** where the applicant can provide reasonable justification of the failure to give timely notice.'" Id. (emphasis added).

Similarly, in Metro Medical P.C., a/a/o William Lopez v. Countrywide Ins. Co., No. 52890/03, (Civil Ct., County of Bronx, February 17, 2006) the Court held that a denial of claim form, based upon late submission of the bill, and not containing the statutorily required language of 11 NYCRR § 65-3.3(e), was invalid.

Most recently, the Appellate Term heard this issue and affirmed what the lower courts had already decided. Where an insurer's Denial of Claim form fails to advise a claimant that a late submission of a claim will be excused with a reasonable excuse, the insurer "waive[s] reliance on the 45-day rule as a basis to deny the claims." SZ Medical, P.C. v. Country-Wide Ins. Co., 2006 NY Slip Op 26194 (Appellate Term for the 2nd & 11th Judicial Districts, 2006).

c. The insurance carrier is required to establish standards for review of late proof of claim, which must include situations in which the claimants have difficulty determining the identity of the insurance carrier, or inadvertently submit a claim to the wrong insurance carrier, although it apparently does not have to release such standards to claimants/public.

d. There is no provision for a special expedited arbitration for the issue of late "proof of claim."

3. **Examinations Under Oath (EUO)**. **65-3.5(d) & (e)**.

a. Under the new regulations, an insurance carrier is authorized to request an examination under oath of the claimant or their **assigns** as often as may be "reasonably" required. Consequently, injured parties, as well **as health care providers** may be required to submit to such examinations. Insurance carriers must demonstrate a "**specific objective justification**" in support of their use of a EUO to be submitted to the State Insurance Department for review, although there does not appear to be any requirement that the carrier provide the claimant with such rationale.

b. 65-3.5(d) adopts the same rules for EUOs as those in effect for Independent Medical Examinations (IMEs), including that the examinee is entitled to reasonable transportation costs and lost earnings as compensation. Moreover, EUO must be scheduled within 30 days of when proof of claim is received.

An insurer asserting ANY defense of "lack of cooperation" must meet a heavy burden. In Thrasher v. US Liability Insurance Company, 278 NYS2d 793, the Court of Appeals enunciated a three-prong test:

(a) that the insurer acted diligently in seeking about the insured cooperation,
(b) that the efforts were reasonably calculated to obtain the insured's cooperation, and,
(c) that the attitude of the insured was one of "willful and avowed obstruction."

4. **Independent Medical Examinations (IME)**. **65-3.5(d) & (e)**.

a. Retroactive IMEs/No Shows

An insurance carrier will often schedule independent medical examinations for the insured and then deny payment when the insured fails to attend two scheduled exams. Some insurance carriers will deny payment from the date of the first missed IME, while others will deny payment from the date of loss. The latter scenario is commonly referred to as the "retroactive IME" issue.

The appearance of the insured for IMEs at any time is a condition precedent to the insurer's liability on the policy. The Appellate Division recently held that an insurer can successfully deny a claim where a claimant fails to appear for an IME regardless of whether or not the failure to appear occurs before the submission of the claim or after the submission. Stephen Fogel Psychological, P.C. v. Progressive Cas., 35 A.D. 3d 720, 827 N.Y.S. 2d 217 (2nd Dept., 2006).

However, in order to succeed in a motion for summary judgment, based on a claimant's failure to appear for an IME, the insurer must "submit evidence in admissible form from anyone with personal knowledge of the nonappearances." Chi Acupuncture, P.C. v. Kemper Auto & Home Insurance Co., No. 2005-01893 SC (App. Term, 9th & 10th Dist., February 14, 2007).

b. Maximum Medical Improvement

Hobby v. CNA Ins. Co., N.Y.A.D. 4th Dep't.700 NYS2d 346.

An insurance carrier terminated no-fault benefits based upon an examination by an IME doctor indicating that the insured reached "maximum medical improvement," meaning that medical treatment was no longer improving her condition rather it was merely relieving her pain.

The Appellate Division (Fourth Department) held, "that the Supreme Court properly granted plaintiff's motion for summary judgment compelling defendant, CNA Insurance Company (CNA), to pay outstanding medical bills pursuant to the no-fault provisions contained in plaintiff's motor vehicle insurance policy."

The Court found no authority in the Insurance Law for discontinuing payment on the ground that the patient reached "maximum medical improvement." In fact, the Court found that Insurance Law 5102 (a)(1) provides up to $50,000 for "**all necessary expenses**" without limitation as to time, "provided that within one year after the date of the accident…it is ascertainable that further expenses may be incurred as a result of the injury."

Interest Accrual.

a. As a penalty for an insurer's failure to timely pay a claim, interest (simple 2% per month) is imposed on all overdue claims (2% per month compounded for old regulation cases). Insurers cannot request that interest be waived even as a condition of settlement. **65-3.9**.

Verification Requests

a. An insurance carrier has 15 business days (old regulations 10 business days) after its receipt of a no-fault claim within which to request additional verification. **65-3.5(b)**.

If any requested additional verification (e.g., IME, EUO or other medical documentation) has not been supplied to the insurer thirty

calendar days after the original request, the insurer shall, within ten calendar days, follow-up with the recalcitrant party "either by telephone call, properly documented in the file, or by mail." 11 NYCRR § 65-3.6(b)

Where an insurer fails to issue a timely follow-up request to its initial verification request, the thirty-day claim determination period is not tolled. See, A.B. Medical Services v. Utica Mut. Ins. Co., 2005 NY Slip Op 25456, 10 Misc. 3d 50 (App. Term 2nd Dept., 2005).

An insurer's failure to strictly comply with follow-up procedures and timetable verification set out in No-Fault law and governing regulations preclude the insurer from denying No-Fault coverage benefits to medical service providers, as insured's assignor. Bronx Med. Services v. Windsor Ins. Co., 2003 NY Slip Op 50885 U, 2003 WL 21173634 (App. Term 1st Dept., 2003).

If the 30 days has lapsed, and the insurance carrier has failed to make a timely follow-up request, the carrier will be deemed to have failed to pay or deny the claim within the statutory time. King's Med. Supply Inc. v. Allstate Ins. Co., 2005 NY Slip Op 50451U, 7 Misc. 3d 128A (App.Term 2nd Dept., 2005).

Pursuant to NYCRR § 65.15(g), a claim for no-fault benefits need not be paid or denied until all demanded verification is provided. The Appellate Division for the Second Department has held that an insurer shall not issue a Denial of Claim form prior to its receipt of all relevant requested verification. NY Hosp. Med. Center of Queens v. Country Wide Ins. Co., 295 A.D. 2d 583, 585, 744 N.Y.S. 2d 201. Further, a Denial of Claim form issued by an insurance carrier before it has received all the information it had requested has no effect. Ocean Diagnostic Imaging v. Utica Mut. Ins. Co., 2005 NY Slip Op 51747U, 9 Misc. 3d 138A (App. Term 1st Dept., 2005).

b. Delay Letters

A delay letter, merely informing a claimant that a decision to pay the claim is delayed pending an investigation, is inadequate to toll the 30-day time period. Melbourne Medical, P.C. v. Utica Mutual Ins. Co., 4 Misc. 3d 92, 781 N.Y.S. 2d 819 (2nd Dept., 2004); Rigid Medical of Flatbush, P.C. v. New York Central Mutual Fire Ins. Co., 2006 NY Slip Op 50582U, 2006 N.Y. Misc. LEXIS 749 (2nd Dept., 2006).

Direct payments/transportation expenses

a. **65-3.11 (a)** entitled "direct payments" instructs that an insurer pay benefits "upon assignment by the applicant …directly to **providers of health care services** as covered under section five thousand one hundred two (a) (1) of the insurance law." Note that Section 5102(a)(1) excludes transportation companies from its list.

b. Thus, a claimant can still recover reasonable transportation expenses but cannot assign its first party right thereto.

Assignment of Benefits Form (NF- AOB). **65-3.11(b)(iv)**.
Enacted pursuant to Emergency Amendments.

a. The AOB prohibits health care providers from pursuing payment directly from the patient, even if the health care provider is unable to obtain reimbursement from the insurance carrier. The regulations allow for certain exceptions to this rule such as the patient's failure to have insurance coverage or for a patient's violation of policy conditions.

The Appellate Division, Second Department, has held that the failure to "allege any deficiency in the hospitals assignment in its denial of claim, "resulted in a waiver of "any such defense" Presbyterian Hospital in the City of New York v. Aetna Casualty and Surety Company 233 A.D. 2d 433, 650 N.Y.S. 2d 602 (2nd Dept., 1996); Hospital for Joint Diseases v. Allstate, 21 A.D.3d 348, 800 N.Y.S.2d 190, (2nd Dept, 2005); Medwide Medical Supply v. Country-Wide Insurance Company, 8 Misc.3d 131(A), (Appellate Term, 2nd and 11th Judicial District, 2005).

b. In addition, both the patient and the health care provider must sign the AOB. The insurance carrier can condition payment upon the claimant's submission of the **original** AOB. **65-3.11(c)**.

c. In lieu of executing the AOB, the claimant can complete an authorization of benefits to the provider which allows payment to be made to such but does not transfer all first party rights and benefits to bring an arbitration or plenary action on its behalf.

Remember, a carrier must accept proof of claim on a document other than the prescribed form if it contains substantially the same information. 65-3.5(a)

Arbitration.

a. Subsections (b thru f) cited below were enacted pursuant to Emergency Amendments, effective for arbitrations submitted **subsequent to March 1, 2002,** while subsections (g thru l) were enacted pursuant to the new Regulation 68-D, effective for all arbitrations submitted **subsequent to April 5, 2002.**

b. The emergency amendments revised the way in which supporting documents are to be submitted by the parties. **The Applicant must submit all documents supporting its position along with its request for arbitration**. Following this initial submission, "no additional documents may be submitted by the applicant other than bills or claims for ongoing benefits." **65-4.2 (b)(3)(i)**. The Respondent has 30 days to provide its documents after which time the "written record shall be closed." **65-4.2(b)(3)(ii) & (iii)**.

d. The amendments also allow for a quicker scheduling of hearings in situations where the Applicant files **promptly**. Accordingly, an Applicant filing for arbitration within 90 days after a claim is denied or overdue shall have a hearing scheduled within 45 days after transmittal from the conciliation center. **65-4.2(i)(ii)**.

e. **A more** significant amendment pertains to the imposition of costs. An arbitrator is permitted to impose administrative costs upon the applicant or apportion them between the parties if the arbitrator determines that the Applicant's request "**was frivolous, was without factual or legal merit or was filed for the purpose of harassing the Respondent**." **65-4.2(t)(i)**.

f. **65-4.5 The regulations** allows disputes submitted to AAA that involve less than $2000 to be determined upon the written submission of the parties.

g. **65-4.5(o)(1)** greatly increases the power of an arbitrator to raise **any** issue or demand **any** information they feel necessary to adjudicate the matter.

h. **65-4.6(b)(1)** increases the attorney fee from **$60 to $80** for denied claims resolved by the **Conciliation center** AAA prior to a hearing.

However, if the claim was simply overdue, but not denied, the attorney fee remains $60. The SID apparently values a denied claim more than one that the insurer simply ignored.

i. Prior to transmittal to arbitration, the insurer may make a non-binding written offer to resolve the dispute. Such offer, if not accepted by the applicant, shall be transmitted to the arbitration forum, but shall not be disclosed to the arbitrator. The parties to the dispute shall also not disclose the offer to the arbitrator. However, if such offer equals or exceeds an award by the arbitrators, the attorney's fee shall not be the normal 20% of the first party benefit awarded, plus interest thereupon, subject to the maximum fee of $850, but rather $60.

j. **65-4.6(j)** provides that if the charges submitted by a health service provider are in excess of those allowed under the fee schedule, no attorney's fee shall be owed. This provision does not apply to interpretations of the fee schedule, however.

IV. Prima Facie Case and Burden of Proof

Two related issues of emerging significance in the area of No-Fault law concern the establishment of a prima facie case and the requisite burden of proof. The most common scenario giving rise to these issues is one in which the insurance carrier, as a result of its failure to deny a claim within the statutorily prescribed thirty day time frame, is precluded from raising any defenses to the applicant's claim for no-fault benefits. The question then becomes how does a claimant establish prima facie entitlement to no-fault benefits.

1. **Plenary action**

The rules of law emerging from the Courts are as follows: An untimely (not within 30 days of receipt by the carrier) denial precludes the carrier from preserving the defense contained in the denial of the claim with few exceptions. Medical necessity is a defense to be raised by the Defendant and subject to preclusion. Consequently, if medical necessity is raised in an untimely denial, the Defendant is precluded from denying the claim and therefore challenging the adequacy of Plaintiff's demonstration of medical necessity (i.e the Plaintiff's prima facie case). Accordingly, the Plaintiff's prima facie burden is satisfied by the mere submission of the statutory forms of proof of claim.

a. The governing decisions.

The Thirty-Day Rule

No-fault benefits are overdue if not paid within 30 days. An insurer's failure to pay or deny a claimant's claim with thirty days of its receipt results in the insurer being precluded from denying the claim. The insurer's time may be tolled when it makes certain timely requests for additional verification. A timely request restarts the 30 day clock in which to pay or deny the claim on the date the insurer receives all the

additional verification, or the date the Examination Under Oath or Independent Medical Examination was held. 65-3.8 (a)(1)

Presbyterian Hospital v. Maryland Casualty Co., 90 N.Y.2d 274, 660 N.Y.S.2d 536 (1997).

The Court of Appeals adopted the Appellate Division's holding that "**preclusion of the insurance company's ability to deny the claim** is the appropriate remedy where…the insurance company neither denies a claim within 30 days after receiving it nor seeks to extend that time by requesting verification in the prescribed forms." (Emphasis added).

Central General Hospital v. Chubb Group of Ins. Co., 90 N.Y.2d 195 (1997).

The Court of Appeals carved out an exception to the 30 day rule by holding that the issue of "lack of coverage" is not subject to preclusion despite an untimely denial. Defendant has burden to establish, through admissible form, the premise based upon well-founded facts (not speculation) that the exception applies. See Mt. Sinai Hospital v. Triboro Coach Inc., 263 A.D.2d 11 (2nd Dep't 1999). It is NOT plaintiff's burden to show that the injuries sustained in the automobile accident are causally related.

State Farm Ins. Co. v. Mallela, 4 N.Y. 3d 313 (2005).

An insurance carrier can withhold no-fault reimbursement to a health care provider that is not incorporated in accordance with NY Business Corporation Law § 1507. Such inquiries, however, are limited solely to situations where there exists "good cause" to do so.

NY Presbetyrn v. Empire Insurance Co, 728 NYS2d 684, carrier is precluded from raising defense that proof of claim was not submitted within 180 days from services. This would also now apply to the 45 day regulation.

The defense that the charges were not submitted in accordance with the fee schedule has also been held to preclusion if not raised within 30 days. See, NY Hosp. Medical Center of Queens v. Countrywide Insurance, 744 NYS2d 20; Mingmen Acupuncture v. Liberty Mutual Ins., Appellate Term, 9th & 10th District, April 2, 2002.

The defense that the accident was a staged event was NOT precluded even If not raised within 30 days. Metro Medical Diagnostic, v. Eagle, 741 NYS2d 28.

Prima Facie Case

Evidence of submission of Proof of Claim establishes a prima facie case of entitlement to No-Fault benefits.

Plaintiff's prima facie case for No-Fault benefits is established and demonstrated upon compliance with the following: (1) submitting the appropriate verification forms, otherwise known as Proof of Claim. Melbourne Medical,P.C. a/a/o Cabreja v. Utica Mutual Ins. Co., (App Term 2nd & 11th Jud Dists, March 26, 2004); A.B. Medical Services PLLC v. Farm Family Casualty Insurance Co., (Kings County Civ. Ct, September 14, 2004); Ocean Diagnostic Imaging, P.C. a/a/o Bogdan Grishchenko v. Lumbermens Mutual Casualty Co., (App. Term, 2nd & 11th Jud Dists, May 26, 2004)

"[A] claimant to receive payment need only file a proof of claim and the insurers are obliged to honor it promptly or suffer the statutory penalties." Dermatossian v. New York City Transit Authority, 67 N.Y.2d 219, 224, 501 N.Y.S.2d 784, 787 (1986). (Citations Omitted). 11 NYCRR 65.12, the section entitled Proof of Claim states in pertinent part:

> In the case of a claim for health service expenses, the eligible injured person or that person's legal representative shall submit written proof of claim to the Company, including full particulars of the nature and extent of the injuries and treatment received and contemplated...

Likewise, in Sehgal a/o Margarit Yanovitsky v. Royal Ins. Co., No. 98-1117 (App. Term, 9th & 10th Dist., 4/8/99), Plaintiffs were granted summary judgment where Defendant insurance carrier failed to deny the claim within the thirty-days proscribed by statute wherein the Court held, "Inasmuch as plaintiff has established a prima facie case by the submission of statutory forms of proof of claim, summary judgment should have been granted in his favor."

Once plaintiff has submitted Proof of Claim to a carrier, defendant must then come forward with evidence of a deficiency or a claimed defect in the Forms or such defense shall be waived unless it was preserved in a timely issued Denial of Claim Form. Presbyterian Hospital v. Aetna Casualty & Surety Co., 658 NYS2d 245 (2nd Dept 1997); Quality Medical Healthcare, P.C. v. Lumberman's Mutual Casualty Co., (App Term 1st Dept, March 19, 2002); Park Health Center v. Eveready Ins. Co.,)App. Term 2nd & 11th Jud Dists, December 17, 2001).

In a recent decision, the district court has held that a plaintiff can establish its prima facie case for no-fault benefits through the submission of a notice to admit. Seaside Medical, P.C. v. General Assurance Co., 2007 NY Slip Op 27258 (Dist. Ct. of Suffolk Cty., May 9, 2007). Similarly, where an insurer admits, via interrogatory responses, that it received plaintiff's no-fault claims, the defendant insurer cannot not subsequently assert that the plaintiff did not mail the claims. Fair price Med. Supply, Inc. v. St. Paul's Travelers Ins. Co., 2007 NY Slip Op 27173 (App. Tem 1st Dept., May 4, 2007).

In another recent decision, the Appellate Term denied a claimant's motion for summary judgment, asserting that the plaintiff had not established prima facie entitlement to No-Fault benefits, as the plaintiff "failed to demonstrate that he possessed sufficient personal knowledge of plaintiff's office practices and procedures so as to lay a foundation for the admission of the annexed documents as business records". Dan Medical, P.C. v. New York Central Mutual Fire Ins. Co., 14 Misc. 3d 44, 2006 WL 3489008 (App. Term 2nd & 11th Jud. Dist. 2006).

However, claims documents offered by the plaintiff, are offered to demonstrate that a claim for payment was made, not to establish that particular claims forms qualified as business records under CPLR 4518. A statement not offered for its truth is admissible if it has independent legal significance apart from the truth of its content. Capra, Evidence, §8.1.1, 702.

2. **Arbitration**

On January 11, 2000 the Office of General Counsel issued an informal opinion representing the position of the New York State Insurance Department on the issue of No-Fault Burden of Proof. The General Counsel opined, "The claimant must make a prima facie case of entitlement to such benefits. **The quantum of proof necessary to meet that burden is a question of fact to be determined by an arbitrator or court on a case by case basis**."

Arbitrators, in contrast, have held that an applicant must establish a prima facie case of medical necessity despite the preclusion of a respondent's defenses. Arbitrators therefore require the introduction of evidence that details the medical necessity of the services rendered and establishes a causal relationship between the injuries and the accident; a burden significantly higher than, and at odds with, the Appellate Courts

V. Motor Vehicle Accident Indemnification Corporation (MVAIC)

MVAIC is a statutorily created entity created to protect citizens from uninsured motorists.

INS LAW §5202- Definitions:

(b) "Qualified person" means (i) a resident of this state, other than an insured or the owner of an uninsured motor vehicle and his spouse when a passenger in such vehicle, or his legal representative, or (ii) a resident of another state, territory or federal district of the United States or province of the Dominion of Canada, or foreign country, in which recourse is afforded, to residents of this state, of substantially similar character to that provided for by this article, or his legal representative. It does not include any operator of or passenger on a snowmobile. In this subsection, "operator" means every person who operates or is in actual physical control of a snowmobile, whether or not it is under way.

Conditions Precedent to Coverage Ins Law § 5208-Notice of Claim:

1. **Designated uninsured**
   Affidavit to MVAIC within 180 days of the accrual of the cause of action or reasonable justification (below)
      Stating making a claim for damages against owner or operator of uninsured vehicle and facts in support

2. **Identity Unascertainable** (hit and run) See also §5218
   Police Report within 24 hrs of accident (or other governmental agency)
   Affidavit to MVAIC within 90 days or reasonable justification (below)
      Stating making a claim for damages against owner or operator of a vehicle whose identity is unascertainable and facts in support
   If no Report within 24 hours may provide reasonable justification
   Reasonable efforts to ascertain identity of the motor vehicle (per §5218)

3. **Disclaimer/Denial/No policy in effect**
   If no policy in effect, timely reasonable efforts to ascertain insurance coverage
   Affidavit to MVAIC within 180 days from disclaimer or denial (not accident)
      Stating making a claim for damages against owner or operator of a vehicle whose insurer has disclaimed or denied coverage or for which there was no policy in effect at the time of the accident and facts in support
   If no affidavit timely ONLY because of incapacity, death or incorrect vehicle identification from police report or DMV may provide reasonable justification (as below) within 31 days of correction or discovery of mistake

Reasonable justification for late filing of affidavit to MVAIC (1,2, and circumstances in 3c)

If no affidavit timely, may provide reasonable justification to MVAIC
If no affidavit timely, may make application to the court.
   Application to the court
      Must be made within 1 year of when time starts to run to provide affidavit.
      Must include an affidavit that sets forth reasonable justification
      Must include copy of proposed affidavit to be filed with MVAIC
      Notice of the return time with a copy of application must be served on MVAIC 8 days before return date by delivery to the person to whom you would serve a summons in an action in supreme court.

Ct must consider:

Did MVAIC get "actual knowledge of essential facts" within 180 days or within a reasonable time thereafter
Lateness due to settlement negotiations
Reasonable error regarding identity of insurer
Is MVAIC substantially prejudiced

*Although a Notice of Intention to Make Claim satisfies the requirements of this section, there is no requirement for the filing of a Notice of Intention to make claim.

CLAIMS PROCESSING:

By virtue of INS LAW § 5221(3) "The corporation shall have only those rights and obligations which are applicable to an insurer subject to article fifty-one of this chapter." (As referred to in New York Hospital Medical Center v. MVAIC 784 N.Y.S. 2d 593)

The thirty day time period for which MVAIC has to pay or deny a claimant's claim, as with insurers, begins to run upon defendant's receipt of the claim forms, and does not depend on whether or not the eligible injured person has been deemed "qualified" by MVAIC. Englinton v. MVAIC, 2007 NY Slip Op 50164(U) (App. Term 2nd Dept., January 31, 2007).

Insurance Law Article 51 is entitled the Comprehensive Motor Vehicle Insurance Reparations Act. Section 5106 is the claims processing section.

§5106 includes:

30 day rule
interest at 2%
attorney fees
may submit to arbitration

Thank you to William Purdy of Israel, Israel & Purdy for his contributions to the written materials

RESPONDING TO NO-FAULT BILLING: PROCEDURAL ISSUES, DEFENSES AND STRATEGIES

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Responding to No-Fault Billing: Procedural Issues, Defenses and Strategies

What is a No-Fault claim?

A breach of contract claim. It is governed by a six (6) year statute of limitations period based upon the failure of the insurer to reimburse for medical treatment tendered due to injuries sustained a motor vehicle accident.

Contrast and Comparison Different Litigation Options

Arbitration

- Inexpensive

- Two-step process:

Conciliation: Mediation phase where both parties exchange respective position, followed by Arbitration

- Relaxed rules of evidence
(i.e. no requirement to authenticate documents)

- No discovery required

- Claimant customarily fails to provide all necessary documents to administer claim (failure to produce initial evaluation, treatment notes, or letter of medical necessity)

- For some Arbitrators a personal appearance is not required.

Litigation

- Slow moving (due to plaintiff inaction)

- Expensive (discovery i.e. written interrogatories, document production)

- Rules of evidence in force (i.e.IME physicians must testify as to IME cut-off)

- Courts unfavorably view no-fault claims

No-Fault Rules and Regulations

30 Day Notice Rule

The process begins when an injured party provides notice to the insurer within 30 after the date of the accident. 11 NYCRR § 65-2.4(b). This notice requirement may be deemed satisfied when the injured party submits an "Application for Motor Vehicle NF Benefits (N.Y.S Form NF-2). " The injured party or that party's assignee (i.e., health care provider) must submit a "written proof of claim" to the insurer for health service expenses within forty-five days after the date services are rendered, and submit proof of work loss within ninety days. 11 NYCRR § 65-2.4(c). For proof of claim for health service expenses, the health care provider usually submits a "Verification of Treatment by Attending Physician or Other Provider of Health Service (N.Y.S Form NF-3)," or less commonly, "Verification of Hospital Treatment (N.Y.S Form NF-4)," or "Hospital Facility Form (N.Y.S Form NF-5)."

Plaintiffs must submit completed proofs of claims in similar form to the NYS NF-3, 4, or 5 Forms. Significantly, the forms provide the defendant with the name of the policyholder, name and address of the provider, policy number, date of accident, date of health care service, place of service, description of treatment/service rendered and charges billed. The NF-3 and NF-4 forms also contain an assignment of no-fault benefits option that may be executed by the injured party.

Next, plaintiffs must show that these claims were mailed to the insurer. This can be accomplished in one of at least three ways. First, plaintiffs may provide an affidavit of service and/or proof of mailing. Second, plaintiffs may provide proof of a standard office practice or procedure designed to ensure that claims are properly addressed and mailed. See Amaze Medical Supply Inc. a/a/o Tsigelman v. Allstate Ins. Co., 3 Misc.3d 133(A), NYLJ, June 2, 2004, at 27, col 6, 2004 N.Y. Slip Op 50447(U), 2004 WL 1197345 (App Term 2d & 11th Jud Dists, May 20, 2004).

Lastly, the date the claim was received as specified on the Denial of Claim (NF-10) form serves as an admission by the insurer and is sufficient proof of mailing. A.B. Medical Services PLLC v. New York Central Mutual Fire Ins. Co., NYLJ, June 2, 2004, at 27, col 4, 2004 N.Y. Slip Op 50507(U), 2004 WL 1302031 (App Term 2d & 11th Jud Dists, May 26, 2004); Ocean Diagnostic Imaging, P.C. a/a/o Grishchenko v. Lumbermens Mutual Casualty Co., NYLJ, June 2, 2004, at 27, col 3, 2004 N.Y. Slip Op 50510(U), 2004 WL 1301952 (App Term 2d & 11th Jud Dists, May 26, 2004).
Once plaintiffs show that properly completed claim forms were submitted to the insurer, they must then demonstrate that the claims were not paid or denied by the insurer within thirty calendar days of receipt thereof.

Pursuant to 11 NYCRR § 65-2.4(b): in the event of sustaining injuries due to an accident, the eligible insured party ("EIP") must notify the carrier as follows:

Notice. In the event of an accident, written notice setting forth details sufficient to identify the eligible injured person, along with reasonably obtainable information regarding the time, place and circumstances of the accident, shall be given by, or on behalf of, each eligible injured person, to the Company, or any of the Company's authorized agents, as soon as reasonably practicable, but in no event more than 30 days after the date of the accident, unless the eligible injured person submits written proof providing clear and reasonable justification for the failure to comply with such time limitation. If an eligible injured person or that person's legal representative institutes a proceeding to recover damages for personal injury under section 5104(b) of the New York Insurance Law, a copy of the summons and complaint or other process served in connection with such action shall be forwarded as soon as practicable to the Company or any of the Company's authorized agents by such eligible injured person or that person's legal representative.

Carrier must include in all NF-10 denials based upon a violation of the 30 day rule explicit language advising the following: "Late Notice may be excused if a reasonable justification for the delay is provided".

What is clear and reasonable justification?

The NYSOGC advised that while "it would be difficult to create an encompassing list which would have uniform applicability" but they did provide examples for further guidance. i.e. The regulation specifies that appropriate consideration must be given to pedestrians and non-related occupants of motor vehicles who may have difficulty ascertaining the insured. Additionally, a denial for late submission should not be based upon a third-party's failure to provide the information necessary to establish the claim.

Procedures on seeking Verification of Billing

The Insurance carrier has 15 business days upon receipt of each batch of bills to timely seek verification and/or delay. Please see 11 NYCRR 65-3.5 65-3.5 Claim procedure.

(b) Subsequent to the receipt of one or more of the completed verification forms, any additional verification required by the insurer to establish proof of claim shall be requested within 15 business days of receipt of the prescribed verification forms. Any requests by an insurer for additional verification need not be made on any prescribed or particular form. If a claim is received by an insurer at an address other than the proper claims processing office, the 15 business day period for requesting additional verification shall commence on the date the claim is received at the proper claims processing office. In such event, the date deemed to constitute receipt of claim at the proper claim processing office shall not exceed 10 business days after receipt at the incorrect office.

Thereafter, the carrier is required to follow-up with the provider after 30 days. Please see 11 NYCRR 65-3.6 Follow-up requirements.

(b) Verification requests. At a minimum, if any requested verifications has not been supplied to the insurer 30 calendar days after the original request, the insurer shall, within 10 calendar days, follow up with the party from whom the verification was requested, either by telephone call, properly documented in the file, or by mail. At the same time the insurer shall inform the applicant and such person's attorney of the reason(s) why the claim is delayed by identifying in writing the missing verification and the party from whom it was requested.

For delaying billing pending SIU, send timely delay letter within 15 days of receipt of billing followed by verification letters every 30 days until the investigation is completed. Make sure to specify why you are conducting an SIU investigation in your delay letter.

Specificity by Insurer in Verification Letters Required

The Courts have repeatedly held that a letter "which merely informs a claimant that a decision on the claim is delayed pending an investigation and which does not specify a particular form of verification and the person or entity from whom the verification is sought, may not be relied upon to toll the 30-day claim determination period" (A.B. Med. Servs. PLLC v. Country-Wide Ins. Co., 6 Misc.3d 137[A], 2005 N.Y. Slip Op 50255[U] [App Term, 2d & 11th Jud Dists].

Basis for Denying No-fault Claim

Completion of NF-10 (Use form with Verification Boxes included)

Must include the following:

- Signed and dated including dates of service billed and when they were received by insured;

- Must include all bases upon which the claim is being denied;

- If conducting SIU investigation and/or peer review, do not send NF-10 -- Send delay letter;

- Unless you have a valid coverage defense (no policy), an untimely denial will be fatal.

An NF-10 that fails to include a number of basic items called for in the prescribed form is "fatally defective" and cannot be corrected nunc pro tunc. (see, Nyack Hospital v. State Farm Mutual Automobile Insurance Co., 2004 WL 2394038 [1st Dept, 2004]).

New York's No-Fault insurance law is strictly construed (see, Presbyterian Hospital in the City of New York v. Atlanta Casualty Co., 210 A.D.2d 210, 211 [2nd Dept, 1994]). The statute requires an insurer to pay or deny the claim, in whole or part, 30 days of receipt of proof of claim (11 NYCRR § 65.15[f][3]).

However, the statute does provide for an extension of the insurer's time to pay or deny the claim if it serves a demand for "additional verification" (11 NYCRR § 65.15[d]). The 30 day period

which the insurer has to either pay or deny the claim does not begin to run until all the information demanded is provided (See New York & Presbyterian Hosp., v. Progressive Cas. Ins. Co., 5 AD3d 568 [2nd Dept., 2004]]; 11 NYCRR § 65.15[g][1][I]).

Independent Medical Examinations (IME) Scheduling/No-Shows/Cut-offs:

Scheduling Letters:

If represented, the carrier must send to both attorney of record and to each individual insured. They may be scheduled at any time. Generally, one month post accident would be advisable as it may take time for the treating physician to diagnose and treat the insured.

All letters must include language that advises the insured that they are entitled to reimbursement for transportation and/or lost income for appearing at any IMEs. All treatment rendered before the first IME no-show must be paid in full. For fractures, bulges, and/or herniations, schedule orthopedist;

For soft tissue injuries, refer to neurologist. If psych, chiropractor, or acupuncture, received, refer to IME physician in each discipline.

The Appellate Division, 2nd Department in Stephen Fogel Psychological, PC v. Progressive Cas. Ins Co. 2006 NY Slip Op 09604, wherein it held that an insurer may deny a claim retroactively to the date of loss for a client's failure to attend IMEs ("when, and as often as the [insurer] may reasonably require (11 NYCRR 65-1.1).

Note: We opine that carriers should continues to provide insured at least 2 opportunities to appear for IMEs per discipline as the Courts may a) quickly change their minds on appeal of this case and b) leave no room for any excuses as to why insured could not appear for his/her IMEs.

For each type of treatment received by insured, try to schedule an IME for that discipline just to be on the safe side. It might be expensive early on but will pay for itself at arbitration or at trial.

Peer Reviews

Situations when it should be considered: Unnecessary and frivolous medical testing and treatment; Availability of alterative low-cost treatment;

Unscientifically proven medical testing, etc.

Who should perform peer reviews? Doctors – Doctors – Doctors: A treating physician's opinion will carry significantly more weight than a nurse practitioner second guessing his/her prognosis.

Usual & Customary Reductions:

Typically carrier retains Third-Party Administrator ("TPA") to fee schedule all billing. All NY PIP benefits are governed under the WCB Medical Coding. In those instances where the billing

is not in conformity with the WCB codes or improper WCB coding is used, a verification letter is required within 15 days of receipt of the billing to advise the provider of the difficulty in processing their billing.

Partial payment is required within 30 days less fee schedule violations if no verification is needed to process the billing. You must attach EOB with NF-10 denial explaining reductions. If further information is required before payment can be tendered within 30 days, please refer back to our discussion of Verification Letters.

Lack of Cooperation Defense

It is entrenched case law that recovery under a policy will be precluded upon an insured's lack of cooperation ("i.e. no-show IME, EUO etc.). The criteria used in assessing what constitutes a " lack of cooperation" are the following:

The Carrier must demonstrate "a showing that the insured's attitude 'was one of willful and avowed obstruction' [Citation omitted] involving a 'pattern of non-cooperation for which no reasonable excuse [is] offered' [citing Argento v. Aetna Cas. & Sur. Co. 184 A.D.2d 487, 488, 584 N.Y.S.2d 607]" (Ingarra v. General Accident/PG Insurance Company of New York 273 A.D.2d 766, at 767-768, 710 N.Y.S.2d 168) or "where the failure to cooperate is persistent" (Levy v. Chubb Insurance, 240 A.D.2d 336, 337, 659 N.Y.S.2d 266; see also Johnson v. Allstate Insurance Co. 197 A.D.2d 672, 602 N.Y.S.2d 876).

Difficult threshold to meet. EUOs must be sought less than four ("4") months of loss to demonstrate that Insurance carrier actively sought their insured's cooperation. Thereafter, it must complete its SIU investigation promptly. Courts are loathe to deny PIP to insureds that paid premiums for their policies.

Provider Fraud

Lack of coverage defense does not encompass defense of provider fraud which is precluded by no-fault insurer's untimely denial McKinney's Insurance Law § 5106(a);11 NYCRR 65-3.8(c). That would include even those instances where there is overwhelming proof that the medical treatment/supplies were not even received by the injured party.

Policy Exhaustion Case Law

See Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., 8 A.D.3d 533, 779 N.Y.S.2d 534; New York & Presbyt. Hosp. v. Progressive Cas. Ins. Co., supra at 570, 774 N.Y.S.2d 72). "[W]here as here, an insurer has paid the full monetary limits set forth in the policy, its duties under the contract of insurance cease" (Presbyterian Hosp. in City of N.Y. v. Liberty Mut. Ins. Co., 216 A.D.2d 448, 628 N.Y.S.2d 396; Hospital for Joint Diseases v. State Farm Mut. Auto. Ins. Co., supra).

11 NYCRR 65-3.15 states:

"[w]hen claims aggregate to more than $50,000, payments for basic economic loss shall be made to the applicant and/or an assignee in the order in which each service was rendered or each expense was incurred, provided claims therefore were made to the insurer prior to the exhaustion of the $50,000. If the insurer pays the $50,000 before receiving claims for services rendered prior in time to those which were paid, the insurer will not be liable to pay such late claims. If the insurer receives claims of a number of providers of services, at the same time, the payments shall be made in the order of rendition of services." (emphasis added)

However, it is well settled that "[n]o-fault benefits are overdue if not paid within 30 calendar days after the insurer receives proof of claim, which shall include verification of all of the relevant information requested " (11 NYCRR 65-3.8[a][1] [emphasis added]).

Bottom line: As soon as your coverage is exhausted, the carrier is not obligated to pay any further billing regardless of whether they timely denied same.

Fraudulent Procurement of the Insurance Policy: Garaging Investigations:

Case law A.B. Medical Services PLLC D.A.V. Chiropractic P.C. LVOV Acupuncture P.C. a/a/o Yevgenya Ioffe, Appellants, v. Commercial Mutual Insurance Co., Respondent, Nos. 2005-390KC, 2005-586KC, N.Y.S. 2d, 2006WL 820389 (N.Y. Sup.App.Term), 2006 N.Y. Slip Op. 26118

The NY Appellate Court has permitted an automobile insurer to deny no-fault benefits to individually named insureds when there are material misrepresentations concerning ownership and the garaging of a vehicle on the policy application. Summary judgment is not available as there remain questions of fact that only a judge/jury may decide at the time of trial.

Must a) Conduct NY investigation to ascertain true residency and principal garaging;

b) Conduct investigation into insured's policy address to ascertain whether he/she has any ties to policy address;

c) Recorded statement and/or EUO instrumental in gathering sufficient circumstantial evidence to conclude fraud occurred;

d) Coverage defense is never waived regardless of whether timely NF-10 denial(s) were issued.

The Anatomy of Fraud

The more common crimes associated with auto insurance are staged accidents, stolen identities, fraudulent police reports, and "jump-ins."

Owners and managers of medical clinics pay "runners" or recruiters to arrange minor auto

accidents and send individuals supposedly injured in the accidents to the clinics for treatment.

Although staged accidents are intended to cause no real injuries to the defendant driver or passengers, the accidents are reported to police so that a record can be created to support the fraudulent insurance claims. Plaintiffs seek as much medical treatment as humanely possible prior to the carrier denying reimbursement based upon the lack of medical necessity wherein the bills can go as high as $50,000 per passenger under the New York no-fault law. A single staged accident with multiple claimants generally results in billings for hundreds or even thousands of treatments.

Bottom Line: Carrier has burden of proof to establish fraudulent conduct. The Courts have raised the bar for carriers to the point where unless there is a “smoking gun” it is difficult to combat fraudulent billing.

Resources: NYS Ins. Dept and NYS OGC Opinions

For all questions not fully addressed in the NY PIP regulations, the NYS Insurance Department for the Office of General Counsel prepare opinion letters on written question presented. Additionally, the NYS Ins. Dept is quite helpful to address any immediate questions or concerns.

NO FAULT LAW AND THE SERIOUS INJURY THRESHOLD

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INSURANCE LAW § 5102(d)

"Serious injury" means a personal injury which results in death; dismemberment, significant disfigurement; a fracture; loss of a fetus; permanent loss of use of 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 eight days immediately following the occurrence of the injury or impairment.

I. GENERALLY

A. Requirement of Serious Injury: Use or Operation/Covered Person

No Cases

B. Requirement of Serious Injury: SUM Coverage

Raffellini v. State Farm, 9 N.Y.3d 196, 848 N.Y.S.2d 1 (2007)

Court holds that Regulation 35-D, which governs optional SUM coverage, properly imposes serious injury threshold requirement, and thus insured motorist who had suffered non-economic losses in collision with underinsured motorist, and who sought SUM coverage from his own automobile insurer after exhausting limits of tortfeasor's coverage was required to show serious injury as condition of recovery.

C. "Threshold" Nature

VanNostrand v. Froehlich, 44 A.D.3d 54, 844 N.Y.S.2d 293 (2d Dep't 2007)

"We find that prejudgment interest is to be calculated from the date common-law liability attaches in favor of the plaintiff, either by default, summary judgment, or bifurcated liability trail, even thought the plaintiff has yet to establish the existence of a serious injury."

Abbas v. Cole, 44 A.D.3d 31, 840 N.Y.S.2d 388 (2d Dep't 2007)

"In this case we address the issue of whether or not a plaintiff, who has been granted a default judgment on the issue of liability in a case seeking compensation for personal injuries arising from a motor vehicle accident, is required to demonstrate the element of serious injury at the inquest on damages. For the reasons that follow, we conclude that, unless the issue of serious injury has been previously determined, the plaintiff must demonstrate at the damages inquest proof of a serious injury before there can be any recovery for pain and suffering arising from a motor vehicle accident." Court also notes a narrow exception exists when a defendant opposes a default motion and fails to include the serious injury threshold among the meritorious defenses discussed. (*See, Beresford v. Waheed*, 302 A.D.2d 342, 343)."

Amato v. Fast Repair, Inc., 42 A.D.3d 477, 840 N.Y.S.2d 394 (2d Dep't 2007)

Court held plaintiff's proof at inquest held upon default was insufficient to establish a serious injury.

Notaro v. U.S. Limousine Service, 2007 N.Y. Slip Op. 50498(U) (App. T. 2d Dep't)

The sole issue raised in plaintiffs' appellate brief was that the court below erred in determining that the injured plaintiff did not suffer a serious injury. "Since the court below found, *inter alia*, that defendants were not negligent as a matter of law, and plaintiffs did not challenge that finding on appeal, the order granting said defendants' motion may not be disturbed. Accordingly, we need not reach the issue of whether the injured plaintiff satisfied the threshold requirement of suffering a serious injury."

D. Conflict Of Laws/Forum Non Conveniens

Wosner v. Elrac, Inc., 48 A.D.3d 274, 851 N.Y.S.2d 192 (1st Dep't 2008)

Court held New York law controlled action where plaintiff New York domiciliary was alleged to have sustained serious injuries when automobile in which he was passenger, and which was being operated by defendant New York domiciliary, was involved in accident in New Jersey with vehicle owned and driven by defendant Pennsylvania resident. It noted that although automobile driven by operator was registered and insured in New Jersey under long-term rental agreement with its owner Delaware corporation with its headquarters in New Jersey, operator primarily used, garaged, and drove vehicle in New York, and at time of accident, he and plaintiff were traveling between two New York locations, but just happened to pass briefly into New Jersey due to fortuitous circumstance.

II. THRESHOLD CATEGORIES

A. Significant Disfigurement

Baker v. Thorpe, 43 A.D.3d 535, 840 N.Y.S.2d 834 (3d Dep't 2007)

"Reviewing whether there is an issue of fact as to whether the scar from the surgery constitutes a significant disfigurement, we find, after a review of the photographs, that a reasonable person would not conclude that it is unattractive, objectionable or the subject of pity or scorn." NOTE: The basis for the claim was the presence of surgical scars on plaintiff's left arm and wrist.

Chmiel v. Figueroa, __ A.D.3d __, __ N.Y.S.2d __ (4th Dep't 2008)

Court held: "We conclude with respect to the significant disfigurement category of serious injury that defendant failed to meet her initial burden of establishing as a matter of law that plaintiff's surgical scars do not constitute a significant disfigurement." NOTE: Court does not state what the claimed disfigurement was.

Mistretta v. Guevarez, 2007 N.Y. Slip Op. 50910(U) (Sup.Ct. Richmond Co.) (Minardo, J.)

Plaintiff suffered, *inter alia*, a knee injury which would require future corrective surgery. "Defendants' claim that plaintiff should be precluded from claiming future scarring as a form of serious injury is without merit. In making this argument, defendants have not taken into account plaintiff's ability to supplement her Bill of Particulars if and when the surgery takes place. In the event that plaintiff can establish at trial "a *prima facie* case that any one of [the] several injuries that … she sustained in [the] accident is a serious injury" within the meaning of Insurance Law § 5102(d), she is entitled to seek recovery for all [of the] injuries incurred as a result of the accident."

Sutcliff v. Hartford, 2007 N.Y.Slip.Op. 52014 (U) (Sup.Ct. Broome Co.) (Lebous, J.)

"The court finds plaintiff's proof establishes the existence of a triable issue of fact as to whether reasonable people could differ on whether plaintiff's scar is unattractive, objectionable or the subject of pity or scorn objectionable. The court has reviewed the photographs of plaintiff's facial scar and finds that, in and of themselves, they raise a question of whether or not the plaintiff's scar is unattractive, objectionable or the subject of pity or scorn objectionable. Additionally, however, plaintiff testified in her deposition that she wore a scarf over her face for a month because she was so embarrassed by the scar, that the scar turns red in the summer, and she was the subject of ridicule while attending school. The court finds that the photographs, when coupled with plaintiff's own testimony that she was the subject of teasing and ridicule when she returned to high school, are more than sufficient to create questions of fact warranting denial of defendants' motion for summary judgment."

McQuaid v. Whispers Taxi, Inc., 2008 N.Y. Slip Op. 51606(U) (Sup. Ct. Bronx Co.) (Hunter, J.)

Plaintiff claimed scar on her face constituted a "significant disfigurement." To defeat summary judgment, plaintiff submitted color photographs of the scar. However, she did not indicate when the color photographs annexed to her affidavit which show the scar above her lip were taken. Plaintiff's physician described the scar as being 2 cm in length whereas the independent physician retained by defendants described the scar as being 1.5 cm in length and of good cosmetic quality. Court held that a view of the photographs submitted by the plaintiff do not depict a scar that would constitute a significant disfigurement. It noted: "The scar is barely visible in the photographs that were submitted by plaintiff. Moreover, it is significant that in one of the unsworn reports submitted by plaintiff, a plastic surgeon, Dr. Leff, reported on January 27, 2004 that the scar was "healing nicely." On July 7, 2005, the plaintiff consulted him again about a lesion on her abdomen and she also asked him to look at her eyes, lip and nose. Dr. Leff stated that plaintiff felt the scar above her lip looked the same and he further stated, "I have suggested that she do nothing since the appearance doesn't bother her."

B. Fracture

Woods v. Johnson, 44 A.D.3d 1201, 843 N.Y.S.2d 862 (3d Dep't 2007)

"While there is no dispute that plaintiff suffered a fracture of the facet of her C# vertabra, whether that fracture was caused by the motor vehicle accident, by degenerative changes in plaintiff's spine, or otherwise, cannot be resolved on this record as a matter of law."

Vogel v. Chichy, __ A.D.3d __, __N.Y.S.2d __ (3d Dep't 2008)

Parties stipulated that plaintiff suffered some type of serious injury, and plaintiff was awarded summary judgment on liability. At trial, plaintiff's proof showed that she sustained, *inter alia*, a fracture of her right hand. Jury awarded no damages. Court initially held that the failure to award any damages for past pain and suffering constitutes a material deviation from reasonable compensation. It next held that based upon plaintiff's unrefuted medical testimony that she suffers a permanent injury to her hand, the award of no future pain and suffering damages could not have been reached upon any fair interpretation of the evidence. Court then added reasonable awards would be $25,000 and $20,000 (25 years) respectively.

Sunness v. Hinshaw, 2007 N.Y.Slip.Op. 52016 (U) (Sup.Ct. Broome Co.) (Lebous, J.)

Court held the hospital record noting "the possibility of a non-displaced fracture cannot be ruled out" and plaintiff's treating physician's notation in his office records of "possible nondisplaced fracture in the distal radius and a questionable dorsal carpal avulsion fracture" was sufficient to raise a triable issue of fact.

C. Fetus

No Cases

D. Permanent Loss of Use

No Cases

E. Permanent Consequential Limitation of Use/Significant Limitation of Use

1. First Department

DeLeon v. Ross, 44 A.D.3d 545, 844 N.Y.S.2d 36 (1st Dep't 2007)

Court held: "Defendants satisfied their burden of establishing *prima facie* that plaintiff in this motor vehicle accident case had not sustained a "significant impairment," submitting an affidavit and reports from Dr. Crane that concluded there was "no objective evidence of any orthopedic residuals related to the accident of 4/4/03." Plaintiff counters that Dr. Crane's affirmation is deficient, as it failed to show range-of-motion tests that are compared to "the norm." In addition to being improperly raised for the first time on appeal, plaintiff's argument is unavailing since an expert's qualitative assessment of a patient's condition may suffice, "provide that the evaluation has an objective basis and compares the limitations to the normal function, purpose and use of the affected body organ, member, function or system." Dr. Crane's report did provide such an objective assessment, clearly comparing plaintiff's diminished range of motion in his right shoulder to the norm. It also provided an objective assessment of plaintiff's diminished range of motion in his cervical and lumbar spine."

Fernandez v. Mercedes, 45 A.D.3d 385, 847 N.Y.S.2d 16 (1st Dep't 2007)

"Plaintiff's self-serving affidavit, which contradicted his deposition testimony as to his return to work, where he lifts 50-to-80-pound boxes a meat delivery driver, was insufficient to establish a serious injury."

Bentham v. Rojas, 48 A.D.3d 314, 851 N.Y.S.2d 514 (1st Dep't 2008)

Court held plaintiff's proof was sufficient to raise a triable issue of fact, stating: "An MRI taken after the accident revealed tears of the medial meniscus and anterior cruciate ligament in plaintiff's left knee, and the affidavit of plaintiff's chiropractor and the affirmation of his physician note that following detailed tests, plaintiff had significant and specified limitations of the range of motion with respect to his lumbar and cervical spine and his left knee both shortly after the accident and more than three years later."

Zamore v. Peralta, 50 A.D.3d 423, 855 N.Y.S.2d 480 (1st Dep't 2008)

Court held trial court did not err when it charged jury that it was to determine whether plaintiff's claimed permanent limitation of use of her neck and lower back involved a body "member"; and that such determination was to be made upon the dictionary definition of "member" given to jury and medical testimony that the neck and lower back was a body "member". NOTE: While the decision makes no mention of this charge, the parties' briefs addressed it. I represented the plaintiff on this appeal.

2. Second Department

Scudera v. Mahbubur, 39 A.D.3d 620, 833 N.Y.S.2d 239 (2d Dep't 2007)

Court held jury verdict for defendant was against the weight of the evidence. In part, the Court noted: "Dr. Blessler [plaintiff's treating neurologist] testified that as a result of this injury, the plaintiff's range of motion in his lumbar spine was significantly limited in that his backwards extension tested at only two degrees as opposed to a normal extension (25 degrees) for someone of the plaintiff's age, the plaintiff's forward flexion measured at 45 degrees which was 50% less than a normal range of motion (90 degrees) and his lateral bending was limited to 10 degrees, also a significant limitation. Dr. Bressler further testified that these limitations persisted during the approximately 20 times she examined the plaintiff since 2001 through the most recent examination, which was two days before the trial. Thus, the plaintiff provided the requisite objective evidence of the extent or degree of limitation and its duration. Significantly, Dr. Tikoo [defendant's expert] failed to test the flexion and extension ranges of motion of the plaintiff's lumbar spine, and Dr. Minkin examined only the MRI films. Indeed, on cross examination, Dr. Tikoo testified that he was not surprised by the findings made by Dr. Bressler as to the plaintiff's loss of range of motion, which he acknowledged could be characterized as significant.

Green v. Nara Car & Limo, Inc., 42 A.D.3d 430, 839 N.Y.S.2d 543 (2d Dep't 2007)

Plaintiff established a *prima facie* case as her treating chiropractor opined in his affidavit, based on his contemporaneous and most recent examinations of the plaintiff, as well as upon his review of the plaintiff's lumbar magnetic resonance imaging report, which showed, *inter alia*, a bulging disc at L5-S1, that the plaintiff's lumbar injuries and range of motion limitations observed were permanent and causally related to the subject accident.

Jin v. Kwon, 42 A.D.2d 445, 839 N.Y.S.2d 796 (2d Dep't 2007)

"While the affirmed report of the defendants' orthopedist stated that the plaintiff's range of forward flexion was 65 degrees, it failed to compare that measurement to the normal range of forward flexion and, in fact, the report appeared to indicate that her range of forward flexion was less than normal."

Jenkins v. Miled Hacking Corp., 43 A.D.3d 393, 841 N.Y.S.2d 317 (2d Dep't 2007)

"The conclusion of the defendants' examining orthopedist, that the plaintiff had minor limitations in range of motion or limitations that were not permanent, was belied by the orthopedist's findings of substantial limitations in range of motion in the plaintiff's cervical flexion and bilateral lumbar lateral bending which existed more than one year and four months after the accident."

Seecoomar v. Ly, 43 A.D.3d 900, 841 N.Y.S.2d 624 (2d Dep't 2007)

The plaintiff also submitted the affirmation of his treating orthopedist whom he saw regularly about every eight months. The orthopedist noted that the plaintiff's MRI was reviewed and showed a disc herniation at L5-S1 as well as disc degeneration. The disc herniation was consistent with traumatic injury. The orthopedist determined that the plaintiff's straight leg raising was 20 to 25 degrees on the left side, in contrast to a normal range of 90 degrees, and the plaintiff "can ambulate with a stiff heel-toe gait." His finding of a limitation of range of motion of straight leg raising on the left side was confirmed in an examination conducted in December 2005 while the motion for summary judgment was pending. "Contrary to the determination of the Supreme Court, the plaintiff submitted objective evidence of the extent of the alleged physical limitations resulting from the disc injury and its duration, corroborated by a recent examination."

King v. Islam, 43 A.D.3d 1001, 842 N.Y.S.2d 511 (2d Dep't 2007)

Plaintiff's treating physician, Dr. Kaisman, stated, *inter alia*, that the plaintiff can under his care in March 1998, after magnetic resonance imaging (hereinafter MRI) examinations of her lumbar and cervical spine revealed disc herniations, and that he saw her on numerous occasions in 1998. However, Dr. Kaisman's affirmation, and the rest of the record, is bereft of any objective evidence of the extent of the alleged physical limitations revealed in those 1998 MRI and physical examinations, resulting from the disc injuries, and their duration. Thus, Court held affidavit was of no probative value.

Sanon v. Moskowitz, 44 A.D.3d 926, 843 N.Y.S.2d 510 (2d Dep't 2007)

In upholding denial of defendant's motion, Court noted, *inter alia*, that plaintiff's physician considered 60 degrees to be the normal range of motion of cervical flexion and extension but defendant's physician considered anything above 30 degrees to be normal.

Fleury v. Benitez, 44 A.D.3d 996, 845 N.Y.S.2d 101 (2d Dep't 2007)

Court held defendants' medical proof was insufficient, noting that both defense orthopedists examined the cervical spine, and one of the orthopedists also examined the lumbar region of the plaintiff's spine. In their respective affirmed medical reports, the orthopedists set forth their findings based on range of motion testing of the plaintiff. However, the orthopedists failed to compare those findings to the normal ranges of motion.

Umar v. Ohrnberger, 46 A.D.3d 543, 846 N.Y.S.2d 612 (2d Dep't 2007)

"The defendant failed to make a *prima facie* showing since the affirmed report of her examining neurologist disclosed that he found a 50% limitation in the plaintiff's range of motion in her lumbar spine, and her examining orthopedist failed to compare his findings as to the range of motion of the plaintiff's cervical and lumbar spines with normal ranges of motion."
Gonzalez v. Fratello, 46 A.D.3d 749, 848 N.Y.S.2d 345 (2d Dep't 2007)

Court held plaintiff raised a triable issue of fact as he presented, *inter alia*, an affidavit from his treating orthopedic surgeon stating that his personal review and comparison of Magnetic Resonance Imaging films taken before and shortly after the subject accident revealed that the accident caused "a posttraumatic lumbar L-5 disc herniation with resultant left S1 nerve root compression," which required a "lumbar L5-S1 laminectomy and discectomy in order to remove the offending disc herniation," and which resulted in specified limitations in the plaintiff's ranges of motion that were significant and permanent in nature.

Sharma v. Diaz, 48 A.D.3d 442, 850 N.Y.S.2d 634 (2d Dep't 2008)

Court held plaintiff's medical proof was insufficient as "one of the plaintiff's treating physicians, examined the plaintiff on January 29, 2004, and concluded on that date, which was within three months of the subject accident, that the plaintiff had full range of motion in the lumbar and cervical regions of his spine."

Washington v. Cross, 48 A.D.3d 957, 849 N.Y.S.2d 784 (2d Dep't 2008)

Court held the medical evidence which the defendants submitted in support of their respective motion and cross motion, *inter alia*, for summary judgment dismissing the complaint, established that, as a result of the subject motor vehicle accident, the plaintiffs sustained only sprains and/or strains, and accordingly, neither of them sustained a serious injury; and plaintiff failed to raise a triable issue thereof in opposition.

Altreche v. Gilmar Masonry Corp., 49 A.D.3d 479, 853 N.Y.S.2d 371 (2d Dep't 2008)

Court held plaintiffs raised a triable issue of fact as to whether the plaintiff sustained a serious injury under the permanent loss and permanent consequential and/or significant limitation of use categories to her cervical and/or lumbar spines as a result of the subject accident. It stated: "The opinion of the plaintiff's treating physician was based both on his contemporaneous and his most recent examinations of the plaintiff, as well as upon his review of, *inter alia*, the plaintiff's cervical and lumbar magnetic resonance imaging reports, which showed, among other things, disc bulges at C2 through C5 and a disc herniation at L5-S1. He opined that the plaintiff's spinal injuries and range of motion limitations observed were permanent, and were causally related to the subject accident."

Edriste v. Morales, 49 A.D.3d 594, 852 N.Y.S.2d 792 (2d Dep't 2008)

"Plaintiff raised a triable issue of fact through the submission of an affirmed magnetic resonance imaging report finding a herniated disc in her lumbar spine and the affirmed report of her examining physician, who averred that her cervical and lumbar spine ranges of motion were diminished on all planes as quantified in the report."

Djetoumani v. Transit, Inc., 50 A.D.3d 944, 857 N.Y.S.2d 601 (2d Dep't 2008)

See V (B) (3)

Scotto v. Suh, 50 A.D.3d 1012, 857 N.Y.S.2d 185 (2d Dep't 2008)

Plaintiff's medical proof was insufficient as the proffered hospital records merely reflect neck strain, which does not constitute a serious injury.

Rodriguez v. Reyes, 51 A.D.3d 654, 857 N.Y.S.2d 233 (2d Dep't 2008)

Court held plaintiff's proof was sufficient to establish *prima facie* that she sustained a serious injury. It noted "Among other things, she submitted the affirmed report of her treating orthopedist, Dr. Frank Carr. His opinion was based on his examination of the plaintiff shortly after the accident, on his examination performed after the motion for summary judgment was made, and upon an arthroscopic procedure he performed upon the plaintiff approximately one month post-accident, which showed, among other things, a tear in the medial meniscus. He opined that the plaintiff's injuries and the range of motion limitations that he observed were permanent, and were causally related to the subject accident."

Kasel v. Szczecina, 51 A.D.3d 872, 858 N.Y.S.2d 346 (2d Dep't 2008)

Court held: "Plaintiff raised a triable issue of fact as to whether she sustained a serious injury under the permanent, consequential, and/or significant limitation of use categories of Insurance Law § 5102(d) to the cervical and/or lumbar regions of her spine as a result of the subject accident. The opinion of the plaintiff's treating chiropractor was based on his most recent examinations of the plaintiff as well as examinations which were contemporaneous with the subject accident. The treating chiropractor also based his opinion on a review of, *inter alia*, the affirmed cervical and lumbar magnetic resonance imaging reports prepared by the plaintiff's treating radiologist, which were submitted by the defendant in support of the motion for summary judgment. Among other things, the reports documented disc bulges at C4-5 and C5-6 and disc herniations at L4-5 and L5-S1. The plaintiff's spinal injuries and range of motion limitations observed were significant and permanent, were causally related to the subject accident, and were not caused by degeneration." COMMENT: A perfectly prepared affidavit!

Fiorillo v. Arriaza, 52 A.D.3d 465, 859 N.Y.S.2d 699 (2d Dep't 2008)

Court held plaintiff's proof was insufficient, noting, *inter alia*: "No range-of-motion testing of the left shoulder was apparent in his report. To the extent that her physician

noted limitation in the plaintiff's cervical spine range of motion, he merely noted that testing showed "reduced" extension. With the exception of a single instance in which he noted that the plaintiff's cervical extension was limited to 50 degrees on August 18, 2004, he provided no quantified findings."

Perez v. Fugon, 52 A.D.3d 668, __N.Y.S.2d __ (2d Dep't 2008)

Court held defendant's orthopedist's range of motion findings with respect to plaintiff's knees were insufficient as the orthopedist failed to compare those findings with normal ranges.

Giordano v. Allstarz Limosine, Ltd., __A.D.3d __, __N.Y.S.2d __ (2d Dep't 2008)

Court held: "Plaintiff raised a triable issue of fact as to whether he sustained a serious injury under the permanent, consequential, and/or significant limitation of use categories to the cervical and/or lumbar regions of his spine as a result of the subject accident. The plaintiff's treating neurologists and chiropractor opined that the plaintiff's spinal injuries and range-of-motion limitations were significant and permanent, and were causally related to the subject accident, based on their contemporaneous and most recent examinations of the plaintiff, as well as their review of the affirmed cervical spine magnetic resonance imaging report prepared by the plaintiff's treating radiologist, which showed bulging discs at C4-5 and C5-6 and a disc herniation at C3-4."

Spahn v. Wohlmacher, 52 A.D.3d 815, __ N.Y.S.2d __ (2d Dep't 2008)

Court held defendant failed to meet her burden, stating: "In support of her motion, the defendant relied upon, *inter alia*, the report of her examining neurologist who examined the plaintiff on December 6, 2006, over one year after the subject accident. During that examination, the plaintiff's lumbar spine and cervical spine were tested. During testing of the plaintiff's lumbar spine, the defendant's examining neurologist noted that the plaintiff was able to bend forward and bring her hands down to the midthigh level. In the supine position, the plaintiff's leg elevation was to 30 degrees bilaterally. Despite making these findings, the defendant's examining neurologist never compared those findings to what is normal. As to the cervical spine, the defendant's examining neurologist merely stated that movements of the neck were "normal" without setting forth the objective tests used to arrive at those conclusions that the plaintiff had full range of motion in the cervical spine."

Kilakos v. Mascera, __A.D.3d __, __N.Y.S.2d __ (2d Dep't 2008)

Court set aside jury verdict for plaintiff and entered judgment in favor of defendant, stating: "The mere existence of herniated or bulging discs, and even radiculopathy, 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. Here, the plaintiff's expert witness admittedly never recorded any range-of-motion findings, nor compared his findings to normal ranges of motion. Rather, he merely made the

conclusory assertion that the plaintiff suffered an approximately 30% limitation in various ranges of motion. Finally, neither the plaintiff nor his expert established that the damages at issue arose from the subject accident rather than from a prior motor vehicle accident in December 2000, during which the plaintiff sustained, *inter alia*, a fractured hip and herniated discs in his lumbar spine."

3. Third Department

Flisch v. Walters, 42 A.D.3d 682, 839 N.Y.S.2d 602 (3d Dep't 2007)

Plaintiff failed to establish a *prima facie* case as her medical experts did not discuss any degree of significant impairment or permanency, nor is there any qualitative analysis of how plaintiff's alleged limitations compare to normal neurological functioning.

Baker v. Thorpe, 43 A.D.3d 535, 840 N.Y.S.2d 834 (3d Dep't 2007)

"We premise our review with a recognition that carpal tunnel syndrome can form the basis for a significant limitation of use. However, where, as here, there are no significant problems after successful surgery and the residual symptoms are nothing more than mild, minor or slight impairments, no triable issues will be raised by this proof."

Cameron v. Engelhardt, 44 A.D.3d 1152, 843 N.Y.S.2d 479 (3d Dep't 2007)

Plaintiff's physicians in their affidavits failed to compare plaintiff's current limitations to normal function, purpose and use of the affected body member.

Saleh v. Bryant, 49 A.D.3d 991, 853 N.Y.S.2d 415 (3d Dep't 2008)

"The only medical evidence presented by plaintiff in opposition to defendant's motion was the report of an otolaryngologist who examined her for the first time in April 2006 as part of an independent medical examination requested by defendant. While this otolaryngologist confirmed the diagnosis of vertigo, he indicated that it had "subsided on its own" and noted that plaintiff did not require treatment at the time he examined her. Although he stated that she was prone to having recurrences, he did not provide an opinion with respect to permanency or indicate that the plaintiff suffered from any limitations or was restricted in her activities."

Scott v. Aponte, 49 A.D.3d 1131, 854 N.Y.S.2d 243 (3d Dep't 2008)

"Following arthroscopic surgery on her shoulder, plaintiff resumed full-time employment after about two weeks and full duty assignment as of June 20, 2005. Indeed, she never sought any subsequent medical treatment for her shoulder after this time. A physical examination conducted by defendant's expert one year later revealed that her right shoulder was "completely normal" with "a complete painless range of all active and passive right shoulder motions." Even her treating orthopedic surgeon opined that she underwent surgery "with good effect" and had no permanent deficit with regard to her shoulder. Additionally, this surgeon never discussed any degree of significant

impairment of the shoulder or provided analysis of any alleged limitation compared to normal functioning which would support a conclusion that it was significant."

Kithcart v. Mason, 51 A.D.3d 1162, 857 N.Y.S.2d 794 (3d Dep't 2008)

In affirming jury finding under both limitation of use categories, Court stated: "The quantitative standard here required objective proof of plaintiff's bulging cervical discs and a medical expert's quantifications of the limitations caused by that condition. Plaintiff's neurologist, who treated her for the four years between her accident and the trial, testified that an X ray taken on the day of the accident depicted a cervical strain and narrowing of the disc spaces for two discs. A subsequent X ray indicated further degeneration and a large disc bulge. An MRI taken a year and a half after the accident indicated the same large disc bulge and an arthritic degenerative condition of the cervical spine. An EMG taken around the same time revealed active nerve impingement, which could lead to radiculopathy. Based upon this objective evidence, the neurologist opined that plaintiff's cervical strain, disc problems and radiculopathy were caused by the accident and limited the range of motion of her cervical spine. He quantified the limitations to her range of motion through his examinations, which included observation of plaintiff's degrees of rotation, flexion and extension, then compared those findings to normal degrees of movement of the cervical spine. Considering his treatment with only slight changes over four years, the neurologist also opined that plaintiff's condition was permanent. Pairing this medical proof with testimony from plaintiff and her husband concerning her inability to perform certain activities of daily living, plaintiffs submitted sufficient proof that plaintiff suffered from a serious injury, not a minor one."

Hildenbrand v. Chin, 52 A.D.3d 1164, __ N.Y.S.2d __ (3d Dep't 2008)

Court found plaintiff's proof was sufficient to raise triable issues of fact under the limitations of use categories, stating, *inter alia*, that his neurologist "noted plaintiff's limitation of physical activities attributable to plaintiff's loss of range of motion and limited use of his left upper extremity, which included restrictions on lifting no more than 10 pounds, his inability to sit or stand more than two hours and limited ability to drive…" and that "Based upon plaintiff's asymptomatic condition prior to the accident, the established decreased range of motion of plaintiff's neck and arm and the cervical MRI revealing disc bulges and nerve impingement, plaintiff's primary care physician opined that plaintiff was permanently disabled as a result of the accident". NOTE: Although the neurologist did not quantify the restrictions in range of motion, defendant's neurologist did, and court used those restrictions to find plaintiff's proof sufficient.

4. Fourth Department

Harris v. Carella, 42 A.D.3d 915, 839 N.Y.S.2d 886 (4th Dep't 2007)

Court held plaintiff's proof was sufficient to establish a *prima facie* case, noting: "Plaintiffs submitted the affidavit of plaintiff's treating chiropractor, who stated that plaintiff had a loss of lordosis in his cervical spine, muscle spasms, and a loss of range of

motion in his cervical and lumbar spine. The chiropractor also stated that plaintiff's injury was significant, permanent, and causally related to the accident, thus raising a triable issue of fact whether plaintiff sustained a serious injury under the permanent consequential limitation of use and significant limitation of use categories. Contrary to defendant's contention, the chiropractor set forth the tests that he used to ascertain the degree of plaintiff's loss of range of motion and correlated that loss to the normal range of motion for the relevant areas of plaintiff's spine."

Barnes v. Estes, 46 A.D.3d 1441, 848 N.Y.S.2d 472 (4th Dep't 2007)

Court held plaintiff's medical proof was insufficient, stating: "The affirmation of plaintiff's treating physician does not provide a numeric percentage representing plaintiff's loss of range of motion, nor does it provide a qualitative comparison of plaintiff's limitations to the normal function of plaintiff's spine."

Bennett v. Muniz, 50 A.D.3d 1464, 857 N.Y.S.2d 828 (4th Dep't 2008)

Court held that the trial court erred in directing a verdict on the issue of serious injury based upon its determination that the injury to plaintiff's ankle constituted a significant limitation of use and a permanent consequential limitation of use as a matter of law. in so ruling, the Court noted that the Court of Appeals has written that "whether there has been a 'significant' limitation of use of a body function or system…can…be a complex, fact-laden determination". It then concluded: "Here, the parties presented conflicting evidence with respect to, *inter alia*, the degree of permanent loss to plaintiff's range of ankle motion, and we conclude on the record that there is a triable issue of fact whether the injury to plaintiff's ankle was significant or consequential."

Beaton v. Jones, 50 A.D.3d 1500, 857 N.Y.S.2d 384 (4th Dep't 2008)

Plaintiff claimed that he sustained, *inter alia*, loss of range of motion in his cervical spine and post-concussive syndrome. Court held that plaintiff's neurosurgeon's opinion that plaintiff sustained 75% loss of range of motion of his cervical spine was legally insufficient as he examined plaintiff more than three years after the accident and did not relate the loss of extension to the herniated disc or any other objective finding, nor did he explain the absence of such findings of restrictions in neck motion for 2-1/2 years before his exam. The Court further held that the views of plaintiff's experts with respect to plaintiff's head pain, including one expert's diagnosis of "occipital neuralgia," were based upon plaintiff's subjective complaints only, and thus were insufficient to defeat defendant's motion.

Campo v. Neary, 52 A.D.3d 1194, 860 N.Y.S.2d 703 (4th Dep't 2008)

Court held trial court correctly directed a verdict for plaintiff on the issue of serious injury with respect to his left hand. It noted "The injury to the top of plaintiff's left hand, including a laceration of the tendons, required stitches to close the wound as well as immobilization of the hand with a splint for four to six weeks. Plaintiff testified that he

had no use of that hand while it was immobilized, and there was no evidence to the contrary. Indeed, defendants' expert stated that the laceration on plaintiff's left hand was significant. While the evidence did not establish that plaintiff sustained a significant permanent injury to his left hand, a showing of permanency was not required under the significant injury limitation of use category of serious injury."

Feggins v. Fagard, 52 A.D.3d 1221, 860 N.Y.S.2d 346 (4th Dep't 2008)

Court held plaintiff's physician's report raised a triable issue of fact as the physician stated therein that plaintiff "has limited range of motion with 50% in all directions of the cervical spine," and "thus plaintiff submitted a quantitative assessment of his decreased range of motion sufficient to defeat the motion with respect to the significant limitation of use category."

5. Other Courts

Burnett v. Yeya Limousine, Inc, 2008 N.Y. Slip Op. 51305(U) (App.T. 1st Dep't)

Court held: "Plaintiff raised a triable issue on his claim of permanent injury by submitting, *inter alia*, the affirmations of treating physicians who attested to quantified restrictions of motion, the presence of muscle spasms and loss of sensation in plaintiff's lower extremities persisting several years after the accident. These findings correlated with similar findings of limitations in the near aftermath of the accident, and were consistent with the results of MRI and nerve conduction testing. The doctors opined that the subject accident caused significant and permanent injuries to plaintiff's spine."

Sunness v. Hinshaw, 2007 N.Y.Slip.Op. 52016 (U) (Sup.Ct. Broome Co.) (Lebous, J.)

Court held a triable issue of fact is present. It stated: "Defendant's own expert concedes that plaintiff suffered from a rupture of the exterior tendon of the right middle finger, diminished right hand function, limited wrist movement, and a moderate degree of dysfunction that could be permanent. In any event, even if the burden had shifted to plaintiff, her own physician, Dr. Weisner, clearly states plaintiff had approximately 15 degrees of extension and 30 degrees of flexion. Moreover, Dr. Weisner avers that plaintiff's chronic mallet finger creates a significant degree of dysfunction in her right hand that is permanent in nature and a result of this accident."

Navarra v. Vaca, 2008 N.Y. Slip Op. 50029(U) (Sup. Ct. Richmond Co.)(Aliotta, J.)

"When read together, the affidavits of Drs. Giovannazzo and Rosenthal are sufficient to raise a triable issue of fact as to the seriousness of the injury to plaintiff's left knew (*i.e.*, the torn meniscus), which was not only objectively determined, but required corrective surgery within three months of the subject accident. In addition, plaintiff's experts have opined that the injury in question was a consequence of this accident, and that it has prevented plaintiff from engaging in the kinds of activities in which he previously

participated. At a minimum, this evidence raises a triable issue of fact as to whether plaintiff sustained a "significant limitation of use of a body function of system."

F. 90/180 Days

1. Burdens

Joseph v. Forman, 16 Misc.3d 743, 838 N.Y.S.2d 402 (Sup. Ct. Nassau Co. 2007) (Galasso, J.)

"This Court determines that when a plaintiff makes a claim under this category in a bill of particulars and that claim is contradicted by plaintiff's own testimony taken before the Independent Medical Examinations are conducted, a plaintiff has effectively abandoned it for purposes of defendant's initial burden of proof on a threshold motion." Expressed another way, a defendant need not submit medical evidence showing non injury/no medical connection to claimed impairment to meet defendant's burden and instead can rely exclusively on plaintiff's EBT to show plaintiff cannot establish serious injury under this category.

Felton v. Kelly, 44 A.D.3d 1217, 845 N.Y.S.2d 137 (3d Dep't 2007)

Court held plaintiff met its burden "with (1) plaintiff's own deposition testimony that, following the accident, he suffered from headaches, blurry vision and pain in his neck and back, and that due to those problems he was out of work for seven months and was unable to work around his house or participate in certain hobbies, (2) Khan's report, which indicated that he had placed plaintiff on total disability during at least four of the six months following the accident, and that he had imposed lifting restrictions upon plaintiff during that time, and (3) the opinion of Aguilar who, after conducting numerous objective tests during his examination of plaintiff, concluded that plaintiff's cervical pain was related to the accident, his preexisting lower back pain was aggravated by the accident , and his headaches were questionably related to the accident."

2. 90/180 Days

Brantley v. New York City Metropolitan Trans. Auth., 48 A.D.3d 313, 852 N.Y.S.2d 81 (1st Dep't 2008)

"Without objective findings of limitations of motion contemporaneous with the accident, plaintiff's assertion that he has "difficulty" engaging in athletic activities, lifting heavy objects, and walking are insufficient to raise a triable issue as to whether there was a curtailment of his customary activities during the requisite 90/180-day period."

Cartha v. Quin, 50 A.D.3d 530, 856 N.Y.S.2d 581 (1st Dep't 2008)

Plaintiff's proof was insufficient as "he returned to work immediately after the accident, and his surgery, followed by his absence from work, did not fall within 90/180 time frame."

Amato v. Fast Repair, Inc., 42 A.D.3d 477, 840 N.Y.S.2d 394 (2d Dep't 2007)

"Since the plaintiff acknowledged at the inquest that he missed only one day of work as a result of the accident and thereafter returned to his usual duties, he failed to establish a *prima facie* case." NOTE: No reference is made to non-work activities.

Sanchez v. Williamsburg Volunteer of Hatzolah, Inc., 48 A.D.3d 664, 852 N.Y.S.2d 287 (2d Dep't 2008)

Court held plaintiff's proof was insufficient as at his deposition, the plaintiff testified that, as a result of the subject motor vehicle accident, he missed approximately five weeks from his job as a welder. NOTE: No reference is made to non-work activities.

Jones v. Gooding, 50 A.D.3d 968, 856 N.Y.S.2d 661 (2d Dep't 2008)

"Since the plaintiff missed only one day of work as a result of the injuries he sustained in the subject motor vehicle accident, he failed to establish a *prima facie* case" under this category. NOTE: The decision is silent as to whether plaintiff proved any non-work impairments.

3. Injury

Curtis v. Brent, 51 A.D.3d 464, 859 N.Y.S.2d 116 (1st Dep't 2008)

"Plaintiff's experts' reports provide neither quantitative nor qualitative assessments of the seriousness of plaintiff's injuries, and contain no competent medical evidence that he sustained a medically determined injury of a nonpermanent nature."

Koulouris v. IMS Car Services, Inc., 43 A.D.3d 879, 842 N.Y.S.2d 470 (2d Dep't 2007)

"Defendants reliance on the affirmed medical report of their examining neurologist, who conducted his examination of the plaintiff four years after the subject accident, was misplaced because he failed to relate his findings for the period of time immediately following the subject accident."

Greenidge v. Righton Limo, Inc., 43 A.D.3d 1109, 841 N.Y.S.2d 791 (2d Dep't 2007)

Defendant's proof was insufficient to support its burden as it showed that the defendant's examining neurologist did not examine the plaintiff until almost two years after the accident, and did not relate his medical findings to this category of serious-injury for the period of time immediately following the accident.

Alexandre v. Dweck, 44 A.D.3d 597, 848 N.Y.S.2d 181 (2d Dep't 2007)

Defendants' proof was insufficient as it showed, *inter alia*, that neither expert related his findings to this category of serious injury for the period of time immediately following the accident.

Pomaquiza v. Sibri, 46 A.D.3d 531, 846 N.Y.S.2d 618 (2d Dep't 2007)

"The defendant's examining orthopedist conducted an examination of the plaintiff almost a year and a half after the accident. He failed to relate his medical findings to this category of serious injury for the period of time immediately following the accident."

Joseph v. Hampton, 48 A.D.3d 638, 852 N.Y.S.2d 335 (2d Dep't 2008)

Plaintiff claimed he was unable to return to work after his accident. Court held his proof was insufficient to defeat defendant's motion, noting: "In October 2005, which was nearly 3 ½ years after the accident, the defendant's examining orthopedic surgeon and examining neurologist conducted separate examinations of Joseph. Neither physician related his medical findings to this category of serious injury for the period of time immediately following the accident. Furthermore, while Joseph also alleged in his bill of particulars that he sustained, among other injuries, a medial tear of the posterior horn of the medial meniscus of his right knee, neither physician indicated that he performed any objective tests with respect to this alleged injury, or even whether he examined Joseph's right knee."

Jenson v. Nicmanda Trucking, Inc., 47 A.D.3d 769, 851 N.Y.S.2d 594 (2d Dep't 2008)

"While the defendants' examining orthopedic surgeon noted in his report that, on the date of his examination, the plaintiff had full range of motion in both shoulders, those findings were made 1 ½ years after the subject accident occurred. There was no opinion proffered by the defendants' experts on whether the plaintiff's alleged shoulder injuries prevented him from going to work for five months during the first 180 days immediately following the accident. Thus, the defendants failed to establish their *prima facie* case."

Tinsley v. Bah, 50 A.D.3d 1019, 857 N.Y.S.2d 180 (2d Dep't 2008)

Court held defendants' medical proof failed to show no serious injury. It noted: "The plaintiff alleged in his bill of particulars that he was confined to his bed and home for a period of 4-1/2 months post-accident. The defendants' examining neurologist conducted his examination of the plaintiff approximately 1-1/2 years after the accident occurred. He did not relate his medical findings to this category of serious injury for the period of time immediately following the accident."

Yung v. Eager, 51 A.D.3d 638, 857 N.Y.S.2d 676 (2d Dep't 2008)

Court held defendants' moving papers did not "adequately address" plaintiff's 90/180 days claims, and denied the summary judgment motion. It stated: "The defendants' examining orthopedic surgeon conducted examinations of the plaintiff more than four months after the subject accident occurred. He did not related his medical findings to this category of serious injury for the period of time immediately following the accident."

Haack v. Kriss, 47 A.D.3d 1007, 849 N.Y.S.2d 697 (3d Dep't 2008)

Court held defendant orthopedist's "speculative" conclusion, rendered after an examination 4 ½ years after the automobile accident, that motorist's claimed limitations were merely an exacerbation of his prior problems which would have lasted for a period of six to eight weeks, was insufficient to demonstrate that motorist did not suffer a serious injury as the orthopedist "failed to review plaintiff's medical records from his physical therapist and his diagnosing and treating physician, which certified him not to return to work and unable to perform substantially all of his usual and customary activities for 90 of the 180 days following the accident. Court noted that orthopedist in these circumstances could not adequately address motorist's limitations during that period or express an opinion concerning the disabling effect that those injuries had on him."

Alcombrack v. Swarts, 49 A.D.3d 1170, 856 N.Y.S.2d 357 (4th Dep't 2008)

"We also reject plaintiffs' contention that the physician's affirmation submitted by defendant was insufficient to establish his entitlement to judgment as a matter of law because the physician failed to address the required time period under the 90/180 category. The physician described his review of decedent's medical records from the relevant time period and set forth his conclusions with respect to those records. The physician's conclusion that decedent "did not sustain a serious head injury" is broad enough to encompass all the categories enumerated in Insurance Law § 5102 (d)."

Sunness v. Hinshaw, 2007 N.Y. Slip Op. 52016(U) (Sup. Ct. Broom Co.)(Lebous, J.)

Court held defendant's moving papers were insufficient, noting that defendant's physician IME "report does not adequately discuss this particular category of serious injury and, further, the IME took place well beyond the expiration of the 180-day period." NOTE: *See also, Wagner v. Hartford*, 2007 N.Y. Slip Op. 52015(U) (Sup. Ct. Broome Co.) (Lebous, J.).

4. Substantially All

DeLeon v. Ross, 44 A.D.3d 545, 844 N.Y.S.2d 36 (1st Dep't 2007)

"Without more, plaintiff's affidavit, stating that he is unable to teach kickboxing or play racquetball or handball, must be viewed as insufficient."

Lloyd v. Green, 45 A.D.3d 373, 846 N.Y.S.2d 29 (1st Dep't 2007)

After noting that plaintiff's submissions lacked objective findings of restrictions, court stated: "Without more, the allegations raised in the injured plaintiff's affidavit - that he was unable to participate on the school's track team, or engage in other recreations sports - were insufficient to raise a triable issue that he did, in fact, sustain a serious injury under the statute."

Onishi v. N&B Taxi, Inc., 51 A.D.3d 594, 858 N.Y.S.2d 171 (1st Dep't 2008)

Court held plaintiff failed to raise a triable issue of fact, stating: "Although he testified that he was advised by his physicians to refrain from landscaping and heavy lifting, and that he was somewhat restricted in the activities of his daily living, such evidence is insufficient to raise a triable issue of fact as to whether plaintiff sustained a "90/180" injury."

Ronda v. Friendly Baptist Church, 52 A.D.3d 440, __ N.Y.S.2d __ (1st Dep't 2008)

"We note that neither the minor curtailment of his activities nor his need to be placed on light duty upon his return to work raised an inference that plaintiff was unable to perform his usual and customary daily activities for 90 of the first 180 days following the accident."

Bozza v. O'Neill, 43 A.D.3d 1094, 842 N.Y.S.2d 88 (2d Dep't 2007)

Subject accident occurred on January 30, 2003. At his deposition on June 8, 2004, the plaintiff testified that he did not return to his job as director of nutrition at Brunswick Hospital following the accident and that his job was, in fact, terminated six months after the accident, when he was unable to provide his employer with a return date. Defendant's failed to refute this proof.

Greenidge v. Righton Limo, Inc., 43 A.D.3d 1109, 841 N.Y.S.2d 791 (2d Dep't 2007)

Defendant's proof was insufficient to support its burden as it showed, *inter alia*, that plaintiff was out of work for 3 ½ months as a result of the accident.

Alexandre v. Dweck, 44 A.D.3d 597, 848 N.Y.S.2d 181 (2d Dep't 2007)

Defendants' proof was insufficient as it showed, *inter alia*, that plaintiff was out of work for six months following the accident.

Hamilton v. Rouse, 46 A.D.3d 514, 846 N.Y.S.2d 650 (2d Dep't 2007)

Court set aside jury verdict for verdict and dismissed complaint. It noted that "plaintiff testified at trial that he missed only one month of work, that he then returned to work on a part-time basis, and that, after another month, he had resumed working on a full-time basis. The plaintiff further acknowledged that he was never directed by his treating physician to refrain from working following the accident.

Baker v. Thorpe, 43 A.D.3d 535, 840 N.Y.S.2d 834 (3d Dep't 2007)

"Plaintiff was on "light duty" at work for four to six weeks and thereafter encountered no difficulties performing either his employment or the activities of daily living. Plaintiff's reported limitations in his care for his horses and golf game were not, in our view, sufficient."

Saleh v. Bryant, 49 A.D.3d 991, 853 N.Y.S.2d 415 (3d Dep't 2008)

"Inasmuch as plaintiff failed to clearly delineate the scope and duration of the usual and customary tasks she was allegedly unable to perform following the accident during her deposition, the requirements of the 90/180-day category were also not satisfied."

Hildenbrand v. Chin, 52 A.D.3d 1164, __ N.Y.S.2d __ (3d Dep't 2008)

Court held plaintiff's proof was sufficient, stating: "Plaintiff averred that his symptoms arose for the first time following the accident and he has been unable to return to work as a school bus driver and home health care aide. He further affirms in his pretrial testimony that he is unable to drive long distances, hold a coffee cup in his left hand, shovel snow, do household chores and take out the trash, and he has difficulty bathing himself. Furthermore, the results of the EMG and MRI, respectively, establish "mild acute denervation" as well as both a mild and severe cord impingement. Moreover, in addition to the various medical reports submitted by plaintiffs regarding plaintiff's causally-related impairments, defendant's own expert, physician Adam Soyer, assessed plaintiff with 'probable left brachial plexopathy, status post motor vehicle accident'".

Gonzalez v. Ceesay, 2008 N.Y.Slip.Op. 50804 (U) (App.T. 1st Dep't)

Plaintiff's proof raised a triable issue of fact "by evidence that he was disabled from work for more than 90 of the first 180 days after the accident as well as admissible medical reports attesting to his "total disability" for several months after the accident, detailing his difficulties with daily activities and asserting that the accident caused an exacerbation of plaintiff's previously asymptomatic underlying degenerative disease." NOTE: Court

held the failure of plaintiff or his physicians to address or explain the nearly five year "gap" in treatment is fatal to plaintiff's serious injury claims under the "significant limitation" and "permanent consequential limitation" categories.

5. Medically Connected

Guadalupe v. Blondie Limo, Inc., 43 A.D.3d 669, 841 N.Y.S.2d 525 (1st Dep't 2007)

"The subjective claims of pain and unsubstantiated claim of inability to perform [her] customary daily activities are insufficient to raise a triable issue of fact."

Johnson v. Marriott Management, 44 A.D.3d 450, 843 N.Y.S.2d 291 (1st Dep't 2007)

"Plaintiff failed to provide objective, admissible evidence of the persistence of her injury during the statutorily relevant period, and her subjective statements are insufficient to create a triable issue."

Rodgriguez v. Abdallah, 51 A.D.3d 590, 858 N.Y.S.2d 169 (1st Dep't 2008)

Court held plaintiff's proof was insufficient, noting that plaintiff submitted only proof of a "self-imposed absence, based upon the injured plaintiff's subjective complaints of pain and discomfort."

Hoxha v. McEachern, 42 A.D.3d 433, 840 N.Y.S.2d 89 (2d Dep't 2007)

"The defendants' claims that the plaintiff's injuries were the result of her 'subjective complaints' and that any restriction in her daily activities 'was of her own volition' were unsupported by any competent evidence. Significantly, the defendants' neurological expert, who reviewed, *inter alia*, the diagnostic test reports generated in the days and weeks following the subject accident, offered no opinion as to the nature, seriousness, or potential cause of any condition or finding documented therein. Consequently, the defendants failed to make out a *prima facie* case with respect to the plaintiff's claim of serious injury based on the 90/180 day category."

Roman v. Fast Lane Care Service, 46 A.D.3d 535, 846 N.Y.S.2d 613 (2d Dep't 2007)

Court held plaintiff failed to submit competent medical evidence that he sustained an injury which prevented him from performing his claimed activities.

Guzman v. Joseph, 50 A.D.3d 741, 855 N.Y.S.2d 636 (2d Dep't 2008)

Court held defendants failed to address that plaintiff did not sustain a serious injury, under this category, as alleged in his bill of particulars, noting that "the plaintiff testified at this examination before trial that as a result of the accident he never returned to work, and the defendant's examining experts noted in their respective reports that the plaintiff missed about a year of work, and defendant's examining neurologist and orthopedist did

not examine the plaintiff until almost 1-1/2 years after the accident, and did not related their medical findings to this category of serious injury for the period of time immediately following the accident."

Hemsley v. Ventura, 50 A.D.3d 1079, 857 N.Y.S.2d 642 (2d Dep't 2008)

"While the plaintiff testified at her deposition that as a result of the accident she was confined to her home for "[t]wo, three months" thereafter, and suffered certain limitations in her activities around the home, Court held there was "no competent medical evidence indicating that she was unable to perform substantially all of her daily activities for not less than 90 out of the first 180 days as a result of the subject accident.".

Ali v. Rivera, 52 A.D.3d 445, 859 N.Y.S.2d 713 (2d Dep't 2008)

Court held: "Defendants' motion papers did not adequately address the plaintiff's claim, clearly set forth in his bill of particulars, that he sustained a medically-determined injury or impairment of a nonpermanent nature which prevented him from performing substantially all of the material acts which constituted his usual and customary daily activities for not less than 90 days during the 180 days immediately following the accident. The subject accident occurred on March 9, 2006. The plaintiff stated in his bill of particulars that he missed six months of work as a result of the subject accident. The defendants' examining orthopedic surgeon and neurologist conducted separate examinations of the plaintiff nearly 16 months after the subject accident. Those experts noted in their respective reports that the plaintiff missed six months from work as a result of the subject accident. Neither physician related his medical findings to this category of serious injury for the period of time immediately following the subject accident."

Saleh v. Bryant, 49 A.D.3d 991, 853 N.Y.S.2d 415 (3d Dep't 2008)

"Plaintiff's self-serving affidavit, in which she sought to remedy deficiencies in her deposition testimony concerning her inability to perform certain activities, was insufficient to raise a question of fact as to the 90/180-day category."

Deeks v. Bass, 2007 N.Y. Slip Op. 50450(U) (Sup. Ct. Nassau Co.)(Palmieri, J.)

"Combined with other tests and positive findings made by Dr. Lee on physical examination, and the confirmation of disc herniations as reported by Dr. Rizzuti, the Court finds that plaintiffs have presented an objective medical basis for their initial complaints of pain, tenderness and restrictions on motion, and that these conditions were caused by the subject accident. This proof thus supports the claimed difficulty in sitting, standing or walking for extended periods of time, and the attendant inability to pursue their business for, respectively, four months (Andre) and five months (Mira) following the accident."

6. Damages

No Cases

G. Emotional/Psychological Injuries

No Cases

H. Disc And Other Injuries

Medina v. Medina, 49 A.D.3d 335, 853 N.Y.S.2d 77 (1st Dep't 2008)

"There is no merit to plaintiff's argument that defendant's *prima facie* showing was rendered deficient by his physician's acknowledgment that a bulging disc was revealed by the MRI of plaintiff's lumbar spine taken shortly after the accident. In opposition, plaintiff adduced no medical evidence of impingement or other neurologic deficits that could be attributed to a bulging disc, and the objectively tested range of motion limitations noted in plaintiff's lumbar spine, as well as her cervical spine, left knee and shoulder, were not assessed until nearly five years after the accident, too remote to raise an issue of fact as to whether the restrictions were caused by the accident."

Pazmino v. Universal Distrib., 45 A.D.3d 554, 845 N.Y.S.2d 401 (2d Dep't 2007)

"This Court has held that the mere existence of a herniated or bulging disc, and even radiculopathy, 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."

Jacobs v. Slaght, 47 A.D.3d 679, 850 N.Y.S.2d 166 (2d Dep't 2008)

"The mere existence of carpal tunnel syndrome is not evidence of a serious injury in the absence of objective testing of the extent and duration of the alleged physical limitations resulting from the injury."

Shvartsman v. Vildman, 47 A.D.3d 700, 849 N.Y.S.2d 600 (2d Dep't 2008)

"The mere existence of a herniated or bulging 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."

Sharma v. Diaz, 48 A.D.3d 442, 850 N.Y.S.2d 634 (2d Dep't 2008)

"The mere existence of radiculopathy 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."

Casas v. Montero, 48 A.D.3d 728, 853 N.Y.S.2d 358 (2d Dep't 2008)

"Even a tear in a tendon" is not *per se* sufficient to establish a serious injury.

Piperis v. Wan, 49 A.D.3d 840, 854 N.Y.S.2d 489 (2d Dep't 2008)

"The mere existence of a herniated or bulging disc, and even a tear in a tendon, is not evidence of a serious injury in the absence of objective evidence of the extent of the alleged physical limitations resulting from the injury and its duration."

Scotto v. Suh, 50 A.D.3d 1012, 853 N.Y.S.2d 185 (2d Dep't 2008)

"The MRI reports of Dr. Waxman and Dr. Diamond showing a disc herniation at C6-7 and a partial left shoulder rotator cuff tear fail to establish the extent of the alleged physical limitations resulting from the injury and their durations."

III. CAUSATION

A. Generally

1. Establishing Casual Connection

Smith v. Cherubini, 44 A.D.3d 520, 844 N.Y.S.2d 29 (1st Dep't 2007)

In reversing verdict for plaintiff and dismissing the action, Court held "plaintiff's medical expert failed to explain or address how the intervening accidents and history of progressively worsening migraines were not the cause of her complaints, and failed to testify as to any current, causally related limitation experienced by plaintiff."

Brantley v. New York City Metropolitan Trans. Auth., 48 A.D.3d 314, 851 N.Y.S.2d 514 (1st Dep't 2008)

Court held that while an MRI taken about three months after the accident indicated a herniated lumbar disc, the only objective evidence of limitations of motion is contained in a report of an orthopedist who examined plaintiff about four years after the accident. It was "too remote to raise an issue of fact as to whether the limitations were caused by the accident."

Kim v. Amaya, 51 A.D.3d 487, 857 N.Y.S.2d 140 (1st Dep't 2008)

Court held: "The affirmed report from the physician who examined plaintiff more than three years after the accident fails to provide a causal connection between the alleged injuries and the accident, and does not account for the degenerative changes that the MRI films revealed."

Cooper v. LI Constr., Inc., 45 A.D.3d 623, 845 N.Y.S.2d 454 (2d Dep't 2007)

In his affirmed medical report, the orthopedist retained by the defendants found that the plaintiff's range of motion was normal in his cervical and lumbosacral spines, as well as in his left knee, right shoulder, and right wrist. Moreover, an MRI report prepared by the plaintiff's own physician, upon which the defendants also relied in support of their motion, indicated that, while there existed a [m]ild, diffuse disc bulge at C5-C6, it does not appear to be impinging on the cord of nerve roots and should not be causing symptoms. In opposition, the medical evidence submitted by the plaintiff failed to raise a triable issue of fact."

Cavender v. Wyeth Pharmaceuticals, 48 A.D.3d 396, 849 N.Y.S.2d 796 (2d Dep't 2008)

"The report of Dr. Monsanto, the defendants' examining hand specialist, noted the surgeries to the plaintiff's left wrist and thumb as well as the "two well healed scars" on her wrist and thumb, which he diagnosed as "post excision of a mass of wrist and mass of thumb." His conclusory assertion that these injuries were not secondary to the accident was insufficient as a matter of law to establish that the plaintiff did not sustain a serious injury as a result of the subject accident."

Morris v. Edmond, 48 A.D.3d 432, 850 N.Y.S.2d 641 (2d Dep't 2008)

Plaintiff's proof was insufficient as her physician did not state that any of the limitations noted were the result of injuries sustained in the subject accident.

Penaloza v. Chavez, 48 A.D.3d 654, 852 N.Y.S.2d 315 (2d Dep't 2008)

Court noted that while the MRI reports revealed disc pathology, "none of the plaintiff's treating radiologists gave any opinion in their reports as to the cause of the pathology noted within those reports."

Cummings v. Gu, 42 A.D.3d 920, 839 N.Y.S.2d 663 (4th Dep't 2007)

Court rejected plaintiff's argument that verdict for defendant was against the weight of the evidence, noting: "In light of the evidence of plaintiff's preexisting injuries and the degenerative changes to plaintiff's neck, there is evidence from which the jury could have found that the spinal fusion surgery was not required solely because of the herniated disc caused by the motor vehicle accident."

2. "Pommells" Rules

a. Generally

Pommells v. Perez, Brown v. Dunlap, Carrasco v. Mendez, 4 NY3d 566, 797 NYS2d 380 (2005):

Pommells

"Plaintiff failed to address the effect of his kidney disorder on his claimed accident injuries. Dr. Rose's report - the only competent evident supporting plaintiffs response to the summary judgment motion - in fact noted the kidney surgery in plaintiff's medical history and then relied on that medical history in opining as to causation. Plaintiffs submission left wholly unanswered the question whether the claimed symptoms diagnosed by Dr. Rose were caused by the accident."

Brown

"As to an alleged pre-existing condition, there is only Dr. Berkowitz's [expert] conclusory notation, itself insufficient to establish that plaintiff's pain might be chronic and unrelated to the accident. As opposed to the undisputed proof of plaintiff's contemporaneous, causally relevant kidney condition in Pommells, here even two of defendants' other doctors acknowledged that plaintiffs (relatively minor) injuries were caused by the car accident. On this record, plaintiff was not obliged to do more to overcome defendants' summary judgment motions."

Carrasco

"While plaintiff provided Dr. Lambrakis's expert's report of specific losses of range of motion in plaintiffs spine, opining that plaintiff suffered serious and permanent injuries which were casually related to the accident, plaintiff did not refute defendant's evidence of a pre-existing degenerative condition. To the contrary, the Lambrakis report supplied by plaintiff explained that the pain and loss of range of motion in the cervical spine was entirely consistent with those formations identified by the MJU and set forth by Drs. Miloradovich and Orlandi [expert] as related to a degenerative condition. In this case, with persuasive evidence that plaintiff's alleged pain and injuries were related to pre existing condition, plaintiff had the burden to come forward with evidence addressing defendant's claimed lack of causation. In the absence of any such evidence, we conclude—as did the trial court and Appellate Division—that defendant was entitled to summary dismissal of the complaint."

b. Defendant's Burden

Brewster v. FTM Servo Corp., 44 A.D.2d 351, 844 N.Y.S.2d 5 (1st Dep't 2007)

"Once a defendant has presented evidence of a pre-existing injury, even in the form of an admission made at a deposition, it is incumbent upon the plaintiff to present proof to mee the defendant's asserted lack of causation."

Kim v. Amaya, 51 A.D.3d 487, 857 N.Y.S.2d 140 (1st Dep't 2008)

Defendant's proof established that the findings on the MRI films and x-rays were degenerative in nature and not the result of the subject car accident. Court held plaintiff's

proof was insufficient as it did not account for the degenerative changes that the MRI films revealed.

Ronda v. Friendly Baptist Church, 52 A.D.3d 440, __ N.Y.S.2d __ (1st Dep't 2008)

Court held: "Defendants carried their initial burden of showing that plaintiff's shoulder tendon tear and other injuries were not proximately caused by the subject accident by submitting reports of plaintiff's previous line-of-duty injuries and the opinion of their examining orthopedist, based in part on the MRI report describing arthritic changes in the shoulder joint as degenerative, that the shoulder injury was among plaintiff's preexisting conditions. Plaintiff ailed to meet his burden to adduce evidence rebutting the asserted lack of causation."

Lea v. Cucuzza, 43 A.D.3d 882, 842 N.Y.S.2d 468 (2d Dep't 2007)

"Any restrictions in the plaintiff's range of motion were attributed by the defendants' examining neurologist to pre-existing degenerative changes noted on radiologic films, and were not causally related to the subject accident."

Bozza v. O'Neill, 43 A.D.3d 1094, 842 N.Y.S.2d 88 (2d Dep't 2007)

"The defendants were not able to offer sufficient evidence to establish that the plaintiff's injuries either were solely attributable to a degenerative condition or were caused by a subsequent accident."

Carridi v. Hassan, 45 A.D.3d 516, 845 N.Y.S2d 426 (2d Dep't 2008)

In support of their summary judgment, defendants submitted the affirmed report of Dr. Rothpearl. As to that report, Court stated: "Based on his review of the MRI film of the plaintiff's left hip, Dr. Rothpearl opined that the plaintiff suffered from "joint effusion," which he described as "a nonspecific finding which is usually idiopathic, inflammatory, infectious, or degenerative in nature," as well as from "[d]egenerative joint disease," which "occurs as a natural consequence of aging." We find that Dr. Rothpearl's report was sufficient to establish, *prima facie*, that the plaintiff's alleged hip injury was unrelated to the subject accident." NOTE: For discussion of plaintiff's response, see next section.

McKenzie v. Redl, 47 A.D.3d 775, 850 N.Y.S.2d 545 (2d Dep't 2008)

In noting that defendants' medical proof in support of motion contained a finding by their examining physician that the range of motion of the plaintiff's lower back was "30 degrees forward flexion", and in another medial report submitted by the defendants, prepared by the plaintiff's long-time treating orthopedist, the same range of motion prior to the accident was 60 degrees flexion, Court held defendants failed to demonstrate *prima facie* entitlement to judgment as a matter of law with evidence that the injuries at issue

were attributable to prior accidents or pre-existing conditions, and were not exacerbated by the accident.

Sforza v. Big Guy Leasing Corp., 51 A.D.3d 659, 858 N.Y.S.2d 233 (2d Dep't 2008)

Court rejected defendants' effort to attribute the plaintiff's injury to an accident in or about 1992 in which the plaintiff's lower back was injured. It stated: "The plaintiff testified at her deposition that she never injured her neck and the injury to he rlower back healed. Accordingly, there is no evidence in this record of a pre-existing injury to the plaintiff's neck. Further, considering the length of time between the two accidents, and the plaintiff's testimony that her lumbar region of the spine completely healed, Dr. Baum's failure to consider the 1992 accident did not render his conclusions speculative."

Holbrook v. Pruiksma, 43 A.D.3d 603, 842 N.Y.S.2d 591 (3d Dep't 2007)

"Cross-examination revealed that the neurologist was not well versed in plaintiff's actual 'pre-accident state.' For example, he acknowledged during cross-examination that plaintiff did not tell him, or a colleague who initially treated her, that she had the 1989 accident following which she made complaints of loss of balance, dizziness, neck pain and neck stiffness. Nor did she tell either treating neurologist about her prior cervical cranial syndrome diagnosis, prior treatment for headaches or prior chiropractic treatment. Nor did either know that she was taking prescription medication on the day of the subject accident for migraines, anxiety and depression. She also never reported her prior complaints of fatigue, dizziness, depression or poor concentration. In fact, plaintiff reported that she had no 'significant past medical history.' Similarly, plaintiff's treating psychologist knew about the 1989 motor vehicle accident but was informed that she had no resulting injuries. Therefore, the verdict of the no serious injury was not against the weight of the evidence."

Ashquabe v. McConnell, 46 A.D.3d 1419, 848 N.Y.S.2d 794 (4th Dep't 2007)

In affirming the Supreme Court's decision, the Court stated: "In support of her motion, defendant submitted the report of a physician who examined plaintiff on behalf of defendant. According to that physician, plaintiff 'incurred a cervical muscle strain as a result of the motor vehicle accident.' The physician further stated that MRI scans of plaintiff's cervical spine 'reveal[ed] degenerative disc disease/spondylosis at [C5-6] and [C6-7, as well as] associated mild disc bulging,' and that MRI scans of plaintiff's thoracic spine 'reveal[ed] degenerative disc disease at [T4] and {T5-6].' The physician failed to address the herniation at C6-7 observed by a radiologist, however, although he indicated that he had reviewed the radiologists' reports accompanying the MRI scans of plaintiff's cervical spine. In addition, the physician noted that plaintiff 'denie[d] history of any similar preexistent pain conditions predating the motor vehicle accident,' but he failed to address the significance of the absence of any prior complaints of similar pain. We thus conclude that the physician's report does not constitute 'persuasive evidence that plaintiff's alleged pain and injuries were related to a preexisting condition.' Indeed, we

conclude that the physician's analysis was conclusory and therefore 'insufficient to establish that plaintiff's pain might be chronic and unrelated to the accident.'"

Ashquabe v. McConnell, 14 Misc.3d 211, 829 N.Y.S.2d 427 (Sup. Ct. Erie Co. 2006) (Curran, J.)

After the accident, plaintiff complained of neck and shoulder pain. Prior to the accident, plaintiff did not have any symptoms or other evidence of a cervical injury. The defendant's IME physician upon a review of the MRI films of plaintiff's cervical spine concluded that there is evidence of degenerative disc disease/spondylosis involving the C5/6 and C6/7 levels and that there is "mild disc bulging at these levels"; that "these images do not bear any evidence of 'focal disc herniation'"; that the mild disc bulging is associated to the degenerative disc disease/spondylosis; and that "the abnormalities identified on MRI of the cervical spine are degenerative in nature and unrelated to the motor vehicle accident of 4/8/04." Defendant then moved for summary judgment solely on the finding of the degenerative condition, arguing that this is a sufficient basis under *Pommells* upon which to shift burden to plaintiff. Court initially noted that plaintiff had a latent condition as opposed to an asymptomatic condition which was patent or known prior to the accident. It then held that a latent degenerative disc condition is a pre-existing condition within the meaning of *Pommells*. However, the court concluded that proof of such condition alone is insufficient to shift the burden to plaintiff. "Rather", the Court held, "a finding of degeneration in the spine must be accompanied by something more such as pre-accident radiological tests establishing the pre-accident degenerative changes or more 'persuasive evidence' then provided in this case." QUAERE: What would constitute such "persuasive evidence"?

Barnes v. Estes, 46 A.D.3d 1441, 848 N.Y.S.2d 472 (4th Dep't 2007)

Court held defendants met their burden by "submitting the affirmation of a physician who examined plaintiff on defendants' behalf, and plaintiffs failed to raise a triable issue of fact. According to the affirmation of defendants' examining physician, the CT scan and MRI studies did not indicate that plaintiff suffered any acute injury as a result of the accident, and the bulging discs at L3-4, L4-5 and L-5-S1 were due to 'congenital abnormalities.'" QUAERE: Is this decision consistent with *Ashquabe*?

Lux v. Jakson, 52 A.D.3d 1253, 859 N.Y.S.2d 813 (4th Dep't 2008)

Court held defendant met their burden with "persuasive evidence" stating: "Defendants met their initial burden by submitting, *inter alia*, an affirmed report of a physician who examined plaintiff on behalf of defendants and concluded that there was no objective evidence that plaintiff sustained a serious injury in her cervical spine as a result of the accident but, rather, plaintiff suffered from a preexisting degenerative condition in her cervical spine and had previously injured her cervical spine."

Chmiel v. Figueroa, __ A.D.3d __, __ N.Y.S.2d __ (4th Dep't 2008)

Court held: "Although defendant met her initial burden with respect to the permanent consequential limitation of use and significant limitation of use categories of serious injury by establishing that plaintiff's alleged injuries were not causally related to the accident but resulted from a preexisting condition (*see generally Pommells v. Perez* 4 NY3d 566, 580), plaintiff raised a triable issue of fact on causation with respect to those categories by submitting objective evidence of his herniated disc as well as his loss of movement resulting from the spinal fusion surgery he underwent following the accident."

Covert v. Samuel, __ A.D.3d __, __ N.Y.S.2d __ (4th Dep't 2008)

Court held a triable issue of fact was present, noting: "In support of the cross motion, plaintiffs submitted the affirmations of plaintiff's treating neurosurgeon and orthopedic surgeon. The neurosurgeon found that plaintiff suffered from a degenerative condition of her cervical spine, and he did not "adequately address how plaintiff's current medical problems, in light of her past medical history, are causally related to the subject accident". Plaintiffs met their burden, however, by submitting the affirmation of the orthopedic surgeon who concluded, based on objective evidence, that the accident aggravated a preexisting problem in plaintiff's right shoulder, resulting in tendinopathy and intrasubstance tearing of the supraspinatus tendon, as revealed by an MR arthrogram. Nevertheless, we conclude that defendants raised an issue of fact sufficient to defeat that part of the cross motion by submitting the report of the physician who examined plaintiff on their behalf, wherein he concluded that plaintiff's 'complaints' resulted from a preexisting condition and were not causally related to the accident."

Urena v. Jack, 2008 N.Y. Slip Op. 28224 (App.T. 1st Dep't)

Court held: "The allegations of defendant's radiologist as to the existence of preexisting conditions in the lumbar spine and right knee were insufficient to establish that plaintiff's injuries were unrelated to the accident, at least in these circumstances where (1) the other two defense medical experts acknowledged that plaintiff's injuries were causally related to the accident, (2) the x-ray of plaintiff's knee, taken on the day of the accident and relied upon by defendant to show no fracture, refuted the finding of significant degenerative changes, and (3) the opinions of the parties' radiologists were divergent as to the existence of tears in the knee and a disc bulge in the cervical spine. On this record, plaintiff was not obliged to do more to overcome defendant's summary judgment motion."

Blanco v. Peterson, 2007 N.Y. Slip Op. 50155(U) (App. T. 1st Dep't)

Plaintiff's physician failed to address plaintiff's preexisting "extensive degenerative disc disease" and "severe" disc narrowing revealed in the CT scan performed at the emergency room on the day of the accident, which defendant's expert opined to be the cause of plaintiff's complaints. NOTE: A "severe" disc narrowing is generally viewed as indicative of a pre-existing condition.

Santiago v. Nimus Serv. Corp., 2008 N.Y. Slip Op. 50253(U) (App. T. 1st Dep't)

"Once a defendant has presented evidence of a preexisting injury or degeneration, it is incumbent upon the plaintiff in a serious injury case to present proof to meet the defendant's asserted lack of causation (*see Brewster v. FTM Sero, Corp*., 44 A.D.3d 351 [1st Dep't 2007])."

Parczewski v. Leone, 2007 N.Y. Slip Op. 50065(U) (Sup. Ct. Queens Co.)(Dollard, J.)

Court held defendants met his *Pommells* burden by his proof, namely: the cervical spine MRI report dated May 22, 2005 prepared by Dr. Lodespoto, a board-certified radiologist reveals that she has "degenerative disc disease, C4/5, C5/6, 6/7 bulges," and Dr. Lodespoto notes in his commentary that "The background cervical degenerative changes are chronic and long standing in nature, unrelated to any acute traumatic event." NOTE: Accident occurred in April, 2002.

c. Plaintiff's Burden

Yagi v. Corbin, 44 A.D.3d 440, 843 N.Y.S.2d 176 (1st Dep't 2007)

Court stated that plaintiff did not sufficiently address his pre-existing injury. NOTE: It does not appear that defendants relied upon this pre-existing injury in support of their motion.

Johnson v. Marriott Management, 44 A.D.3d 450, 843 N.Y.S.2d 291 (1st Dep't 2007)

"The affidavit of plaintiff's chiropractor failed to demonstrate that the cervical disc herniations or any other injury plaintiff suffered were causally related to the accident and were not, instead, related to a prior injury or degenerative condition."

Becerril v. Sol Cab Corp., 50 A.D.3d 261, 854 N.Y.S.2d 695 (1st Dep't 2008)

In response to defendants' medical proof that plaintiff's MRI films revealed degenerative disc disease, and no evidence of post-traumatic injury to the disc structures, Court held plaintiffs failed to raise a triable issue of fact as to whether he sustained a serious injury. It noted: "Although plaintiff submitted an affirmed report from his treating chiropractor detailing the objective testing employed during plaintiff's examination and revealing limited ranges of motion, no adequate explanation was provided that plaintiff's injuries were caused by the subject accident. Notably, plaintiff conceded at his deposition that he sustained injuries to his neck and back in a prior accident, and an MRI conducted shortly after the subject accident showed degenerative disc disease. In these circumstances, it was incumbent upon plaintiff to present proof addressing the asserted lack of causation."

Lunkins v. Toure, 50 A.D.3d 399, 858 N.Y.S.2d 96 (1st Dep't 2008)

"Plaintiff's opposition failed to raise a triable issue of fact as to whether she sustained a serious injury. Her deposition testimony revealed that she was involved in a second motor vehicle accident more than one year after the subject accident, in which she injured her neck, back and shoulder. The conclusion of plaintiff's treating orthopedist regarding the range of motion limitations found in plaintiff's neck, back and right shoulder, two years after the subject accident, failed to adequately address the possibility that plaintiff's limitations were caused by the second accident."

Seecomar v. Ly, 43 A.D.3d 900, 841 N.Y.S.2d 624 (2d Dep't 2007)

Defendant's proof showed a disc bulge at C5-S1 and disc degeneration in the lumbar and thoracic spine; and that plaintiff's range of motion in cervical and lumbar spine was normal. In opposition, plaintiff submitted an affidavit stating that prior to the accident he never had pain in his neck or back and had never been treated for any pain in the neck or back. Subsequent to the accident the plaintiff immediately sought treatment and underwent active physical therapy until September 2004 when there was no improvement other than temporary symptomatic relief. At the time the motion was made, the plaintiff was doing exercises at home, wore a back brace, and took prescription medication for pain in his neck and back. He was unable to return to this job as a part-time real estate salesman because he could not sit at a desk or go up and down stairs. An affirmation of a radiologist confirmed that an MRI of the plaintiff taken one month after the accident showed a disc herniation at L5-S-1 and bulging discs at L1 through L-4. His orthopedist found that the plaintiff exhibited evidence of cervical myositis as well as lumbar radiculopahty. He stated that he plaintiff used a back brace to control his condition. In the opinion of the orthopedist, the plaintiff suffered a permanent partial disability to his neck and low back as a result of the accident. Additionally, the plaintiff's primary treating physician corroborated the orthopedist's findings. Court found issues of fact were present sufficient to require denial of motion.

Munoz v. Koyfman, 44 A.D.3d 914, 844 N.Y.S.2d 111 (2d Dep't 2007)

"The affidavit of plaintiff's treating chiropractor failed to raise a triable issue of fact. His conclusions were speculative because he failed to account for the numerous accidents, both before and after the subject one, in which plaintiff injured the same parts of her body that she alleges were injured in this action."

Carridi v. Hassan, 45 A.D.3d 516, 845 N.Y.S.2d 426 (2d Dep't 2008)

Court stated: "In opposition, the plaintiff submitted the affirmed report of Dr. Tobin, who, reading the same MRI film, opined that the plaintiff sustained a "tear of the superolateral acetabular labrum," and specifically noted "no significant joint effusion." We find that these conflicting medical opinions regarding the nature and etiology of the plaintiff's alleged hip injury raises triable issues of fact."

Nigro v. Kovac, 45 A.D.3d 547, 845 N.Y.S.2d 404 (2d Dep't 2007)

Plaintiff established *prima facie* a serious injury as her treating chiropractor causally related plaintiff's injuries to the accident and that they were not the result of any pre-existing degenerative conditions.

Pazmino v. Universal Distrib., 45 A.D.3d 554, 845 N.Y.S.2d 401 (2d Dep't 2007)

Court held plaintiff's expert medical affidavit was insufficient as the physician after noting that plaintiff was involved in several accidents in the year before he was examined, "were the result of the subject accident. These conclusions were clearly rendered speculative in light of the fact that he failed to address what those prior accidents involved."

Roman v. Fast Lane Car Service, 46 A.D.3d 535, 846 N.Y.S.2d 613 (2d Dep't 2007)

"The plaintiff failed to raise a triable issue of fact. The plaintiff principally relied upon the affidavit of his treating physician, Dr. Emil Stracar, which incorporated therein many of his reports. Dr. Stracar concluded in his affidavit that, as a result of the subject accident, the plaintiff sustained significant and permanent injuries to the cervical and lumbar regions of his spine. Dr. Stracar failed to address, however, the findings of the defendants' examining radiologist that the injuries to the plaintiff's cervical and lumbar regions of his spine were the result of pre-existing degenerative disc disease and were unrelated to the subject accident. This omission rendered speculative Dr. Stracar's conclusions that the cervical and lumbar injuries and limitations he noted in his affidavit were the result of the subject accident."

Rashid v. Estevez, 47 A.D.3d 786, 850 N.Y.S.2d 181 (2d Dep't 2008)

Plaintiff's proof was insufficient as his treating chiropractor failed to address the fact that the plaintiff had been injured previously in a football game, nor did he address the finding of the defendant's examining radiologist that the plaintiff suffered from pre-existing degenerative disc disease in the lumbar region of the spine. "Thus, these omissions rendered speculative his conclusions that the injuries and limitations he noted in the plaintiff's cervical and lumbar regions of his spine were the result of the subject accident."

Penaloza v. Chavez, 48 A.D.3d 654, 852 N.Y.S.2d 315 (2d Dep't 2008)

Court held plaintiff's medical proof was insufficient. It stated: "The affirmation fo the plaintiff's treating neurologist, Dr. David Zelefsky, noted significant range of motion limitations in the plaintiff's cervical and lumbar spine based on recent and contemporaneous range of motion testing. Despite the fact that he concluded that the cervical and lumbar spine injuries and limitations were the result of the subject accident an were permanent, he failed to adequately address the fact that the plaintiff had two prior accidents in which she injured her back and neck. While he did make a notation in his

affirmation that she was involved in the two prior accidents, he merely took the plaintiff's word for the fact that the plaintiff recovered form any injuries sustained therein. Dr. Zelefsky never reviewed any of the plaintiff's prior medical records related to those accidents (*see Vidor v. Davila*, 37 A.D.3d 826, 830 N.Y.S.2d 772). Due to his failure to adequately address these two prior accidents, his conclusions that the injuries and limitations noted in the plaintiff's cervical and lumbar spines were the result of the subject accident were clearly rendered speculative."

Marrache v. Akron Taxi Corp., 50 A.D.3d 973, 856 N.Y.S.2d 239 (2d Dep't 2008)

"The submissions of plaintiff's expert physicians were insufficient to raise a triable issue of fact. Neither expert addressed the findings of the appellants' examining radiologist, who concluded that the injured plaintiff suffered from degenerative disc disease in the C2 through C7 levels of her cervical spine. This failure rendered speculative their respective conclusions that the injuries and limitations that they noted were caused by the subject accident."

Sforza v. Big Guy Leasing Corp., 51 A.D.3d 659, 858 N.Y.S.2d 233 (2d Dep't)

Defendant's medical proof asserted, *inter alia*, that the restrictions plaintiff, 64 years old, complained of were age-related crepitus and arthritis. Court held plaintiff's proof in response raised a triable issue of fact. It observed: "An affirmed MRI report indicated that the plaintiff suffered herniated discs in the cervical region of the spine and herniated and bulging discs in the lumbar region of the spine. An initial X-ray of the cervical spine revealed 'some degenerative change.' However, Dr. Baum, the plaintiff's treating orthopedist, concluded that 'while this patient may have had some underlying development of degenerative joint disease due to her age, the MRI findings of multi-level bulging and herniated discs to both her neck and back are a direct result of the impact she sustained as a result' of the accident. Dr. Baum noted that the plaintiff suffered quantified restrictions of range of motion of the cervical and lumbar spine based upon examinations shortly after the accident, and based upon a recent examination."

Woods v. Johnson, 44 A.D.3d 1201, 843 N.Y.S.2d 862 (3d Dep't 2007)

Court held: "While there is no dispute that plaintiff suffered a fracture of the facet of her C3 vertebra, whether that fracture was caused by the motor vehicle accident, by degenerative changes in plaintiff's spine or otherwise, cannot be resolved on this record as a matter of law. Moreover, if plaintiff sustained a fracture in the motor vehicle accident, and the injury was aggravated by the physicians who operated, defendants would remain liable for the aggravation of the injury."

Coston v. McGray, 49 A.D.3d 934, 853 N.Y.S.2d 206 (3d Dep't 2007)

Defendant's medical expert averred that plaintiff's complaint of cervical and lumbar spine pain were attributable to a prior fall, accident and gunshot wound. Court held: "The evidence submitted by plaintiffs in opposition, however, did not refute defendants'

showing of preexisting injuries. Plaintiffs relied solely upon the affirmation of Luis Mendoza Jr., who began treating plaintiff in December 2002, following the first of the two accidents at issue here. That affirmation provides no objective basis for concluding that plaintiff's injuries were caused by these two accidents rather than prior gunshot, accidents and falls; indeed, Mendoza's affirmation makes no reference at all to the prior incidents and injuries. As such, 'there is an inadequate foundation to support [Mendoza's] conclusion that plaintiff's medical conditions are causally related to the accident[s]' at issue and Supreme Court properly dismissed the complaint."

Scott v. Aponte, 49 A.D.3d 1131, 854 N.Y.S.2d 243 (3d Dep't 2008)

As a result of the accident, plaintiff claimed that she sustained a "torn shoulder" warranting surgery, loss of use of her right shoulder and a disc herniation. In upholding grant of summary judgment, Court noted: "In opposing summary judgment, plaintiff's treating orthopedic surgeon submitted a relatively brief narrative of her medical history following which he summarily opined, without detail or explanation, that plaintiff's shoulder 'symptoms' were cause by the accident. With respect to the numbness associated with her disc herniation, his opinion was not only summary but equivocal, i.e., he opined, again without detail or explanation, that plaintiff's radicular symptoms 'were either a delayed effect of the original motor vehicle accident or a preexisting condition that was exacerbated by the [arthroscopic] shoulder surgery.' In our view, this was insufficient to raise a question of fact on the issue of causation. In particular, the treating surgeon failed to explain the effect of plaintiff's prior shoulder injury on the claimed accident injury, failed to explain the delay in the onset of her shoulder and numbness complaints and failed to provide any foundation or objective medical basis supporting his conclusion that the injury was actually caused by the accident."

Anania v. Verdgeline, 45 A.D.3d 1473, 846 N.Y.S.2d 831 (4th Dep't 2007)

"Plaintiff's submissions in opposition to the motion did not adequately address how plaintiff's current medical problems, in light of [plaintiff's] past medical history, are causally related to the subject accident. Although plaintiff's orthopedic surgeon stated that plaintiff's right carpal tunnel syndrome and resulting surgery approximately four years after the accident at issue herein were causally related to the accident, that surgeon's opinion was not supported by the requisite competent medical evidence based upon objective medical findings and diagnostic tests."

Parmer v. Opportunities Unlimited of New York, 48 A.D.3d 1252, 852 N.Y.S.2d 540 (4th Dep't 2008)

Defendant's proof as submitted was that any injury plaintiff sustained in accident in issue had resolved and a second accident is the cause of her recent complaints. Court held "that plaintiff raised a triable issue of fact with respect to that category by submitting the report of a physician who examined her and concluded that she did not sustain any injuries in the second accident and the affidavit of one of her treating physicians who

averred that plaintiff had sustained a permanent consequential limitation of use of her cervical spine as a result of the first accident and thus was totally disabled."

Kneeppel v. Casem, 50 A.D.3d 1508, 857 N.Y.S.2d 379 (4th Dep't 2008)

Court held plaintiff adequately addressed defendants' proof that plaintiff's alleged injuries were preexisting. It stated: "Plaintiffs submitted the affidavit of plaintiff's treating chiropractor sworn to in October 2006, in which the chiropractor stated that he began treating plaintiff in 1996. The chiropractor set forth the normal range of cervical movement and compared it to plaintiff's range of cervical movement in 1996 and again in 2006, approximately one week after the accident. According to the chiropractor, the extension of plaintiff's cervical spine "had decreased significantly" following the accident. Plaintiffs also submitted the affidavit of plaintiff's treating orthopedic surgeon, who stated that plaintiff 'clearly suffered a trauma to his lower back' as a result of the accident and that 'the exacerbation of the L4-5 and L5-S1 discs…[was] causally related to the motor vehicle accident.' The orthopedic surgeon also noted plaintiff's 'limited lumbar flexion range of motion.'"

Lux v. Jakson, 52 A.D.3d 1253, 859 N.Y.S.2d 813 (4th Dep't 2008)

Court held: "The affidavit of plaintiff's treating chiropractor submitted in opposition to the motion is insufficient to raise an issue of fact whether plaintiff's condition was caused by the accident inasmuch as the chiropractor did not address degenerative changes in plaintiff's cervical spine or the prior injury thereto."

Perez v. Mastro Concrete, Inc., 2007 N.Y. Slip Op. 51878(U) (App. T. 1st Dep't)

"Plaintiffs' treating physician failed to address defendants' showing that the abnormalities shown on MRI films were longstanding degenerative conditions and non-traumatic in origin."

d. Trial

Sanz v. MTA-Long Island Bus, 46 A.D.3d 867, 849 N.Y.S.2d 88 (2d Dep't 2007)

Plaintiff claimed that, as a result of the accident, she sustained herniated discs in her cervical spine and numbness and tingling in both hands. Approximately one month after the accident, the plaintiff underwent an anterior cervical discectomy, with an allograft and plate fusion. At trial, the defendant failed to call as witnesses any of the doctors whom it had retained to examine the plaintiff. Instead, the defendant's strategy was to show that the plaintiff's various injuries were the result of an earlier accident, which occurred in January 1994. On appeal, the defendant contended that the plaintiff failed to establish a *prima facie* case that her injuries were sustained in the subject motor vehicle accident, as her medical experts failed to indicate an awareness of the prior accident. Court held: "We disagree. Notably, the plaintiff presented testimony from her internist, who had conducted a routine annual physical exactly one week prior to the subject

accident, and found full cervical range of motion and no spinal tenderness at that time. In addition, the plaintiff's treating physician, Dr. Burstein, stated that he would not change his opinion that the plaintiff's injuries were caused by the subject accident as a result of learning of the prior accident in 1994, for which she underwent physical therapy for a number of years. He explained that the large extruded disc fragment which was found in the plaintiff's cervical spine was the result of an acute episode of the kind which generally follows a whiplash type of injury.

B. Aggravation and Exacerbation

Gorden v. Tibulcio, 50 A.D.3d 460, 815 N.Y.S.2d 55 (1st Dep't 2008)

Court held plaintiff's medical proof was insufficient. It stated: "Dr. Rose's report cites an MRI taken of plaintiff's knees a few weeks after the accident, revealing "intrasubstance tear and/or mixoid degeneration involving the posterior horn of both menisci." Dr. Rose diagnosed "internal derangement …with possible medial meniscal tear." However, he does not explain why he ruled out degenerative changes as the cause of the internal derangement. This failure rendered his opinion speculative that the derangement was caused by the accident. Similarly, MRIs of plaintiff's spine taken shortly after the accident revealed herniations and other pathologies that plaintiff's expert opines were sustained in the September 2000 motor vehicle accident and exacerbated by the instant September 2002 accident, but the expert does not indicate that he reviewed the medical records concerning plaintiff's condition immediately following the previous accident. Thus, there is no objective basis by which to measure the claimed aggravation of injuries, or to attribute any new injuries to the later accident."

Lea v. Cucuzza, 43 A.D.3d 882, 842 N.Y.S.2d 468 (2d Dep't 2007)

"Plaintiff's physician's report failed to qualitatively assess how the plaintiff's alleged exacerbated vertigo compared to the degree of vertigo experienced prior to the accident."

Luciano v. Luchsinger, 46 A.D.3d 634, 847 N.Y.S.2d 622 (2d Dep't 2007)

"While Dr. BenEliyahu [plaintiff's expert] did note that he was treating Angelina [plaintiff] for injuries she sustained to her back and neck from a prior accident at the time the subject accident occurred, his conclusions that the subject accident aggravated dormant conditions in her neck and back were without any foundation. This is so because Dr. BenEliyahu failed to provide any medical evidence of her condition when he treated her prior to the subject accident so as to compare what her limitations were before and after the subject accident. Thus, there is no foundation for Dr. BenEliyahu's conclusions that the subject accident aggravated the prior conditions in Angelina's spine to the extent that her range of motion was significantly diminished thereafter."

Scarano v. Wehrews, 46 A.D.3d 797, 847 N.Y.S.2d 644 (2d Dep't 2007)

Court held: "Defendants failed to negate the existence of a triable issue of fact as to whether the plaintiff's injuries from prior accidents or conditions predating the subject automobile accident were exacerbated by the subject accident, necessitating the surgeries which they respectively underwent within a relatively short time after the accident."

Seck v Minigreen Hacking Corp., __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held: "The affidavit of the plaintiff's treating chiropractor failed to raise a triable issue of fact. The chiropractor did not set forth any objective evidence to support the assertion that a pre-existing "injury" from a prior accident, which he failed to describe, was "exacerbated" by and causally related to the subject accident. The conclusions in the affidavit that the injuries and limitations noted in the plaintiff's lumbar spine were the result of the subject accident were rendered speculative in light of the fact that the chiropractor failed to adequately address that prior accident and injury. The CT scan of the plaintiff's lumbar spine, which was affirmed by the plaintiff's treating radiologist, was performed a little more than two years after the subject accident occurred, and was the only one performed on the plaintiff. Therefore, that scan could not prove that the injuries alleged by the plaintiff in this action were caused by the subject accident rather than the previous accident."

Talcott v. Zurenda, 48 A.D.3d 989, 853 N.Y.S.2d 192 (3d Dep't 2008)

In upholding plaintiff's verdict, Court noted: "With respect to plaintiff's asymptomatic degenerative condition, plaintiff's treating physician opined that the trauma of the motor vehicle accident aggravated this condition and it was possible that plaintiff could have remained asymptomatic throughout his life but for the accident."

Sconiers v. Barber, 51 A.D.3d 1403, 857 N.Y.S.2d 410 (4th Dep't 2008)

Court held plaintiff's medical proof was sufficient to show *prima facie* that he sustained a serious injury as a result of the accident. The proof consisted of the affirmation of plaintiff's treating physician, who indicated that, based on a lumbar MRI, plaintiff had severe L4-5 and L5-S1 disc herniations with marked disc desiccation, that his lumbar range was 45% to 50% of normal, that his condition was permanent, and that the accident caused the soft tissue component of the disc herniations and activated the degenerative conditions in his spine.

Spitz v. Lavo, 2008 N.Y.Slip.Op. 50333 (U) (Sup.Ct. Broome Co.) (Lebous, J.)

Court found plaintiff's treating chiropractor's affidavit insufficient to support her claim. Court stated: "It is undisputed here that plaintiff was involved ion at least three prior accidents and had been treating with Dr. Cooper prior to this accident. In short, plaintiff had a symptomatic preexisting condition. As such, it was plaintiff's burden to submit objective medical evidence to distinguish the aggravation of her preexisting condition

from the preexisting condition itself. A review of the plaintiff's medicals reveals that she had failed to meet her burden by failing to submit any objective evidence, expert or otherwise, "[b]y which the claimed aggravation of [her] injuries can be measured [citation omitted]". Dr. Cooper does make a reference to plaintiff's neck curve reversal and anterolisthesis being "made worse", but does not otherwise explain that statement in medical terms. Additionally, Dr. Cooper does not provide any objective evidence by which to establish whether plaintiff's 75% disability relates to her underlying preexisting condition, the subject accident, an aggravation, or some combination thereof. Finally, the court notes that Dr. Cooper's opinion as to the permanency, if any, of plaintiff's injuries are without probative value given the fact that permanency is not a necessary element of this category."

IV. DAMAGES

A. Generally

Tarrazi v. Bonamassa, 2007 N.Y. Slip Op. 51095(U) (Sup. Ct. Nassau Co. 2007)

Jury found serious injury under 90/180 and significant limitation categories, but not permanent consequential limitation category, and awarded loss of future earnings for 30 years and future pain and suffering. Court held that such damages awards were proper as a finding of serious injury permits plaintiff to recover all damages proximately caused by accident.

B. Recovery of Basic Economic Loss

Hutchinson v. Clare Rose of Nassau, Inc., 40 A.D.3d 702, 835 N.Y.S.2d 698 (2d Dep't 2007)

"The jury award in the sum of $25,000 for lost wages must be reduced to $0, since the first $50,000 in combined lost wages and medical expenses constitutes basic economic loss, the plaintiff made no claim to recover medical expenses in any event, and basic economic loss is not recoverable in a personal injury action arising from a motor vehicle accident."

V. SUMMARY JUDGMENT MOTIONS

A. Generally

1. Timeliness Of Motions/Submissions

Washington v. Delossantos, 44 A.D.3d 748, 843 N.Y.S.2d 186 (2d Dep't 2007)

"We are not unmindful that Dr. Sultan's report raised serious questions regarding the plaintiff's credibility, including the extent of his cooperation in the medical examination process. A defendant in a personal injury action has the unquestioned right to have the

plaintiff medically examined by a designated physician. (*see* CPLR 3212). Where there is evidence that the plaintiff refuses to cooperate in the examination process, the proper remedy is for the defendant to move, not for summary judgment pursuant to CPLR 3212, but rather for sanctions such as preclusion of evidence, or dismissal of the complaint."

Covert v. Samuel, __ A.D.3d __, __ N.Y.S.2d __ (4th Dep't 2008)

Defendant's moved for summary judgment on the ground that plaintiff did not sustain a serious injury, and plaintiff cross-moved for partial summary judgment on liability and serious injury. Court held plaintiff's cross-motion for partial summary judgment on liability was time-barred under CRR 3212(a), but not on serious injury because that part of the motion "was made on nearly identical grounds" as defendants' timely motion.

2. Burdens

Onishi v. N&B Taxi, Inc., 51 A.D.3d 594, 858 N.Y.S.2d 171 (1st Dep't 2008)

Court observed: "We recently rejected the notion that a defendant cannot meet its initial burden on summary judgment of demonstrating the absence of "serious injury" where the defendant's expert fails to address diagnostic reports indicating that the plaintiff has herniated or bulging disks." NOTE: *See also, Style v. Joseph*, 32 A.D.3d 212, 820 N.Y.S.2d 26 (1st Dep't 2006); *Santana v Khan*, 48 A.D.3d 318, 851 N.Y.S.2d 515 (1st Dep't 2008).

Coleman v. Shangri-La Taxi, Inc., 49 A.D.3d 587, 852 N.Y.S.2d 794 (2d Dep't 2008)

Court held the defendants failed to meet their *prima facie* burden of showing that plaintiff did not sustain a serious injury. It commented: "The defendants failed to even address the plaintiff's allegation that she suffered a left shoulder injury as a result of the subject accident."

Deeks v. Bass, 2007 N.Y. Slip Op. 50450(U) (Sup. Ct. Nassau Co.)(Palmieri, J.)

"Although far less common than one made by a defendant, a motion for summary judgment on the issue of "serious injury" may be granted in a plaintiff's favor in a proper case. Accordingly, if the plaintiff can make a *prima facie* showing of such an injury, a defendant must address the issue and advance proof proving that an issue of fact exists with regard thereto, under the well-established rules of summary judgment."

3. Reply Papers

Barrera v. MTA Long Island Bus, 52 A.D.3d 446, 859 N.Y.S.2d 483 (2d Dep't 2008)

Court held: "To meet its *prima facie* burden, the defendants could not rely on the evidence submitted for the first time in its reply papers."

4. Objections to Submissions

O'Connor v. Singh, 16 Misc.3d 30, 842 N.Y.S.2d 119 (App.T.1st Dep't 2007)

"Since the defendants' medical reports were not properly subscribed, Civil Court appropriately refused to consider them with respect to defendants' threshold burden, and this even though no specific objection to the form of the reports was raised in plaintiff's opposition papers. While a party generally may not challenge the form of an adversary's motion submission for the first time on appeal (*see e.g. Shinn v. Catanzaro,* 1 A.D.3d 195, 198 1st Dep't [2003]), this rule should not be extended so as to preclude a motion court from rejecting on its own initiative a submission palpably deficient in form (*see Daus v. Cassavaugh,* 17A.D.3d 837, 838 3d Dep't [2005]; but *cf. Scudera v. Mahbubur* 299 A.D.2d 535 [2d Dep't 2002])"

5. Other

Gonzalez v. Laurent, 2008 N.Y.Slip.Op. (U) (Sup.Ct. Kings Co.) (Jacobson, J.)

Defendant moved for summary judgment. Prior to making motion, trial court precluded him from testifying at trial because he never showed up for his EBT. Court denied motion, stating "Defendant's failure to appear for scheduled depositions and to comply with Court orders poses no less of a threat to the integrity of our judicial system that did the situations present in *Brill*. Although defendant's deposition testimony may not have included testimony regarding the question of "serious injury", granting a non-compliant movant summary judgment on this or any grounds would condone and encourage the willful and contumacious behavior of litigants. To grant defendant summary judgment would be to reward him for his willful conduct by allowing him to avoid a trial, unscathed by any serious sanctions for his openly defiant failure to comply with court orders."

6. Sufficiency of Defendant's Moving Papers

TEACHING: Courts will scrutinize defendant's moving papers to determine if defendant has affirmatively shown that plaintiff has not sustained a serious injury or subject automobile accident did not cause complained of injury; and a defendant cannot meet his/her burden by stating that plaintiff cannot establish that he/she sustained a serious injury or that the subject automobile accident did not cause complained of injury.

a. First Department

Martinez v. Pioneer Trans. Corp., 48 A.D.3d 306, 855 N.Y.S.2d 194 (1st Dep't 2008)

Court noted, in denying defendants' motion, that defendants' submissions were contradictory. It stated: "Some of their submitted medical reports and opinions indicate that objective tests were negative, and others reflect limitations in the range of motion of

the spine, legs and back of each of these plaintiffs, and herniated and bulging discs for both of them. The contradictory findings raise a triable issue of fact."

Patterson v. Rivera, 49 A.D.3d 337, 852 N.Y.S.2d 762 (1st Dep't 2008)

"The motion was properly denied on the ground that defendants' expert did not address the MRI reports showing herniated discs, which in conjunction with other evidence was indicative of serious injury."

b. Second Department

Monkhouse v. Maven Limo, Inc., 44 A.D.3d 630, 848 N.Y.S.2d 175 (2d Dep't 2007)

Court held defendant's motion papers were insufficient as the plaintiff's bill of particulars alleged that as a result of the subject accident, she was confined to her home and bed for three months post-accident; Maven Limo's examining neurologist conducted his examination of the plaintiff more than 3 ½ years post-accident, and noted in his report that the plaintiff lost eight months of work as a result of the subject accident; he never related his medical findings to this category of serious injury for the period of time immediately following the subject accident. ACCORD: *Daddio v. Shapiro*, 44 A.D.3d 699, 844 N.Y.S.2d 76 (2d Dep't 2007).

Page v. Belmonte, 45 A.D.3d 825, 846 N.Y.S.2d 351 (2d Dep't 2007)

Court held defendants' moving papers were insufficient to meet their burden. It noted: "In his affirmed medical report following thoracic and lumbar range of motion testing, defendants' examining orthopedic surgeon merely stated that forward bending was carried out to 80 degrees, right to left lateral bending was symmetrical at 20 degrees and [t]hese ranges of motion are considered excellent for a patient of the same age and body habitus. Nowhere were these findings compared against what is normal range of motion."

Pomaquiza v. Sibri, 46 A.D.3d 531, 846 N.Y.S.2d 618 (2d Dep't 2007)

Court held defendant's motion was properly denied as his motion papers did not adequately address the plaintiff's claim, clearly set forth in his bill of particulars, that he was asserting a serious injury under this category.

Joissaint v. Starrett-1, Inc., 46 A.D.3d 622, 848 N.Y.S.2d 259 (2d Dep't 2007)

"Among the medical submissions relied upon by the defendants-appellants was the affirmed medical report of their examining orthopedist. In his report, the examining orthopedist identified significant limitations in the ranges of motion of the plaintiff's cervical and lumbar spines based upon his examination of the plaintiff, which took place almost two years after the subject accident. Since the appellants failed to meet their initial burden, it is unnecessary to consider whether the plaintiff's papers, submitted in opposition, were sufficient to raise a triable issue of fact.

Larkin v. Goldstar Limo Corp., 46 A.D.3d 631, 848 N.Y.S.2d 254 (2d Dep't 2007)

"The plaintiff's submissions failed to address the finding of Goldstar's examining radiologist that the condition of the plaintiff's cervical spine resulted from pre-existing degeneration and was not caused by the subject accident. Goldstar's examining radiologist also noted that the magnetic resonance imaging studies of the plaintiff's lumbar spine evinced that he had a transitional vertebra, which was congenital, and predisposed him to abnormal movements and premature degenerative disc disease. The failure of the plaintiff's experts to address these findings rendered speculative any conclusions they made that the plaintiff's spinal restrictions were causally related to the subject accident."

Rosenbaum v. Cruz, 49 A.D.3d 799, 855 N.Y.S.2d 567 (2d Dep't 2008)

Court held defendants failed to meet their *prima facie* burden of establishing that neither of the plaintiffs sustained a serious injury. In their affirmed reports, Rosenbaum's examining orthopedic surgeon and neurologist failed to compare their findings with regard to Cruz's range of motion in various operations of the cervical and lumbosacral regions of the spine and in the right and left shoulders to what is considered the normal range of motion for those operations. (*See, Somers v. Macpherson*, at 743, 536 N.Y.S.2d 620). In addition, in his review of the magnetic resonance imaging (hereinafter MRI) study performed on Cruz's cervical region of the spine, approximately 10 days after the occurrence, Board Certified radiologist Robert Scott Schepp found central posterior bulging discs at C4-C5 and C5-C6, which were deforming the thecal sac diffusely. In support of his motion insofar as it related to Sadykov, Rosenblum submitted, *inter alia*, a report prepared by Sadykov's medical expert, Dr. Leon Bernstein, in which he indicated that, when he last performed range of motion testing on Sadykov's right knee, on June 28, 2006, the knee ranged from 0° to 110°, whereas the norm is 0° to 145°. In additiona, the report prepared by Dr. Schepp with regard to an MRI study of Sadykov's right knee performed five days after the accident found a partial meniscus tear.
Colacino v. Andrews, 50 A.D.3d 615, 854 N.Y.S.2d 771, (2d Dep't 2008)

Court held defendants' proof was insufficient as they relied upon the reports of plaintiff's treating physicians and these reports did not sufficiently quantify or qualify the limitations in range of motion so as to establish that they were insignificant.

Dux v. Maddaloni, 51 A.D.3d 967, __N.Y.S.2d __ (2d Dep't 2008)

Court held defendant failed to meet her burden of proof, stating: "In support of her motion the defendant relied upon, *inter alia*, the affirmed medical report of her examining orthopedic surgeon who evaluated the injured plaintiff almost two years after the subject accident occurred. In that report, the surgeon noted significant limitations in the range of motion of the injured plaintiff's cervical spine, lumbar spine, and left shoulder."

Sajid v. Murzin, 52 A.D.3d 493, 860 N.Y.S.2d 559 (2d Dep't 2008)

Court held defendants failed to meet their burden of proof, stating: "The defendants' experts failed to perform any range of motion testing with respect to the respondent's thoracic spine, despite the fact that she allegedly sustained a herniated disc and bulging discs as a result of the subject accident."

Moorer v. Amboy Bus Co., Inc., 52 A.D.3d 587, __ N.Y.S.2d __ (2d Dep't 2008)

Court held defendants failed to meet their burden, stating: "In support of their motion, the defendants relied upon, *inter alia*, the affirmed medical report of their examining orthopedist. In that report, Dr. Aprin noted significant range-of-motion limitations in the plaintiff's cervical spine, left shoulder, and lumbar spine, based upon his examination of the plaintiff one year after the subject accident. The range-of-motion limitations belie Dr. Aprin's conclusion that the condition of the left shoulder was resolved, that restrictions of the cervical spine were not supported by objective findings, and that the restrictions of the lumbosacral spine were only mild."

Gaccione v. Krebs, __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held defendants failed to meet their burden stating: "In support of their motion, the defendants relied upon, *inter alia*, the report of their examining neurologist, who examined the plaintiff on November 2, 2006. During testing of the plaintiff's lumbar spine, the plaintiff's leg elevating was to 60 degrees on the right side and to 30 degrees on the left side. Thus, a clear limitation was noted, the full extent of which is not known due to the examining neurologist's failure to compare these numerical findings to what is normal."

c. Third Department

Alteri v. Benson, 50 A.D.3d 1274, 855 N.Y.S.2d 713 (3d Dep't 2008)

Court held defendant, on his motion for summary judgment in personal injury action, established *prima facie* that passenger in motor vehicle did not sustain serious injury. As to his proof, Court stated: "According to the report and affidavit of defendant's expert, his physical examination of plaintiff 'was completely normal…in every respect.' She exhibited symmetric range of motion of both shoulders and had good strength in her rotator cuffs. The extension of her spine was normal and she was bale to reach down and touch her toes, walk on her toes and heels and perform a deep knee bend. Her straight leg test was 'completely normal' and she also had a good range of motion in her hips and knees with no evidence of muscle atrophy. Furthermore, according to this expert, certain complaints during the examination had a psychological, rather than physical, basis."

d. Fourth Department

Feggins v. Fagard, 52 A.D.3d 1221, 860 N.Y.S.2d 346 (4th Dep't 2008)

Court held defendants failed to meet their burden of proof with respect to limitations of use category, stating: "The report of the neurologist who examined plaintiff at their request indicated that, based on the CT report, plaintiff sustained a disc herniation at C6/C7 that was mildly compressing the thecal sac and narrowing the neural foramen. In addition, the neurologist noted "a decrease of cervical range of motion of a mild to moderate degree on the right and a moderate to severe decrease on turning to the left," and he characterized a report of plaintiff's treating physician as finding that plaintiff had a "rigid posture and limited range of motion, 50% in all directions." Another physician who examined plaintiff at defendants' request concluded that plaintiff had suffered a cervical strain as a result of the accident. Thus, defendants' own submissions raise triable issues of fact whether plaintiff sustained a qualifying injury under the significant limitation of use category."

7. Plaintiff's Summary Judgment Motions

Griffin v. Pennoyer, 49 A.D.3d 341, 852 N.Y.S.2d 765 (1st Dep't 2008)

Plaintiff was awarded partial summary judgment on liability. In affirming, Court stated: "There is no basis, on this record, for finding that bifurcation of the fault and serious injury issues was improper or in any way prejudicial to defendant."

Kontomichalos v. County of Nassau, 49 A.D.3d 506, 855 N.Y.S.2d 175 (2d Dep't 2008)

Court upheld denial of defendants' motion for summary judgment and granted plaintiff's cross-motion on the issue of serious injury. In so ruling, Court noted that "in support of their motion, the defendants relied on the affirmed medical reports of their examining orthopedic surgeon and neurologist, which described significant limitation in the range of motion in the plaintiff's cervical and lumbar spines." NOTE: Decision rejects "common wisdom" that plaintiffs cannot obtain summary judgment on serious injury under a limitation of use category.

B. Proof In Admissible Form

1. Affidavits/Affirmations/Sworn Reports

Tubbs v. Pallone, 45 A.D.3d 959, 845 N.Y.S.2d 166 (3d Dep't 2007)

"Although plaintiff's attorney asserted that plaintiff had undergone four serious operations which left her with a permanent defect, he failed to support this claim with any medical evidence whatsoever. Therefore, plaintiff did not meet her burden of proof."

Guzman v. Bowen, 46 A.D.3d 617, 847 N.Y.S.2d 630 (2d Dep't 2007)

"In support of their motions, the defendants relied on the report of Alan R. Belsky, which was not in proper form. Dr. Belsky was a chiropractor and pursuant to CPLR 2106 he cannot affirm the contents of a medical report.

Vista Surgical Supplies, Inc. v. Travelers Ins. Co., 50 A.D.3d 778, __ N.Y.S.2d __ (2d Dep't 2008)

Court held that: "Writings submitted as affirmations pursuant to CPLR 2106 that contain "computerized, affixed, or stamped facsimiles of the [affirmant's] signature," "without any indication as to who placed them on the reports, nor…any indicia that the facsimiles were properly authorized," "[do] not constitute competent evidence."

Perdomo v. Scott, 50 A.D.3d 1115, 857 N.Y.S.2d 212 (2d Dep't 2008)

"Plaintiffs relied upon medical reports from their treating chiropractor. However, those reports were not competent evidence because they were not in affidavit form (*see* CPLR 2106)."

Park v. Orellana, 49 A.D.3d 721, 854 N.Y.S.2d 447 (2d Dep't 2008)

"Although we note that the defendant failed to raise in Supreme Court his argument that the affirmation of the plaintiff's physician in Maryland did not constitute competent evidence because she was not "authorized by law to practice in the state" (CPLR 2106), even if we were to consider that affirmation, it did not raise a triable issue of fact, because the plaintiff's Maryland physician failed to set forth the objective tests she relied upon in arriving at her conclusions."

Dalmasi v. Corporan Corp., 2008 N.Y.Slip.Op. 50311 (U) (App.T. 1st Dep't)

"The reports submitted by plaintiff's physician, affirmed to be "true and accurate to the best of [the physician's] knowledge were not in compliance with CPLR 2106, which requires a physician's statement to be "affirmed … to be true under the penalties of perjury"."

Fouchong v. Gordon, 2007 N.Y. Slip Op. 52220(U) (Sup. Ct. Kings Co. 2007)

Court held that plaintiff may properly rely upon an affidavit submitted by his medical expert, formerly licensed to practice medicine in New York, which license was revoked by the State DOH upon a finding that he stole money from Medicaid and Medicare.

2. Unsworn Medical Records/Reports and Uncertified Records

Navedo v. Jaime, 32 A.D.3d 788, 822 N.Y.S.2d 43 (1st Dep't 2006)

Supreme Court held that plaintiff's medical expert's affirmation was insufficient as he relied upon unsworn reports by another physician. Court rejected that conclusion holding: "Because reference was made to the results of the unsworn reports in the affirmation of the expert submitted in opposition to the motion, they were properly before the court. (*see Pommells v. Perez*, n. 5)." *See also, Uddin v. Cooper*, 32 A.D.3d 270, 820 N.Y.S.2d 414 (lst Dep't 2006) (Maguire, J., dissenting).

Speirer v. Bloomingdale's, 43 A.D.3d 664, 841 N.Y.S.2d 299 (1st Dep't 2008)

In a non-serious injury case, Court held that ex parte report of an opposing party, though unsworn and unofficial, is admissible in support of and in opposition to, a motion of summary judgment.

Sung v. Mihalios, 44 A.D.3d 500, 843 N.Y.S.2d 317 (1st Dep't 2007)

"The passing reference in the report of plaintiffs' expert to an unsubmitted physician report was not improper (*see Navedo v. Jaime*, 32 A.D.3d 788, 789-790, 822 N.Y.S.2d 43 [2006])."

Hammett v. Diaz-Frias, 49 A.D.3d 285, 852 N.Y.S.2d 128 (1st Dep't 2008)

In reversing grant of defendants' summary judgment motion, Court held: "The affirmed report of Dr. Howell, who first examined plaintiff four days after the incident, connected plaintiff's injuries to the incident and raised a triable issue of fact as to whether they constituted a "serious injury". While Howell did not provide qualitative limitations inhis report or specify the tests he conducted, his reference to an unsworn report of Dr. Sloan, which did provide such data, should have been considered by the motion court, since 'evidence, otherwise excludable at trial, may be considered to deny a motion for summary judgment provided that this evidence does not form the sole basis for the court's determination.'"

Hammett v. Diaz-Frias, 49 A.D.3d 285, 852 N.Y.S.2d 128 (1st Dep't 2008)

As both parties' medical experts referred to plaintiff's MRI reports, which were not submitted on the motion, in their affirmations, the report could be used by plaintiff's expert to establish existence of disc bulges and herniations.

Batts v. Medical Express Ambulance Corp., 49 A.D.3d 294, 853 N.Y.S.2d 54 (1st Dep't 2008)

"Plaintiffs unsworn MRI report noting a disc herniation at L5-S1 was admissible, as it was cited in the affirmations of both plaintiff's and defendants' medical experts. (*see Pommells v. Perez*, 4 N.Y.3d 566, 577 n.5)."

Nociforo v. Penna, 42 A.D.3d 514, 840 N.Y.S.2d 396 (2d Dep't 2007)

"The plaintiffs relied on the hospital records of the injured plaintiff which related to his prior accident in February 2001. These submissions were without probative value since they were uncertified. The plaintiffs further relied on the report of the injured plaintiff's treating neurologist which again dealt with the prior accident. This report was also without probative value since the report was unaffirmed (*see, Rodriguez v. Cesar*, 40 A.D.3d 731; *see also, Grasso v. Angerami*, 79 N.Y.2d 813, 814) as were the submitted June 14, 2001 cervical spine nerve conduction and lower extremity somatosensory studies of the injured plaintiff."

Verette v. Zia, 44 A.D.3d 747, 844 N.Y.S.2d 71 (2d Dep't 2007)

"The plaintiff's reliance on uncertified hospital records and unaffirmed magnetic resonance imaging reports failed to raise a triable issue of fact since those submissions were without probative value."

Govori v. Agate Corp., 44 A.D.3d 821, 843 N.Y.S.2d 459 (2d Dep't 2007)

"The plaintiff's hospital records and magnetic resonance imaging reports were without probative value since they were neither affirmed nor certified."

Tarhan v. Kabishi, 44 A.D.3d 847, 844 N.Y.S.2d 89 (2d Dep't 2007)

"The plaintiffs' medical expert improperly relied upon unsworn magnetic resonance imaging reports by another physician in arriving at his diagnosis and conclusions." ACCORD: *Govori v. Agate Corp.*, 44 A.D.3d 821, 843 N.Y.S.2d 459 (2d Dep't 2007).

Gibson v. Tordoya, 44 A.D.3d 1000, 844 N.Y.S.2d 431 (2d Dep't 2007)

"The reliance by the plaintiff and her experts on the MRI reports was proper despite the fact that the reports submitted by the plaintiff were unaffirmed, since the results of these reports were set forth in the report of the defendants' examining orthopedic surgeon."

Malave v. Basikou, 45 A.D.3d 539, 850 N.Y.S.2d 114 (2d Dep't 2007)

"The plaintiff principally relied upon the submission of voluminous unaffirmed reports and uncertified medical records, which were without any probative value."

Patterson v. N.Y. Alarm Response Corp., 45 A.D.3d 656, 850 N.Y.S.2d 114 (2d Dep't 2007)

Plaintiff's medical submissions were without probative value since those submissions consisted of either uncertified records or unaffirmed medical reports.

Casas v. Montero, 48 A.D.3d 728, 853 N.Y.S.2d 358 (2d Dep't 2008)

Plaintiff's physician properly relied upon unsworn MRI report because defendant's medical expert set forth in detail the results thereof in his own report submitted in support of motion.

Wang v. Harget Cab Corp., 47 A.D.3d 777, 850 N.Y.S.2d 537 (2d Dep't 2008)

"The plaintiff's hospital records were without any probative value in opposing the motion of the appellants since they were uncertified."

Gonzales v. Fiallo, 47 A.D.3d 760, 849 N.Y.S.2d 182 (2d Dep't 2008)

"The unaffirmed and uncertified reports and records relied upon by the plaintiff are without probative value."

Browne v. M&P Distributors Corp., 52 A.D.3d 638, __N.Y.S.2d __ (2d Dep't 2008)

Court noted plaintiff properly relied on the magnetic resonance imaging reports of the cervical and lumbar regions of her spine "since the results of those reports were set forth in the affirmed medical report of the defendants' examining orthopedist."

Eberts v. Makarczuk, 52 A.D.3d 772, __ N.Y.S.2d __ (2d Dep't 2008)

In a non-serious injury, wrongful death action, Court stated: "While the defendants submitted an autopsy report and a report from their expert physician in support of their motion, the autopsy report was not properly certified, and, in any event, not probative of the issue of causation."

Landicho v. Rincon, __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held plaintiff's treating physician's medical reports "were without any probative value since they were unaffirmed, and were not incorporated into his affirmation by reference."

Landicho v. Rincon, __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held the MRI reports of her treating physicians as well as the physical therapy reports concerning the plaintiff were without any probative value since they were unaffirmed.

Smeja v. Fuentes, __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held unaffirmed reports of her treating physician were properly relied upon by the plaintiff since they were relied upon by the defendants and the results of the reports were noted in the report of defendant's examining neurologist.

Feggins v. Fagard, 52 A.D.3d 1121, 860 N.Y.S.2d 346 (4th Dep't 2008)

Court rejected defendants' argument that "none of the unsworn reports and uncertified medical records may be considered because they are not in admissible form. Plaintiff may rely on unsworn reports and uncertified medical records if they were submitted by defendants (*see Kearse v. New York City Tr. Auth.*, 16 AD3d 45, 47 n1, 789 NYS2d 281, 283 n1 [2d Dep't 2005]), or were referenced in the reports of physicians who examined plaintiff on their behalf, and submitted the reports of their experts (*see Brown v. Achy*, 9 AD3d 30, 32, 776 NYS2d 56, 58 [1st Dep't 2007])."

Molina v. Gonzalez, 2007 N.Y. Slip Op. 51368(U) (App. T. 1st Dep't)

Court held that defendant "permissibly relied upon the unsworn report of plaintiff's treating doctor, who found that plaintiff's injuries had resolved within two months of the vehicular accident. Plaintiff, in opposition, submitted various unsworn reports and records, which may be considered only to the extent relied upon by defendant's experts (*see, Hernandez v. Almanzar*, 32 A.D.3d 360 [2006]; *compare, Engles v. Claude*, 39 A.D.3d 357 [2007])."

Basu v. Wolff, 2007 N.Y. Slip.Op. 52303(U) (App.T. 2d Dep't)

Court noted that a defendant may rely on the unsworn medical report of plaintiff's doctor in support of its motion for summary judgment.

3. Miscellaneous

Djetoumani v. Transit, Inc., 50 A.D.3d 944, 857 N.Y.S.2d 601 (2d Dep't 2008)

Court held that the requisite limitation of use was established by the affirmation of his treating orthopedist, Dr. Rose. It further held: "Contrary to the defendants' argument, the failure of Dr. Rose to compare his range-of-motion findings to the norm does not, on the record presented here, preclude a finding of a triable issue of fact. In general, in the absence of an assertion of the normal range of motion, an expert's finding as to the plaintiff's range of motion is insufficient to establish the significant or consequential limitation of use necessary to sustain a claim because it requires the court to speculate as to the meaning of the physical finding. Here, however, no such speculation is necessary because the applicable normal ranges of motion were set forth in the reports of the defendants' examining physicians that were submitted in support of the motion. A statement by an expert that is put forward by a party in litigation constitutes an informal judicial admission that is admissible against, although not binding upon, the party that

submitted it. Thus, just as a nonmoving plaintiff in a serious injury case may rely upon the unsworn report of the plaintiff's treating physician once it has been submitted by the moving defendant, a nonmoving plaintiff may rely upon the statement by the moving defendants' expert of the applicable normal range of motion."

C. Competent Medical Proof

1. Generally

Alcombrack v. Swarts, 49 A.D.3d 1170, 856 N.Y.S.2d 357 (4th Dep't 2008)

In support of his summary judgment motion, defendant submitted the affirmation of a physician who reviewed the medical records of decedent and determined that he had not sustained a serious head injury. Defendant also submitted medical records indicating that decedent sought medical treatment for a variety of symptoms following the collision but that none of the tests performed on his head revealed a medically determined injury that caused his headaches. Court held: "We thus conclude that defendant met his initial burden with respect to the 90/180 category, and plaintiffs failed to raise a triable issue of fact. Contrary to plaintiffs' contention, the failure of defendant to obtain an independent medical examination of defendant did not require denial of his cross motion. A qualified physician's opinion based upon a review of decedent's medical records may constitute competent evidence sufficient to meet defendant's burden."

Fuchs v. Johnson, 2007 N.Y. Slip Op. 33578(U) (Sup. Ct. Wayne Co.)(Nesbitt, J.)

Court observed: "The courts of this State have recognized that information from a chiropractor can be used to meet a plaintiff's burden in a No-Fault case involving a soft-tissue injury. Thus, an affidavit from a chiropractor cannot be categorically discounted."

2. Proper Basis of Opinion

a. Pommells

Pommells v. Perez, 4 N.Y.2d 566, 797 N.Y.S.2d 380 (2005)

In opposing defendant's motion, plaintiff submitted the affidavit of his treating physician who in rendering an opinion as to plaintiffs medical condition relied upon unsworn MRI reports (in the record) that showed plaintiff had herniated and bulging discs. Court made the following observation in FNS: "Though the MRI reports were unsworn, the various medical opinions relying on those MRI reports are sworn and thus competent evidence (*see Grasso v. Angerami*, 79 NY2d 813, 814, 580 NYS2d 178, 1790." NOTE: *Grasso v. Angeratni*, relied upon by the Court, held only that an unsworn letter-report prepared by plaintiff's treating physician is in "inadmissible form" and my not be used to defeat defendant's motion. QUAERE: In the aftermath of *Pommells* may a party's expert in his/her affidavit or affirmation rely upon an unsworn report without meeting the *Sugden/Hambsch/Goldstein* test for relying upon non-offered or inadmissible evidence?

If so, why should summary judgment motions be treated differently than trials? In considering these questions, it should be pointed out that in *Pommells* defendant submitted the unsworn reports, relied upon by plaintiff, in his moving papers.

b. Post -Pommells

Hernandez v. Almanzar, 32 A.D.3d 360, 821 N.Y.S.2d 30 (1st Dep't 2006)

Court held: " To the extent plaintiff's medical expert's conclusions were based on the unaffirmed reports of plaintiff's treating physicians, such reports do not constitute admissible evidence, and therefore do not suffice to defeat a well-supported summary judgment motion. the defense experts' review of such unaffirmed reports (as noted in their reports) did not open the door to plaintiffs' reliance on them, since defendants did not submit such reports in support of the motion, nor did their experts rely on them informing their conclusions. In any event, such reports, which were created within two months after the February 2002 accident, are not probative of the existence of a permanent injury."

Verette v. Zia, 44 A.D.3d 747, 844 N.Y.S.2d 71 (2d Dep't 2007)

"The affirmed medical report of the plaintiff's treating physician was also without probative value as she relied on the unsworn reports of others in reaching her conclusions about the plaintiff."

Carridi v. Hassan, 45 A.D.3d 516, 845 N.Y.S2d 426 (2d Dep't 2008)

In support of their motion for summary judgment, defendant submitted the affirmed report of Dr. Katz. As to that report, the Court stated: "Based on his examination of the plaintiff and his review of her medical records, Dr. Katz diagnosed her with "contusion to the left ankle now resolved," "[l]umbosacral strain resolved," and "[l]eft hip derangement unrelated." While Dr. Katz provided objective medical evidence in support of his diagnoses with respect to the plaintiff's complaints regarding her ankle and lumbosacral spine, his only basis for concluding that the plaintiff's complaints regarding her hip were "unrelated" to the subject accident was that "doctors' notes reviewed do not indicate any problem to the left hip following this incident of 09/17/04 [and a]n MRI of the left hip and pelvis was not performed until 01/03/06 which is more than one year after the accident." However, Dr. Katz did not attach any of the prior medical records to his report, and the defendants otherwise failed to submit any such records in support of their motion, as they were certainly entitled to do (*see Kearse v. New York City Tr. Auth.*, 16 A.D.3d 45, 47 n. 1, 789 N.Y.S.2d 281; *Pagano v. Kingsbury*, 182 A.D.2d 268, 271, 587 N.Y.S.2d 692). Therefore, Dr. Katz's report, standing alone, failed to establish, *prima facie*, that the plaintiff's alleged hip injury was unrelated to the subject accident."

Rodriguez v. Huerfano, 46 A.D.3d 794, 849 N.Y.S.2d 275 (2d Dep't 2007)

Court held plaintiff failed to raise a triable issue of fact. It stated: "The MRI report regarding the plaintiff's lumbar region of the spine, upon which the plaintiff's treating chiropractor relied in opposing the motion, was without probative value, since it was not affirmed by the plaintiff's physician, and was not actually relied upon by the defendants' expert. Even if the underlying MRI report were admissible (*see Pommells v. Perez*, 4 N.Y.3d 566, 577 n. 5), the report of the plaintiff's treating chiropractor still failed to provide objective and recent evidence of the extent or degree and duration of the claimed limitation of the plaintiff's lumbar region of the spine."

Casas v. Montero, 48 A.D.3d 728, 853 N.Y.S.2d 358 (2d Dep't 2008)

Plaintiff's physicians and chiropractors affidavits were insufficient as they relied upon unsworn reports.

Hargrove v. New York City Trans. Auth., 49 A.D.3d 692, 854 N.Y.S.2d 182 (2d Dep't 2008)

"The affirmation of Dr. Arden Kaisman, one of the plaintiff's physicians, also was insufficient to raise a triable issue of fact since Dr. Kaisman relied on an unsworn report of another physician in reaching his conclusions."

Seebaran v. Mendonca, 51 A.D.3d 658, 858 N.Y.S.2d 248 (2d Dep't 2008)

Court held: "The affirmed medical report of the plaintiff's treating orthopedic surgeon was also without probative value, and thus failed to raise a triable issue of fact, since he clearly relied on the unsworn report of Dr. Frelich in arriving at his conclusions."

Matra v. Raza, __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held: "The affirmed medical report of Dr. Gideon Hedrych was without any probative value since he relied on unsworn reports of others in reaching his conclusions. Similarly, although Dr. Donald Rose was able to objectively observe the plaintiff's menisci during arthroscopic surgeries he performed on the plaintiff's knees in May and June 2006, the portion of the opinion in his report regarding proximate causation is based upon unsworn evidence and is therefore without probative value particularly as Dr. Rose had earlier found full range of motion in both knees during his initial evaluation of the plaintiff in April 2006." COMMENT: Note the citation of *Navedo*. (*see Navedo v. Jaime*, 32 A.D.3d 788, 789, 822 N.Y.S.2d 43, 45 [1st Dep't 2006]).

Harris v. Carella, 42 A.D.3d 915, 839 N.Y.S.2d 886 (4th Dep't 2007)

Court held: "Defendant's physician properly relied upon an MRI report and similar reports prepared by plaintiff's treating physicians in rendering his opinion. Although

'[those] reports were unsworn, the . . . medical opinion[ ] relying on those . . . reports [is] sworn and thus competent evidence' (*Brown v. Dunlap*, 4 N.Y.3d 566, 577 n. 5."

3. Objective Medical Findings

a. Need

Smith v. Cherubini, 44 A.D.3d 520, 844 N.Y.S.2d 29 (1st Dep't 2007)

Court noted that plaintiff's medical proof was insufficient as her expert failed to identify any objective basis for the percentages attributed to the restricted ranges of motion, and did not objectively relate the MRI findings to plaintiff's current complaints.

Fernandez v. Mercedes, 45 A.D.3d 385, 847 N.Y.S.2d 16 (1st Dep't 2007)

"Plaintiff alleges soft tissue injuries, but his doctor failed to identify any objective basis for the percentages attributed to the restricted ranges of motion, and did not objectively relate the diagnostic findings to plaintiff's current complaints. Absent any description of the objective nature of his findings, plaintiff's doctor's affidavit must be viewed as conclusory and insufficient to establish a serious injury." QUAERE: What evidence would satisfy the court's objective requirement here?

Page v. Rain Hacking Corp., 52 A.D.3d 229, 859 N.Y.S.2d 159 (1st Dep't 2008)

Court held plaintiff's proof was insufficient, noting: "Although the MRI reports were sufficient to establish the existence of herniations, plaintiffs' expert attributed present pain to an unquantified loss of range of motion, and did "not report his personal observations of plaintiff[s] while sitting or standing, or identify the tests, if any, he performed," or compare his observations to the norm."

Paradizov v. Doan, 46 A.D.3d 787, 848 N.Y.S.2d 303 (2d Dep't 2007)

"The defendants did not provide any objective evidentiary basis for their expert orthopedist's opinion that each of the plaintiffs enjoyed a "full range of motion" and that the plaintiff Nikolai Paradizov experienced only "slight restrictions of motion of the back" which, in the expert's view, were 'entirely ascribable' to the subsequent accident."

Felton v. Kelly, 44 A.D.3d 1217, 845 N.Y.S.2d 137 (3d Dep't 2007)

"Plaintiffs rely heavily on the report of neurologist Mustafa Khan. However, while Khan noted that mobility of plaintiff's cervical spine was limited, he provided no qualitative or quantitative assessment of this limitation which would support a conclusion that it was either permanent or significant. Furthermore, although Khan's report detailed plaintiff's subjective complaints of pain and discomfort and opined that plaintiff's migraine headaches, blurred vision and cervical sprain were related to the accident, neither a subsequent MRI nor any other tests performed by Khan showed abnormalities

attributable to the accident. In the absence of such objective evidence, Khan's opinion that plaintiff suffers from a permanent partial disability lacks sufficient probative value to sustain plaintiffs' burden."

b. Specify/Describe Tests

Lamb v. Rajinder, 51 A.D.3d 430, 859 N.Y.S.2d 4 (1st Dep't 2008)

Court held defendants' medical proof failed to establish that plaintiff did not sustain a serious injury as the "affirmed report of defendants' examining neurologist failed to set forth the objective tests performed supporting his claims that there was no limitation of range of motion, and their otologist's affirmed report, finding, *inter alia*, that plaintiff's external auditory canals and tympanic membranes were within normal limits, suffered from the same infirmity."

Rodriguez v. Abdallah, 51 A.D.3d 590, 858 N.Y.S.2d 169 (1st Dep't 2008)

Court faulted plaintiff's medical proof, noting: "It failed to properly explicate the range-of-motion test results cited by disclosing the tests used and how the assessment was made."

Washington v. Delossantos, 44 A.D.3d 748, 843 N.Y.S.2d 186 (2d Dep't 2007)

Court held defendants' medical proof was insufficient as, *inter alia*, their orthopedic expert, Dr. Sultan, "failed to specify the objective tests he performed, or attempted to perform, to evaluate the plaintiff's cervical range of motion, indicating only that [c]ervical spine range of motion testing is met with voluntary resistance and that [w]hen not being tested, the plaintiff is noted to be moving his head and neck without any apparent restriction. Similarly, Dr. Sultan's report fails to list any range of motion test performed in an attempt to determine the abduction and forward flexion of the plaintiff's right shoulder, although the report does note that the internal rotation of the right shoulder was complete. Again, Dr. Sultan's report opines that range of motion testing of the right shoulder was met with voluntary resistance, with the plaintiff holding his right upper arm against his chest wall and claiming an inability to move his right shoulder. Dr. Sultan opined that [t]here was obvious voluntary resistance with abduction and forward flexion."

Cameron v. Engelhardt, 44 A.D.2d 1152, 843 N.Y.S.2d 479 (3d Dep't 2007)

Plaintiff's physicians in their affidavits failed to describe the diagnostic tests employed.

Flisch v. Walters, 42 A.D.3d 682, 839 N.Y.S.2d 602 (3d Dep't 2007)

Plaintiff claimed a serious injury based on dizziness and neurological dysfunctions. Court held plaintiff's medical proof was insufficient, noting "The evaluations performed by plaintiff's treating nurse practitioner are of limited evidentiary value because she does

not identify any diagnostic tests performed or show that her findings are based on anything other than plaintiff's and her parents' subjective reports of headaches, dizziness, memory loss and mood swings."

Fuchs v. Johnson, 2007 N.Y. Slip Op. 33578(U) (Sup. Ct. Wayne Co.)(Nesbitt, J.)

Court held: "A plaintiff cannot play "hide the hall" by failing to reveal the nature of the range of motion tests performed and results quantifying loss of motion by comparing plaintiffs performance with medically accepted norms. The medical affidavit here describes the nature of the tests, and asserts that the tests were capable of, and in fact did, yield, among other things, a result quantifying a 50 percent reduction in the cervical active range of motion, primarily in extension, lateral flexion and right rotation. Issues that one may raise as to the validity of the chiropractor's findings and conclusions go to the weight of the evidence, a matte rto be resolved at trial and not by summary judgment.

c. What Constitutes Objective Medical Findings

Parreno v. Jumbo Trucking, Inc., 40 A.D.3d 520, 836 N.Y.S.2d 593 (1st Dep't 2007)

Court made the following statements: (1) "Viewing the trial evidence in a light most favorable to plaintiff, as we must, his medical evidence failed to establish a *prima facie* case of serious injury under either a quantitative or qualitative analysis. With respect to the quantitative findings, we note that although Dr. Kaplan testified to a 30% loss of range of motion of the neck, and further found that the results of plaintiff's straight leg raising test yielded a 20º difference from the normal result, any fair reading of the record demonstrates that these numerical restrictions on range of motion were premised exclusively on plaintiff's subjective indications of pain. Indeed, plaintiff's doctor candidly admitted that the results of the straight leg raising test will depend on the patient's assertions of pain, rather than a verifiable inability to raise one's leg more than seventy degrees. Accordingly, the failure of plaintiff's medical expert to demonstrate the objective tests performed to determine the loss of range of motion renders these numerical findings insufficient to demonstrate serious injury. (2) "Although plaintiff's expert did identify some objective evidence of plaintiff's injury – a herniated disc, a bulging disc and multiple points of muscular spasm – this evidence alone was insufficient to establish serious injury, in the absence of objective medical evidence showing the extent or degree of the limitations resulting from these specific injuries and their duration." (3) "Nor did plaintiff establish a significant limitation based upon a qualitative assessment of his condition. The record discloses that at the end of his testimony, Dr. Kaplan was asked what was the 'qualitative difference' between plaintiff's injured cervical and lumbar spine and that of a 'normal healthy spine.' After Dr. Kaplan stated that he did not understand the question, which plaintiff's counsel rephrased, the doctor stated that 'he certainly has pain with activities, acquires pain, complained of pain with activities, complained of pain with weather changes. He has muscular spasm that limits his motion, worse at times than other times. And, so, he has limited function, certainly.' Manifestly, this vague testimony fails to compare plaintiff's limitations to the normal function, purpose and use of the cervical and lumbar regions of his spine. Likewise, Dr.

Kaplan's' assertion that plaintiff's injuries were 'significant' was conclusory and tailored to the meet the statutory and decisional requirements." QUAERE: Why didn't the straight-leg raising together with the spasm suffice as an objective finding? (*Compare*, *Brown v. Achy*, 9 A.D.3d 30, 776 N.Y.S.2d 56 (1st Dep't 2004) (Marlow, J.).

Scudera v. Mahbubur, 39 A.D.3d 620, 833 N.Y.S.2d 239 (2d Dep't 2007)

See Section II, E, 2.

Seecoomar v. Ly, 43 A.D.3d 900, 841 N.Y.S.2d 624 (2d Dep't 2007)

The plaintiff submitted, *inter alia*, the affirmation of his treating orthopedist whom he saw regularly about every eight months. The orthopedist noted that the plaintiff's MRI was reviewed and showed a disc herniation at L5-S1 as well as disc degeneration. The disc herniation was consistent with traumatic injury. The orthopedist determined that the plaintiff's straight leg raising was 20 to 25 degrees on the left side, in contrast to a normal range of 90 degrees, and the plaintiff "can ambulate with a stiff heel-toe gait." His finding of a limitation of range of motion of straight leg raising on the left side was confirmed in an examination conducted in December 2005 while the motion for summary judgment was pending. Court held plaintiff demonstrated *prima facie* a serious injury.

Tallcott v. Zurenda, 48 A.D.3d 989, 853 N.Y.S.2d 192 (3d Dep't 2008)

Court held plaintiff's medical proof at trial in support of her claims of injury was sufficient. It stated: "Plaintiffs presented the unrefuted testimony of Kamlish Desai, the orthopedic surgeon that plaintiff treated with since one week after the accident and who diagnosed him with "[c]hronic cervical, thoracic and lumbar syndrome," which was secondary to the motor vehicle accident. Desai testified that the repeated range of motion tests which he qualitatively measured over a two-year period demonstrated a marked restriction of flexion, extension and rotation compared with normal results. He stated that this was consistent not only with plaintiff's subjective complaints of pain, but also with the diagnosis of soft tissue injuries sustained in the accident and his continued objective observation of plaintiff over a long period of time. In addition, Desai indicated that, during the course of plaintiff's treatment, muscle palpations were detected and reflex tests of the upper extremities evidenced diminished reflexes."

Alcombrack v. Swarts, 49 A.D.3d 1170, 856 N.Y.S.2d 359 (4th Dep't 2008)

"The affidavit of decedent's treating physician is insufficient to establish plaintiff's entitlement to judgment as a matter of law because it is based solely on decedent's subjective complaints of headaches. Plaintiffs content that the affidavit constituted objective evidence of a medically determined injury because it was based upon the physician's observation of actual, quantified limitations. We reject that contention. The headaches suffered by decedent were not physical limitations that could be observed by his treating physician, and, in any event, the affidavit did not include any observations of quantified limitations."

Burnett v. Yeya Limousine, Inc, 2008 N.Y. Slip Op. 51305(U) (App.T. 1st Dep't)

Court held: "Plaintiff raised a triable issue on his claim of permanent injury by submitting, *inter alia*, the affirmation of treating physicians who attested to quantified restrictions of motion, the presence of muscle spasms and loss of sensation in plaintiff's lower extremities persisting several years after the accident. These findings correlated with similar findings of limitation in the near aftermath of the accident, and were consistent with the results of MRI and nerve conduction testing. The doctors opined that the subject accident caused significant and permanent injuries to plaintiff's spine."

Sanford v. Machauareaw, 2007 N.Y.Slip.Op. 51833(U) (Sup.Ct. Richmond Co.) (Minardo, J.)

Court held plaintiff's proof was sufficient as it consisted, *inter alia*, of: Dr. Schepp, a Board Certified neuroradiologist and Board Certified radiologist, affirmed he read plaintiff's MRI of his left knee which was taken approximately two (2) weeks post accident and found a partial meniscal tear involving the posterior horn of the meniscus and supratella effusion. Dr. Verde, an orthopedic surgeon, affirmed he first examined plaintiff on March 18, 2005, six (6) weeks post accident. His examination revealed mild medial joint line tenderness and a trace positive McMurray's sign. His initial diagnosis was partial medial meniscus tear of the left knee as per the MRI. Dr. Verde's last examination of plaintiff was performed on December 18, 2006. His examination revealed crepitus on flexion/extension with a mild join line discomfort and a positive McMurray's sign. His opinion is that no further objective or subjective improvement is expected. Dr. Verde concluded plaintiff's partial meniscal tear involving the posterior horn of the medial meniscus was causally related to the accident of February 3, 2005.

4. Need for Further Explanation

Cariddi v. Hassan, 45 A.D.3d 516, 845 N.Y.S.2d 426 (2d Dep't 2007)

"While plaintiff's physician, Dr. Katz, provided objective medical evidence in support of his diagnoses with respect to the plaintiff's complaints regarding her ankle and lumbosacral spine, his only basis for concluding that the plaintiff's complaints regarding her hip were unrelated to the subject accident was that doctors' notes reviewed do not indicate any problem to the left hip following the this incident of 09/17/04 [and a]n MRI of the left hip and pelvis was not performed until 01/03/06 which is more than one year after the accident. However, Dr. Katz did not attach any of the prior medical records to his report, and the defendants otherwise failed to submit any such records in support of their motion, as they were certainly entitled to do. Therefore, Dr. Katz's report, standing alone, failed to establish, *prima facie*, that the plaintiff's alleged hip injury was unrelated to the subject accident.

Guzman v. Bowen, 46 A.D.3d 617, 847 N.Y.S.2d 630 (2d Dep't 2007)

"The report of Dr. Gary J. Florio, a physiatrist, merely stated that upon examination of the plaintiff, the plaintiff's cervical and thoraco-lumbar spine ranges of motion for flexion, extension, lateral flexion, and rotation were within "functional" limits. This statement was, at best, vague and conclusory."

Rashid v. Estevez, 47 A.D.3d 786, 850 N.Y.S.2d 181 (2d Dep't 2008)

Court held the affirmation of the plaintiff's treating physician, along with his reports, failed to establish a triable issue of fact, as the physician's initial conclusion that the plaintiff suffered from lumbar and cervical radiculopathy was contradicted by his own testing results which revealed that the plaintiff did not suffer from those injuries.

Rico v. Figueroa, 48 A.D.3d 778, 853 N.Y.S.2d 129 (2d Dep't 2008)

Court held plaintiff's proof was insufficient, noting that "while plaintiff's treating physician opined that he was unable to return to work full time until November 30, 2004, this was belied by plaintiff's own deposition testimony in which he stated that he was able to return full time to work within 2½ months of the accident."

Piperis v. Wan, 49 A.D.3d 840, 854 N.Y.S.2d 489 (2d Dep't 2008)

"Contrary to the Supreme Court's determination, however, the plaintiff failed to raise a triable issue of fact in opposition. The plaintiff did not see Sheila Horn, his treating osteopath, until July 1, 2005, two weeks after the accident. Her report of the examination at that time, while reflecting a significant limitation in certain of the plaintiff's ranges of motion, failed to set forth the objective tests that were used to reach that result. Horn's report of her examination of the plaintiff on September 9, 2005, reflects, however, that the plaintiff's ranges of motion were virtually normal. In light of this, the unexplained determination by the plaintiff's examining physician, David Delman, that the subject accident caused the injuries and limitations he noted in the plaintiff's cervical spine, lumbar spine, and left knee on February 28, 2007, was speculative and conclusory, and therefore insufficient to raise a triable issue of fact."

Motrie v. Reid, 45 A.D.3d 941, 845 N.Y.S.2d 841 (3d Dep't 2007)

Court held plaintiff's medical proof was insufficient as her physician "in reliance on a report from a physician at the Hand Center of Western New York, who examined plaintiff and conducted an MRI study, concluded that plaintiff sustained a scapholunate ligament disruption. Careful analysis of these two reports leads us to conclude that plaintiff has failed to submit competent evidence that raises an issue of fact that this ligament tear was caused by this motor vehicle accident or that the injury is 'serious' as there appears to be no permanent consequential or significant limitation of use."

Gibbs v. Rivera, 2007 N.Y. Slip Op. 50790(U) (Sup. Ct. Kings Co. 2007) (Ruchelsman, J.)

Defendant moved for summary judgment relying upon affirmed medical report of a physician who examined plaintiff 3 months after the accident at the request of defendant's No-Fault carrier. The physician opined that plaintiff had "no disability" at the time of examination and any further treatment would be considered "excessive." Plaintiff opposed the motion, submitting, *inter alia*, a medical report prepared by his examining physician the same physician whose report was submitted by defendant; conducted four years after his earlier examination to oppose the motion. This time the physician opined that plaintiff was disabled, but did not address or even acknowledge his earlier examination and finding or that in the second examination he relied on prior MRI's to find disability, which MRI, he discounted on the earlier examination. In a thoughtful decision, Supreme Court concluded that plaintiff's papers were insufficient as the physician did not reconcile his second opinion with his first opinion.

Vasquez v. Velez, 2007 N.Y. Slip Op. 50105(U) (Sup. Ct. Bronx Co.)(Hunter, J.)

Court held defendant's moving medical affidavit was insufficient, noting, *inter alia*, that while the physician examined plaintiff, the only records reviewed by him were plaintiff's bill of particulars, and there was no indication that he reviewed any of plaintiff's medical records including the MRI taken of his lumbar and cervical spine which indicated that there were disc herniations."

D. Medical Examinations/Treatment

1. "Contemporaneous" With Accident

Guadalupe v. Blondie Limo., Inc., 43 A.D.3d 669, 841 N.Y.S.2d 525 (1st Dep't 2007)

"The quantitative range-of-motion assessment plaintiff did submit was made more than two years after the accident by a physician who examined her only on that one occasion. There is thus a failure of proof relating this doctor's findings to an accident that occurred more than two years prior to his examination."

Hammett v. Diaz-Frias, 49 A.D.3d 285, 852 N.Y.S.2d 128 (1st Dep't 2008)

In reversing grant of defendants' motion for summary judgment, Court held: "Even though he did not examine plaintiff until 10 months after the incident, plaintiff's doctor was able to report that plaintiff's symptoms were caused by the June 2004 accident, that her condition was permanent in nature, in part an "exacerbation of underlying degenerative joint disease and prior injuries," and that she sustained permanent consequential limitation in her cervical and lumbosacral spine. This was sufficient to raise a triable issue of fact as to the permanence of the injury."

Ali v. Khan, 50 A.D.3d 454, 857 N.Y.S.2d 71 (1st Dep't 2008)

Court held plaintiff's medical proof was insufficient. It held: "Where only objective evidence of limitation of motion is contained in report of an orthopedist who examined the plaintiff several years after the accident, the finding is 'too remote to raise an issue of fact as to whether the limitations were caused by the accident.' Nor was there any contemporaneous 'admissible evidence that [either] plaintiff was ever diagnosed by her treating physician with a fracture that resulted from the accident,'"

D'Onofrio v. Floton, Inc., 45 A.D.3d 525, 845 N.Y.S.2d 421 (2d Dep't 2007)

"The affidavit of the plaintiff's treating neurologist showed range of motion limitations in the plaintiff's spine based on a recent examination. However, neither the plaintiff nor his treating neurologist proffered competent medical evidence that showed range of motion limitations in the plaintiff's spine that were contemporaneous with the subject accident."

Morales v. Theagene, 46 A.D.3d 775, 848 N.Y.S.2d 325 (2d Dep't 2007)

Court held plaintiff's medical proof raised a triable issue of fact, noting that her physician "set forth significant range of motion limitations in her lumbar spine based on an examination that was performed contemporaneously with the subject accident, and found similar significant lumbar range of motion limitations roughly three years later during a recent examination."

Shvartsman v. Vildman, 47 A.D.3d 700, 849 N.Y.S.2d 600 (2d Dep't 2008)

"While there was evidence in plaintiff's physician's report of range-of-motion limitations in the plaintiff's cervical spine that was based upon a recent examination, neither the plaintiff nor his physician proffered any competent medical evidence that showed range-of-motion limitations in the plaintiff's cervical spine or left knee that were contemporaneous with the subject accident."

Cameron v. Engelhart, 44 A.D.3d 1153, 843 N.Y.S.2d 479 (3d Dep't 2007)

"It is noted that in large measure plaintiff's evidence concerning serious injury begins several years after the accident in question and several years after repeated medical exams which consistently failed to reveal any significant injury to plaintiff causally related to the accident. Given the lack of probative medical evidence that plaintiff suffered a serious injury contemporaneous with the subject accident."

Smith v. Quick Transit, Inc., 2008 N.Y. Slip Op. 50356(U) (App. T. 1st Dep't)

"The 2006 findings of plaintiff's treating physician as to continuing and significant restrictions of motion were consistent with similar limitations found in the near aftermath of the 2004 vehicular accident, and adequately substantiated the existence of a serious injury casually related to the subject accident."

2. Recent

Guadalupe v. Blondie Limo, Inc., 43 A.D.3d 669, 841 N.Y.S.2d 525 (1st Dep't 2007)

"Despite the positive MRI report, there were no objective findings immediately following the accident to demonstrate any initial range-of-motion restrictions on plaintiff's cervical and lumbar spine, or any detailed explanation for their omission. The quantitative range-of-motion assessment plaintiff did submit was made more than two years after the accident by a physician who examined her only on that one occasion. There is thus a failure of proof relating this doctor's findings to an accident that occurred more than two years prior to his examination."

Brown v. Singh, 52 A.D.3d 367, 858 N.Y.S.2d 885 (1st Dep't 2008)

Court held: "The report of a physician who examined plaintiff more than five years after the accident was too remote in time to show any contemporaneous range of motion limitations in his cervical and lumbar spine resulting from the accident, and therefore fails to raise an issue of fact as to whether his injuries were permanent or significant." QUAERE: Why couldn't the physician opine five years later that plaintiff's injuries were permanent?

McComb v. Bender, 45 A.D.3d 819, 847 N.Y.S.2d 123 (2d Dep't 2007)

"The plaintiffs relied principally on the affirmed medical reports of the injured plaintiff's treating neurologist. A review of those reports fails to indicate that they were based on a recent examination of the plaintiff."

Morales v. Theagene, 46 A.D.3d 775, 848 N.Y.S.2d 325 (2d Dep't 2007)

Court held plaintiff's medical proof raised a triable issue of fact, noting that her physician "set forth significant range of motion limitations in her lumbar spine based on an examination that was performed contemporaneously with the subject accident, and found similar significant lumbar range of motion limitations roughly three years later during a recent examination."

Berkowitz v. Taylor, 47 A.D.3d 740, 851 N.Y.S.2d 597 (2d Dep't 2008)

"The plaintiff's submissions failed to raise a triable issue of fact as to whether she sustained any such serious injury, since none of those submissions were based on a recent examination."

Landicho v. Rincon, __ A.D.3d __, __ N.Y.S.2d __ (2d Dep't 2008)

Court held plaintiff failed to raise a triable issue of fact that she sustained a serious injury stating: "While [her treating physician] concluded that the plaintiff sustained permanent

injuries and significant limitations, the findings contained in his affirmation were not based on a recent examination."

3. "Gap In Treatment"

Pommells v. Perez, Brown v. Dunlap, Carrasco v. Mendez, 4 N.Y.3d 566, 797 N.Y.S.2d 380 (2005):

In soft-tissue injury cases involving complaints of pain and plaintiff's attempt to establish a serious injury under the limitation of use categories and 90/180 days category, court notes the "vexing" task courts confront and that the courts have approached them with a "well-deserved skepticism." Court then holds that "even where there is objective medical proof, 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 pre-existing condition—summary dismissal of the complaint may be appropriate."

Pommells

"We first address the "gap in treatment" noted by the trial court and Appellate Division—the period of time between the end of plaintiff's physical therapy in 1998 and his visit to Dr. Rose to obtain an expert medical report in 2002. Defendants argue that the "gap" both renders the medical expert's later opinion on causation speculative and places into question the seriousness of the injuries themselves. "In the present case, the so-called gap in treatment was, in reality, a cessation of all treatment. Plaintiff ended his physical therapy six months after the accident and sought no other treatment until years, later, when he visited Dr. Rose in connection with this case. While a cessation of treatment is not dispositive—the law surely does not require a record of needless treatment in order to survive summary judgment—a plaintiff who terminates therapeutic measures following the accident, while claiming "serious injury," must offer some reasonable explanation for having done so. Here, plaintiff provided no explanation whatever as to why he failed to pursue any treatment for his injuries after the initial six-month period, no did his doctors."

Brown

"Neither of the dispositive grounds in *Pommells* applies here. First, as to the so- called gap in treatment—the two and one-half years when plaintiff's injuries received no outside attention—Dr. Melamed explained that, once he determined further medical therapy would "be only palliative in nature," he terminated treatment and instructed plaintiff to continue exercises at home. A plaintiff need not incur the additional expense of consultation, treatment or therapy, merely to establish the seriousness or casual relation of his injury. Unlike *Pommells* plaintiff's cessation of treatment was explained sufficiently to raise an issue of fact and survive summary judgment."

Lorsirisup v. Russo, 2007 N.Y. Slip Op. 51394(U) (Sup. Ct. Richmond Co.) (Minardo, J.)

"Needless to say, there is no mathematical formula for calculating how much of an interval between visits constitutes a "gap" in treatment, nor is there a specific standard regarding which explanations are 'reasonable.'"

Yagi v. Corbin, 44 A.D.3d 440, 843 N.Y.S.2d 276 (1st Dep't 2007)

"Plaintiff failed to meet that burden because his expert's report, dated nearly three years after his last treatment of plaintiff, does not satisfactorily explain why plaintiff terminated treatment. Therefore, notwithstanding the objective medical proof offered by plaintiff, when additional contributory factors interrupt the chain of causation…such a gap in treatment…or a pre-existing condition-summary dismissal of the complaint may be appropriate."

Sung v. Mihalios, 44 A.D.3d 500, 843 N.Y.S.2d 317 (1st Dep't 2007)

"The one-year gap in plaintiffs' treatment was adequately explained by the expert's opinion that further treatment would be palliative."

DeLeon v. Ross, 44 A.D.3d 545, 843 N.Y.S.2d 36 (1st Dep't 2007)

"Plaintiff's so-called gap in treatment was, in reality, a cessation of all treatment. While a cessation of treatment is not dispositive, a plaintiff who terminates therapeutic measures following the accident, while claiming serious injury, must offer some reasonable explanation for having done so. Here, there was an undisputed, 20-month gap before plaintiff's last examination, beginning 17 months after the accident and continuing until the submission of defendants' motion for summary judgment. By way of explanation, plaintiff offers only the irrelevant claim, unsupported by an y documentation from defendants' insurance carrier, that he failed to appear at an independent medical examination scheduled by defendants' insurance carrier because he forgot the date, and was not given an opportunity for a makeup."

Edgecomb v. Ixat Transit, Inc., 45 A.D.3d 360, 846 N.Y.S.2d 20 (1st Dep't 2007)

"Plaintiff's claims of permanent and significant injuries were properly rejected where, in opposition to defendants' *prima facie* showing of no such injuries, plaintiff offered no explanation why she did not seek any treatment starting nine months after the accident."

Brown v. Singh, 52 A.D.3d 367, 858 N.Y.S.2d 885 (1st Dep't 2008)

Court held: "Plaintiff offered no explanation for the absence of any evidence that he underwent any medical treatment or physical therapy in the five years since he was examined, X-rayed and released by the hospital emergency room immediately after the automobile accident in which he claims to have sustained 'serious injury'."

Seecoomar v. Ly, 43 A.D.3d 900, 841 N.Y.S.2d 624 (2d Dep't 2007)

"There were no 'gaps' in medical treatment since the plaintiff regularly saw his orthopedist about every eight months and was taking prescription pain medication. The plaintiff explained that active physical therapy was discontinued after six months on the ground that he experienced no further improvement."

Verette v. Zia, 44 A.D.3d 747, 844 N.Y.S.2d 71 (2d Dep't 2007)

"Plaintiff failed to adequately explain the essential cessation of her physical therapy treatment five to six months post-accident."

Morales v. Theagene, 46 A.D.3d 775, 848 N.Y.S.2d 325 (2d Dep't 2007)

"Contrary to the contentions of the defendants, there was no lengthy gap in plaintiff's treatment. The plaintiffs' treating chiropractor stated in his affidavit that plaintiff was treated by him on a regular and continuous basis from his initial treatment date with her on May 12, 2003."

Wang v. Harget Cab Corp., 47 A.D.3d 777, 850 N.Y.S.2d 537 (2d Dep't 2008)

"The plaintiff's treating physiatrist's affirmations, while setting forth limitations as to the plaintiff's ranges of motion as to various parts of his body, were insufficient in that they failed to account for the 10-month gap between the physiatrist's last treatment of the plaintiff and the plaintiff's examination on January 9, 2007. There was no evidence that the plaintiff underwent any medical treatment in this time period and no explanation as to why none was appropriate."

Casey v. Mas Trans., Inc. 48 A.D.3d 610, 852 N.Y.S.2d 373 (2d Dep't 2008)

"Contrary to the defendants' assertions, the affidavit of the plaintiff adequately explained any gap in her treatment history." NOTE: Court did not state what that explanation was.

Ferraro v. Ridge Car Serv., 49 A.D.3d 498, 854 N.Y.S.2d 408 (2d Dep't 2008)

In granting summary judgment to defendants, Court held: "Neither the plaintiff not her treating osteopath adequately explained the significant gap in treatment between May 2005, when, based on the plaintiff's assertions, she was last treated by a chiropractor and March 2007, when she was examined by her treating osteopath in direct response to the defendant's motion for summary judgment."

Cadena v. Espinal, 49 A.D.3d 582, 852 N.Y.S.2d 795 (2d Dep't 2008)

"The plaintiff failed to raise a triable issue of fact. The affidavit of the plaintiff's treating chiropractor failed to establish that he had personal knowledge of the plaintiff's condition prior to the alleged accident or of the reasons that caused the plaintiff to discontinue

treatment after five months. In the absence of such knowledge, the chiropractor's affidavit was insufficient to explain the cessation of treatment, as was necessary."

Cornelius v. Cintas Corp., 50 A.D.3d 1085, 857 N.Y.S.2d 637 (2d Dep't 2008)

"Neither David nor his treating physicians adequately explained the lengthy gap in his treatment between the time he stopped treatment in April 2004 and his most recent examination performed by Bernstein on August 31, 2005."

Kasel v. Szczecina, 51 A.D.3d 872, 858 N.Y.S.2d 346 (2d Dep't 2008)

Court held: "Contrary to the defendant's contention on appeal, the plaintiff adequately explained the gap in her treatment between January 2005 and her most recent examination on June 30, 2006." NOTE: Court does not specify what the explanation was.

Coleman v. New Ridgewood Car Service, 2008 NY Slip Op. 51029(U) (Sup. Ct. Kings Co.) (Miller, J.)

Court rejected plaintiff's attempt to explain the 4 ½ years gap, stating: (1) "The court also finds Dr. Mollins' (testifying physician) opinion with regard to the futility of further treatment, made approximately four years after treatment terminated, to be without probative value."; and (2) "Herein, plaintiff fails to corroborate the claim that she was unable to afford further treatment after no fault benefits were exhausted." NOTE: The decision is a thoughtful and thorough discussion of the "gap in treatment" doctrine.

VI. RENEWAL MOTIONS

Beyl v. Franchini, 37 A.D.3d 505, 829 N.Y.S.2d 699 (2d Dep't 2007)

Court held plaintiff's renewal motion was properly denied. Supreme Court had originally granted defendant's summary judgment motion on the ground that plaintiff's medical affidavit was not based upon a recent examination. In affirming denial of renewal motion, Court stated: "Plaintiffs moved for leave to renew based upon more recent examinations, including an examination made after the motion was submitted and an examination made after the motion was decided. The plaintiffs alleged that the injured plaintiff's treating physician was unable to schedule these examinations earlier. However, there was no explanation as to why the treating physician had sufficient time to prepare an affidavit, but did not have sufficient time to conduct an examination before the submission of the defendants' motion for summary judgment, nor was there an explanation as to why the plaintiffs did not seek an adjournment of the defendants' motion until an examination could be scheduled."

Gibbs v. Harp, 46 A.D.3d 1010, 847 N.Y.S.2d 686 (3d Dep't 2007)

Plaintiff moved for leave to renew and reargue asserting that she had submitted to the court clerk a sworn report by a pain management specialist, which ostensibly was not forwarded to Supreme Court. "We agree that Supreme Court properly granted renewal as to the report, the worn copy of which was not before the court through no fault of plaintiff. And, upon reconsideration, such report, which failed to address plaintiff's numerous preexisting conditions involving the same areas allegedly injured in the subject accident, did not provide a basis for deviating from the original decision."

VII. MISCELLANEOUS MATTERS

A. Bill of Particulars

Sharma v. Diaz, 48 A.D.3d 442, 850 N.Y.S.2d 634 (2d Dep't 2008)

"Since the plaintiff did not allege in his complaint or bill of particulars that he sustained a significant disfigurement as a result of the subject accident and did not move for leave to amend the bill of particulars, the evidence pertaining to any scar on his forehead was nto considered."

B. Medical Authorizations

Weber v. Ryder, TRS, Inc., 49 A.D.3d 865, 854 N.Y.S.2d 480 (2d Dep't 2008)

In this discovery dispute, Court held information as to the nature and severity of personal injury plaintiff's previous right shoulder injury and right shoulder surgery were material and necessary to the issue of damages, if any, recoverable for a claimed loss of enjoyment of life due to the current injuries sustained by him in the subject motor vehicle accident, and, thus, plaintiff should have been compelled to provide authorizations for the release of his medical records pertaining to the injury and surgery.

C. Trial

Moreno v. Fabre, 46 A.D.3d 254, 847 N.Y.S.2d 61 (1st Dep't 2007)

Court held trial court improperly refused the defendant's request for a missing witness charge, "since the physician who treated plaintiff during the four months following the accident was the only potential witness who could testify regarding plaintiff's condition during the six months following the accident. However, such testimony was only material to plaintiff's 90/180 claim, *i.e.*, his ability to resume his usual and customary activities for at least 90 days during the 180 days following the accident. Inasmuch as the jury was asked to return a special verdict in this case, the question of "serious injury" was established with its affirmative answer to the first question ("significant limitation of use of a body function or system"), regardless of the alternative 90/180 test of the statute."

Desimone v. Royal GM, Inc., 49 A.D.3d 490, 856 N.Y.S.2d 628 (2d Dep't 2008)

By failing to move for a directed verdict pursuant to CPLR 4401 on the issue of whether the plaintiff sustained a "serious injury" under Insurance Law § 5102(d), the defendants implicitly conceded that the issue was for the trier of fact. Furthermore, the jury verdict finding, *inter alia*, that the plaintiff sustained a "significant limitation of use of a body function or system" should not be set aside as against the weight of evidence, as it could have been reached on a fair interpretation of the evidence."

Campo v. Neary, 2007 WL 50885(U) (Sup.Ct. Monroe Co.)(Polito, J.)

Plaintiff's two treating orthopedic surgeons opined that plaintiff's ankle fracture was causally related to the accident. Upon defendant's examining IME neurologist's agreement, defendant obtained expert testimony from Dr. Cohn, a radiologist, who, upon a peer review of the records and without sound medical basis disagreed, and testified that the fracture was likely the result of plaintiff wearing an improperly fitting hunting boot twenty years prior thereto. Such testimony was contrary to the twenty year old record, since a review of that record indicated the plaintiff complained of lower leg pain in 1982 and not ankle pain. Trial court set aside jury finding of no causal relationship. It noted: "Dr. Cohn indicated that his opinion relied on inferential facts derived from facts stated from the examining doctor records 20 years previously, which inferences had no real basis from the facts stated therein and was conjecture. The peer review was not only based on impermissible references solely from a 20 year old medical record, but also without examination of the patient and without discussion with that treating physician, where the treating physician's diagnosis and treatment resolved the problem. Such peer review opinion does not meet the required factual basis and/or medical rationale necessary, medically and legally, to contradict the diagnosis of the prior treating physician.

D. Default

Rivera v. Serrata, 19 Misc.3d 379, 852 N.Y.S.2d 830 (Sup. Ct. Bronx Co. 2008)(Suarez, J.)

In a thoughtful opinion addressing an issue of first impression trial court held that at an inquest at which serious injury and damages were to be tried before a jury, conducted upon defendant's default (answer struck due to discovery non-compliance), 22 NYCRR §202.46(b) did not permit plaintiff to establish her claims through sworn medical affidavits.

E. Arbitration

No Cases

F. Liens

Burns v. Varriale, 9 N.Y.3d 207, 849 N.Y.S.2d 1 (2007)

Plaintiff was involved in a work-related automobile accident. The workers' compensation carrier was directed to pay him $400 a week upon a finding of permanent partial disability, and plaintiff agreed to a settlement of his third-party tort action in the amount of $300,000, which the carrier consented to. A proceeding was commenced to determine the amount of the lien, which was computed to be $46,523.26 (total lien of $96,523.26 minus $50,000 paid in lieu of no-fault benefits). Plaintiff then sought $20,000 in "fresh money" for litigation expenses incurred in the third-party action. Court held: (1) permanent partial disability determination did not entitle claimant to weekly compensation benefits at specific rate over his life or over set period; (2) present value of future compensation benefits was speculative at time that nonscheduled permanently partially disabled claimant recovered damages in third-party action; and (3) trial court could not use present value of future benefits in nonscheduled permanent partial disability case for purposes of calculating workers' compensation carrier's equitable share of claimants' attorney's fees and costs.