SOFT TISSUE INJURIES
DISCUSSION OF DIAGNOSTIC STUDIES, ANATOMY OF THE SPINE AND TYPES OF TREATMENT

by

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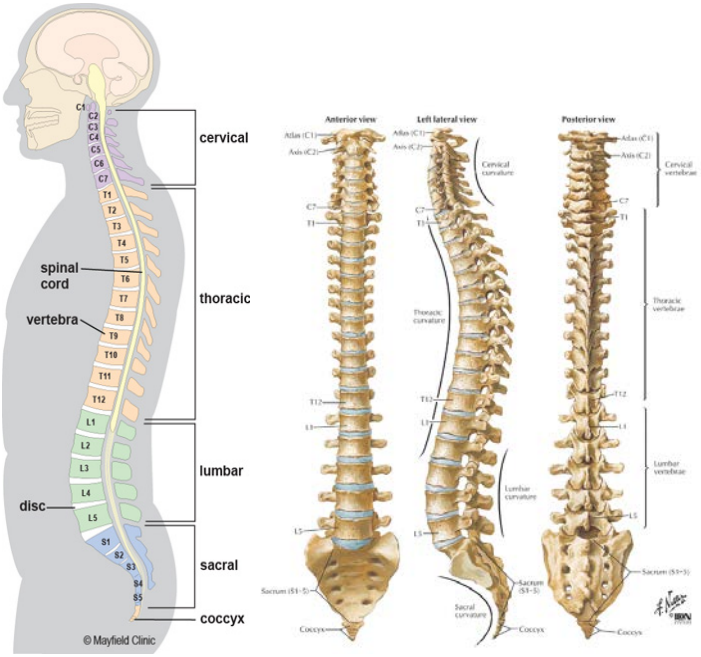
1. Anatomy of the Spine

a. There are many demands placed on your spine. It holds up your head, shoulders, and upper body. It gives you support to stand up straight, and gives you flexibility to bend and twist. It also protects your spinal cord.

b. The spine is made up of three segments: the cervical spine, the thoracic spine and the lumbar spine. Small bones, called vertebrae, are stacked on top of one another and cause the natural curves of the back. These bones connect to create a canal that protects the spinal cord. The cervical spine is made up of seven small vertebrae that begin at the base of the skull and end at the upper chest. The thoracic spine is made up of twelve vertebrae that start from the upper chest to the middle of the back and connect to the rib cage. The lumbar spine consists of five larger vertebrae in the lower back.

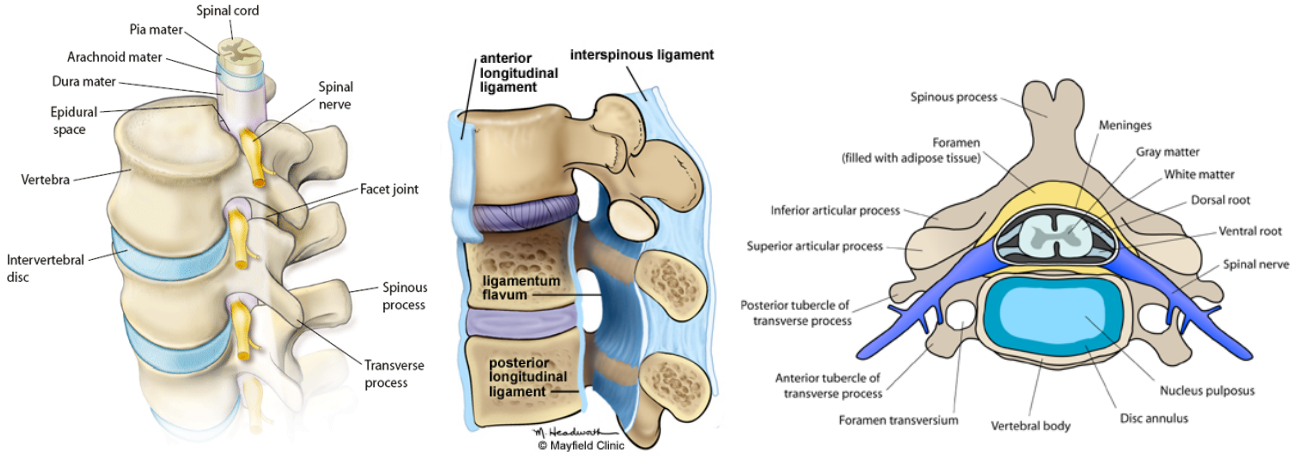


c. The spinal cord extends from the skull to your lower back and travels through the middle part of each stacked vertebra, called the central canal. Nerves branch out from the spinal cord through openings in the vertebrae, called foramen and carry messages between the brain and muscles. The spinal cord ends around the first and second lumbar vertebrae and continues as nerve roots. This bundle of nerve roots is called the cauda equina.

d. Muscles and ligaments provide support and stability for your spine and upper body. Strong ligaments connect your vertebrae and help keep the spinal column in position.

e. Intervertebral discs sit in between the vertebrae. They are flat and round, and about one-half inch thick. Intervertebral discs are made up of two components: the nucleus pulposus and the annulus fibrosus. The nucleus pulposus is jelly-like and makes up the center of the disc. The jelly is partly made of water and gives the disc flexibility and strength. The annulus fibrosus is the flexible outer ring of the disc. It is made up of several layers, similar to elastic bands. In effect, discs act as shock absorbers for the spine.

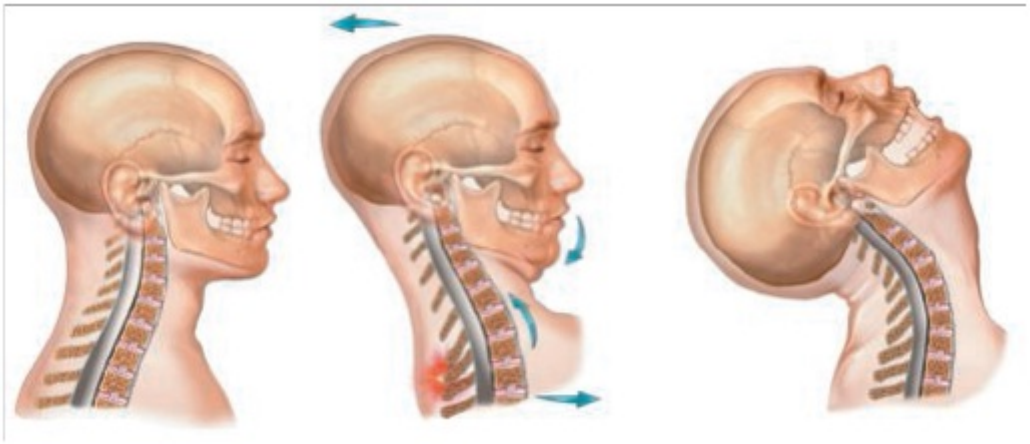
f. Between the back of the vertebrae are small joints that also help your spine move. These facet joints have a cartilage surface and are important for allowing rotation of the spine.



2. Injuries

a. Soft tissue injuries involve damage to the ligaments, tendons and muscles. Types of soft tissue injuries include: sprains, strains, contusions, tendonitis and bursitis.

b. **Whiplash**. Although it's usually associated with automobile accidents, any impact or blow that causes the head to jerk forward or backward can cause neck strain. Neck strains involve injury to soft tissues that contract and move, such as muscles and tendon, whereas neck sprains involve injury caused by tearing of the ligaments, the tissues that connect the bones to each other.

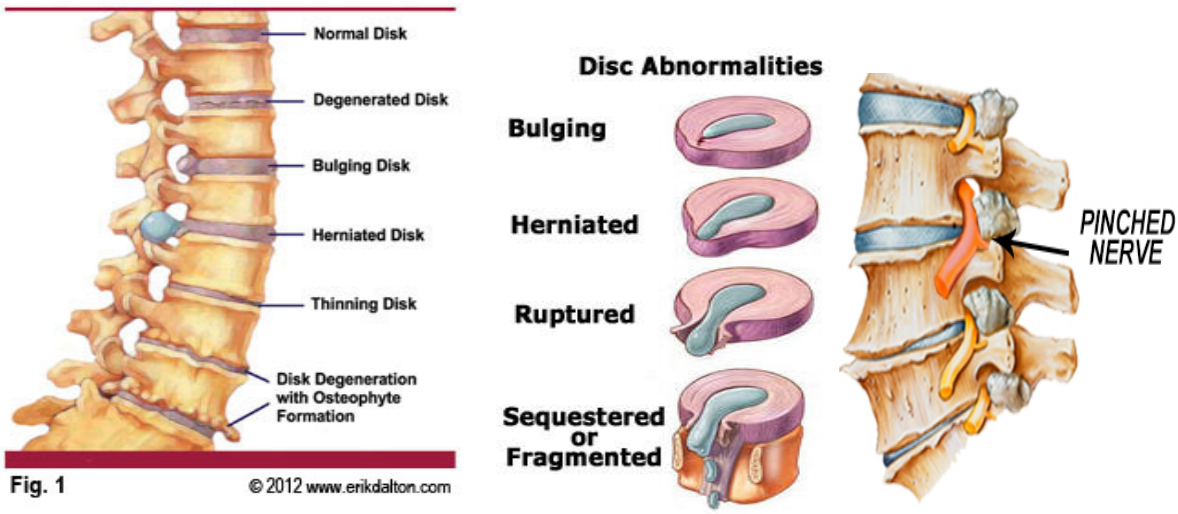


c. **Herniated Disc**. When people say they have a "slipped" or "ruptured" disc in the neck or lower back, what they are actually describing is a herniated disc. A disc herniates or ruptures when part of the center nucleus pushes through the outer edge of the disc and back toward the spinal canal. This puts pressure on the nerves and causes pain. A cervical herniation results in radiating pain in the shoulder and numbness in hands. A lumbar herniation results in radiating pain down the leg, numbness and tingling. A thoracic herniation results in pain to the chest or stomach, and may be exacerbated when coughing or sneezing.

d. **Bulging Disc**. A bulging disc extends outside the space it should normally occupy, but the nucleus pulposus does not rupture. Bulging discs are very common and many people are unaware of its presence until the bulging disc impinges on the nerves of the spinal column.

e. **Pinched nerve (or compressed nerve)**. When a patient has a symptomatic herniated disc, the disc itself is not painful, but rather the material that is leaking out inside of the disc is pinching or irritating a nearby nerve. This produces radicular pain (nerve root pain) that may radiate to other parts of the body.

f. **Disc Degeneration**. As people age, the water content in the discs decreases and the discs become less flexible. The discs begin to shrink and the spaces between the vertebrae get narrower. In some cases, they may collapse completely and cause the facet joints in the vertebrae to rub against one another. This "wear and tear" on the facet joints is referred to as osteoarthritis. When a patient has a symptomatic degenerated disc, it's the disc space itself that is painful and the source of the pain. The type of pain is typically called axial pain.



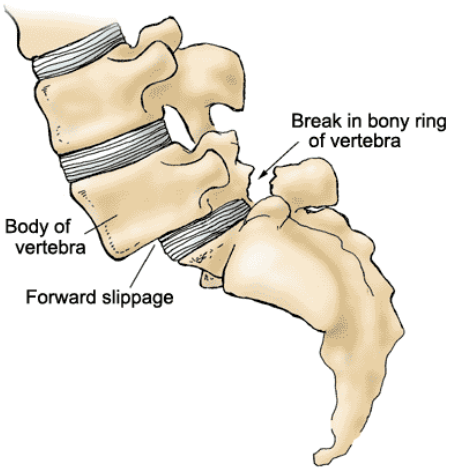
g. **Spondylolisthesis**. This occurs when one of the vertebra slips forward and out of place and may occur anywhere along the spine, but is most common in the lumbar spine.

   i. **Degenerative Spondylolisthesis**. Changes from aging and general "wear and tear" make it hard for the joints and ligaments to keep the spine in the proper alignment. The vertebrae move more than they should, and one vertebra can slip forward on top of another. If too much slippage occurs, the bones may begin to press on the spinal nerves.

   ii. **Spondylolytic Spondylolisthesis**. This occurs when a bone in the back breaks, causing a vertebra to slip forward. The break most often occurs in the area of the lumbar spine called the pars interarticularis (a small segment of bone joining the facet joints in the back of the spine).

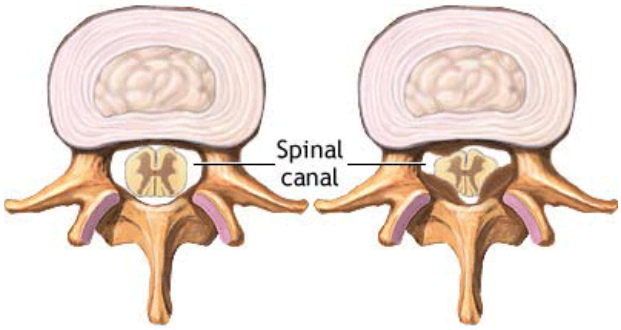
h. **Spinal Stenosis**. This occurs when the space around the spinal cord narrows and puts pressure on the cord and spinal nerves. It can be caused by aging, spondylolisthesis, or trauma. Symptoms associated with spinal stenosis include low back pain, and pain in the legs. One may also experience clumsiness, falling, pain and difficulty walking and numbness and tingling in the legs.

Spondylolisthesis



Side View of Low Backbone

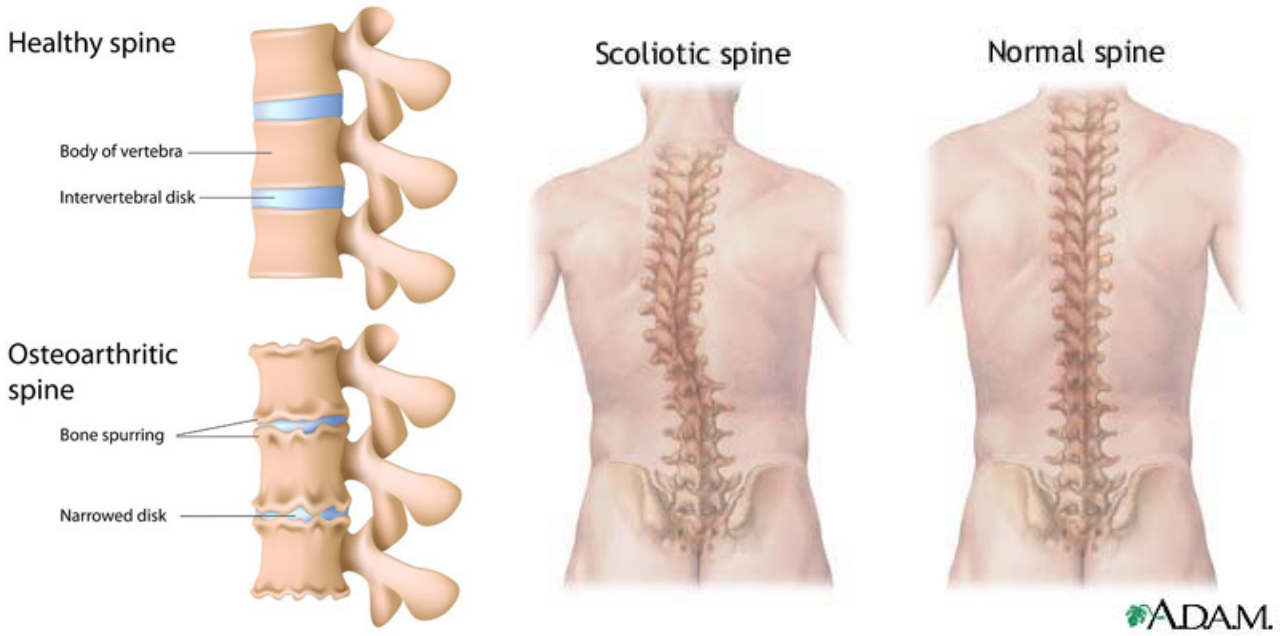
Spinal stenosis is a narrowing of the spinal canal



i. **Radiculopathy**. This condition is caused by a compressed nerve of the spine or irritation, common in the lower back and in the neck. It is caused by a disc herniation, disc bulge, bone spur or from thickening of surrounding ligaments and is diagnosed through complaints of numbness, pain and tingling.

j. **Spurs**. When intervertebral discs collapse and osteoarthritis develops, the body may respond by growing new bone in the facet joints to help support the vertebrae. Overtime, this bone growth, called spurs, can lead to a narrowing of the spinal canal.

k. **Scoliosis**. This is an abnormal curve of the spine that may develop in children, most often during their teenage years. It also may develop in older individuals who have arthritis. This spinal deformity may cause back pain and possibly leg symptoms, if pressure on the nerves is involved.



3. Treatments

a. Nonsurgical treatment options include: rest, modified activity, soft collars, exercise, nonsteroidal anti-inflammatory medications (NSAIDs), epidural steroid injections, transcutaneous electrical nerve stimulation (TENS), chiropractic manipulation, and physical therapy.

b. Surgical treatment options may include:

i. diskectomy (the removal of part of a disc to relive pressure on the nerve);

ii. corpectomy (the removal of the vertebral body as well as the disc spaces);

iii. fusions (surgically "welding" vertebrae together to immobilize them);

iv. laminoplasty (a procedure in which the lamina are hinged laterally opened like a door, and secured in their new position with bone to enlarge the spinal canal);

v. laminectomy (removing a small amount of vertebral bone);

vi. microsurgery (removing some of the soft core of a swollen disc with a hollow needle); and

vii. artificial disc replacement (similar to a hip or knee joint replacement, this surgical procedure substitutes a mechanical device for an disc in the spine).

4. Diagnosing a Soft Tissue Injury

a. Diagnostic test are used to confirm any abnormality or disease as a cause of pain. Some diagnostics are more subjective than others, such as the physical examination which involves a patient's history and response to tests. The more objective diagnostics involve imaging and tests that are not dependent upon the patient's response.

b. Physical examination. A physical exam will reveal a lot about one's health. Obvious signs and symptoms of health include atrophied or asymmetrical muscles, improper alignment, swelling and changes in skin color. The exam may also involve a gait analysis, palpation, muscle testing, flexibility testing, reflex responses and laboratory tests. A physical examination should include a neurological examination to detect weakness or sensory loss. Sensory tools may include a reflex hammer, a safety pin, and a marking pen. The patient's history often will be used for proximate cause.

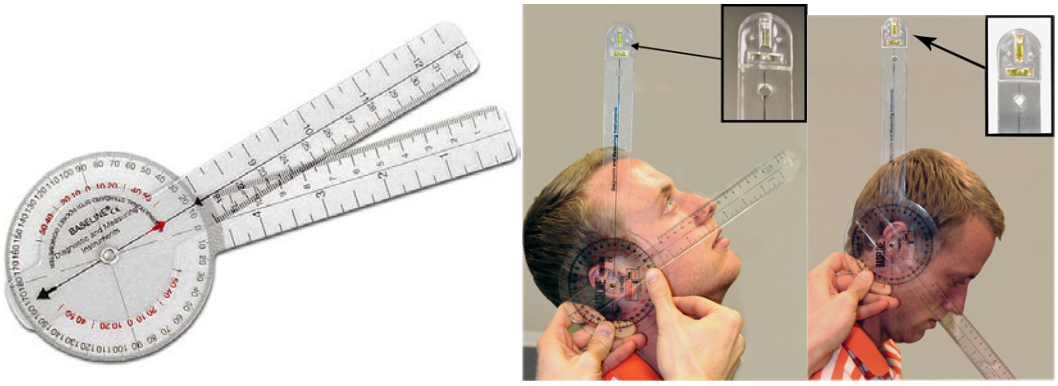
1. **Heel walk test**. A patient should normally be able to walk several steps on the heels.

2. **Toe walk test**. Walking for several steps on the toes with the heels raised will normally produce no discomfort to the patient.

3. **Muscle tests**. Because muscles are soft tissues, they do not appear on X-rays. Weakness in muscle may indicate injury to the tendon that connects the muscle to the bone, injury to the nerves that enervate the muscle, or a generalized weakness of the muscle itself. To test the strength of one's muscle, the doctor may ask the patient to move in certain ways while he or she applies a resistive force. The doctor may also measure grip strength.

4. **Palpation**. During the physical exam, a doctor may feel the joints to see if they are warm or swollen, which are signs of inflammation. He or she may apply pressure to a muscle or joint to identify an area of tenderness.

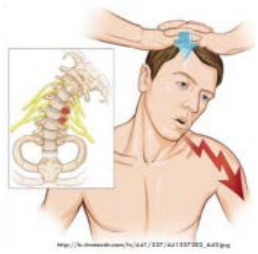
5. **Range of motion tests**. Range of motion tests or flexibility tests are used to measure the range of motion in a joint. They may be used to help determine whether there is a muscle imbalance or arthritis in a joint. Range of motion tests may be active or passive. In active tests, the patient does all the movement. In passive tests, the doctor will hold the extremity and move it. For example, while a patient is seated, the doctor may hold the leg still while moving the heel. A goniometer is a devise often used in physical therapy and by chiropractors to measure and document the range of motion.



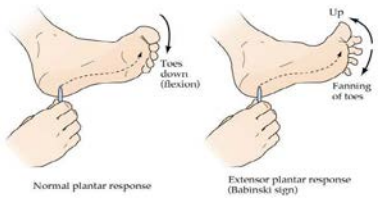
6. **Straight leg raise (SLR) test**. This test is conducted during the physical examination to determine whether a patient with low back pain has an underlying herniated disc, often located at L5.

7. **Spurling Test**. This is a medical maneuver used to assess nerve root

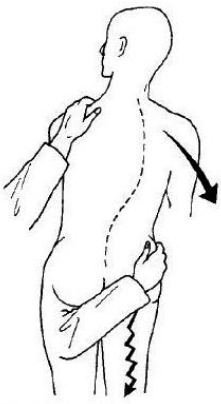
pain (aka radicular pain). This test is performed by the patient bending his neck toward the side of their pain. The test is positive if pain is exacerbated by this position. Additional pressure may be applied by the examiner at the top of the patient's head.



8. **Babinksi's sign**. This test measures the response of the big toe after stimulation of the sole of the foot. A positive or abnormal response results in the extension of the big toe and spreading of the smaller toes, which indicates damage to the central nervous system. A negative or normal response is flexion of the toes or no response.



9. **Kemp's Test**. This test assesses the lumbar spine facet joints and uses the patient's body as a lever to induce tension and as a compression force. The examiner stands behind the patient and reaches around the body to the chest to provide support to the patient. The patient is directed to lean forward, then to one side and then around to eventually bend backward. If this compression causes or aggravates a pattern of radicular pain in the thigh and leg, the sign is positive and suggests nerve root compression. It may also indicate a strain or sprain. This test can be performed both while standing and sitting.



10. **Waddell's signs**. This test measures "nonorganic" or psychological behavioral responses to a physical examination. Historically this test has been used to detect malingering in patients with chronic low back pain. If upon physical examination, the patient indicates the presence of three or more "signs," the pain may be exaggerated or the result of emotional distress rather than, or in addition to, physical injury. The doctor will test for the following:
    a. Superficial and widespread tenderness or non-anatomic tenderness: when skin discomfort on light palpation or tenderness crosses over non-anatomical boundaries.
    b. Stimulation tests: when axial loading (pressing down on the top of the patient's head) or rotating the shoulders and pelvis together, elicits pain
    c. Distracted straight leg raise: when a repeat of the test while distracted does not elicit the same response
    d. Non-anatomic sensory changes: where regional weakness or a regional sensory change occurs over a widespread area that cannot be explained based on anatomy or neurological patterns
    e. Overreaction: when exaggerated responses are elicited or certain responses cannot be reproduced.

c. Imaging

i. **X-rays**. X-rays are the most common and widely available diagnostic imaging technique. X-rays are used for fractures and joint dislocations, and may also be

used if a doctor suspects damage to a bone or joint from other conditions, such as arthritis. The X-ray machine briefly sends electromagnetic waves (radiation) through the body and will show broken bones, aging changes, curves or deformities. X-rays do not show discs, muscles, or nerves.

ii. **Computed Tomography (CT) scan.**[1] A CT scan combines X-rays with computer technology to produce a more detailed, cross-sectional image of the body. CT scans show the bones in finer detail, including bone spurs. A CT scan also shows soft tissues and can be used diagnose herniated and bulging discs. To improve tissue contrast with CT scanning, a contrast dye may be administered.

iii. **Magnetic resonance imaging (MRI)**. An MRI uses magnetic fields and a sophisticated computer to take high resolution pictures of the patient's bones and soft tissues, resulting in a cross-sectional image of the body. It can be used to help diagnose torn muscles, ligaments and cartilage, herniated discs and other conditions. The MRI creates a magnetic field around the patient, then pulses radio waves to the area of the body to be pictured. The radio waves cause the tissues to resonate. A computer records the rate at which the body's various parts (tendons, ligaments and nerves) give off these vibrations, and translates the data into a detailed, two-dimensional picture. An MRI can show if nerve compression is caused by soft tissue, such as a bulging disc and herniations.

d. **Electromyography (EMG)** and **nerve conduction studies (NCS)** help determine whether muscle weakness, sensory loss or both result from injury to the spinal nerve route, peripheral nerve, connections between the nerve and muscle or to the muscle.

i. An EMG records and analyzes the electrical activity in the muscles. During an EMG, small, thin needles are placed in the muscle to record the electrical activity of the muscle when the muscle is at rest and when it is contracting. An EMG measures possible denervation (loss of nerve supply) of the muscle. If positive, the muscle is receiving an inadequate nerve supply.

[1] The terminology CT scan and CAT (Computed Axial Tomography) scan are interchangeable. CT is the preferred, modern terminology.

ii. NCS measures the speed at which motor or sensory nerves conduct impulses and are often done along with an EMG to determine if a nerve is functioning normally. During this test, electrodes are taped to the skin in various places along the nerve pathway. The doctor then stimulates the nerve with an electric current. As the current travels down the nerve pathway, the electrodes placed along the way capture the signal and measure its speed. By measuring the time the impulse takes to reach the muscle and the distance from the stimulating electrode, doctors can calculate the speed of nerve conduction. In healthy nerves, electrical signals can travel at speeds of up to 120 miles per hour. If the nerve is damaged, however, the signal will be slower and weaker. By stimulating the nerve at various places, the doctor can determine the specific site of the injury.

5. SERIOUS INJURY THRESHOLD

a. To maintain a claim for personal injuries arising from a motor vehicle accident, the plaintiff must prove that he sustained either basic economic loss or serious injury and that his injuries were causally related to the accident at issue. Pommells v. Perez, 4 N.Y.3d 566 (2005); N.Y. Insurance Law § 5104(a).

b. Section 5102(d) of the Insurance Law defines the term "serious injury" as a personal injury which results in:

1. death;

2. dismemberment;

3. significant disfigurement;

4. fracture;

5. loss of a fetus;

6. permanent loss of use of a body organ, member, function or system;

7. permanent consequential limitation of use of a body organ or member;

8. significant limitation of use of a body function or system; or

9. 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.

ii. The serious injury threshold was put in place to "weed out frivolous claims and limit recovery to significant injuries." Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345, 350 (2002).

1. Whether a plaintiff has sustained a serious injury is initially a question of law for the court. Licari v. Elliott, 57 N.Y.2d 230 (1982).

2. The defendant bears the initial burden of presenting competent evidence that there is no cause of action. Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345 (2002); Wadford v. Gruz, 35 A.D.3d 258 (1st Dept. 2006).

    a. The defendant can establish plaintiff's injuries are not serious within the meaning of Insurance Law §5102(d) by submitting affidavits or affirmations of medical experts who examined the plaintiff and conclude that no objective medical findings support the plaintiff's claim. Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345 (2002); Grossman v. Wright, 268 A.D.2d 79 (1st Dept. 2000).

3. Thereafter, the burden shifts to the plaintiff to come forward with

sufficient evidentiary proof in admissible form to demonstrate the existence of an issue of fact as to whether he or she suffered a serious injury. Gaddy v. Eyler, 79 N.Y.2d 955 (1992); Grossman v. Wright, 268 A.D.2d 79 (1st Dept. 2000).

a. The plaintiff's burden requires objective proof of plaintiff's injury in order to satisfy the statutory serious injury threshold; subjective complaints alone are not sufficient. Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345, 350 (2002).

c. Permanent Loss of Use of a Body Organ, Member, Function or System

i. "Only a total loss of use is compensable under the permanent loss of use exception to the no-fault remedy." Oberly v. Bangs Ambulance, Inc., 96 N.Y.2d 295 (2001).

ii. The removal of discs nor the loss of use of vertebrae after a fusion constitute a permanent loss. Schou v. Whiteley, 9 A.D.3d 706 (3d Dept. 2004); see also Slisz v. Miga, 14 A.D.3d 953 (4th Dept. 2005) (holding plaintiff failed to meet burden under permanent loss of use where plaintiff failed to submit any evidence that he sustained a "total loss" of use of his lumbar spine); Raugalas v. Chase Manhattan Corp., 305 A.D.2d 654 (2d Dept. 2003) (finding no serious injury where plaintiff did not suffer total loss of use of her cervical or lumbar spine).

d. Permanent Consequential Limitation or Significant Limitation of Use

i. The plaintiff must demonstrate more than a "mild, minor or slight limitation of use." Licari v. Elliott, 57 N.Y.2d 230 (1982).

ii. The plaintiff must submit objective proof of the extent or degree of an alleged physical limitation resulting from disc injuries in order to raise a triable issue of fact. Plaintiff's subjective complaints of pain are insufficient to establish a serious injury. Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345, 350 (2002).

a. In order to prove the extent or degree of physical limitation, an expert's designation of a numeric percentage of plaintiff's loss of range of motion can be used to substantiate a claim of serious injury.

b. An expert's qualitative assessment of a plaintiff's condition also may suffice, provided that the evaluation has an objective basis and compares the plaintiff's limitations to the normal function,

purpose and use of the affected body organ, member, function or system.

i. In Vasquez v. Reluzco, 28 A.D.3d 365 (1st Dept. 2006), the plaintiffs failed to meet their burden to demonstrate they had sustained serious injuries, despite expert submissions that set forth numerical ranges of motions of plaintiffs' cervical and lumbosacral spines, where their experts did not specify what objective tests, if any, their doctor performed to get such measurements, or what the normal range of motion should be. The court also noted plaintiff had unexplained gaps in their medical treatments.

ii. In Perl v. Meher, 18 N.Y.3d 208 (2011), the Court of Appeals rejected a rule that would make contemporaneous quantitative measurements a prerequisite to recovery.

iii. "It is well settled that the mere existence of bulging or herniated discs are not, in and of themselves, evidence of serious injury without competent objective evidence of the limitations and duration of the disc injury." Rubencamp v. Arrow Exterminating Co., Inc., 79 A.D.3d 509 (1st Dept. 2010); Pommells v. Perez, 4 N.Y.3d 566 (2005); Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345, 350 (2002); Levinson v. Mollah, 105 A.D.3d 644 (1st Dept. 2013); Francis v. Christopher, 302 A.D.2d 425 (2nd Dept. 2003); Miki v. Shufelt, 285 A.D.2d 949 (3d Dept. 2001).

e. 90/180 Day Limitation

i. The plaintiff must present objective evidence of a medically determined injury or impairment of a non-permanent nature. Licari v. Elliott, 57 N.Y.2d 230 (1982); Toure v. Avis Rent A Car Sys., 98 N.Y.2d 345 (2002).

a. The curtailment of plaintiff's usual and customary activities must rise to the level of "a great extent rather than some slight curtailment" based upon objective medical findings. Licari v. Elliott, 57 N.Y.2d 230 (1982)

b. Courts have been unwilling to find a serious injury under this category where the plaintiff's treating physician places no restrictions on them or their activities. See, e.g., Gomez v. Salmeron, 46 Misc.3d 1219(A) (Sup. Ct. Nassau Co. 2015); Gonzalez v. Green, 24 A.D.3d 939 (3d Dept. 2005).

c. In Canaday v. Knapp, 44 Misc.3d 1228(a) (Sup. Ct. Broome Co. 2014), the trial court found the chiropractor's objective observation of spasm, seen and felt by the chiropractor on examination, was adequate to raise a question of fact on whether plaintiff's missed days were medically indicated and not based on plaintiff's subjective complaints of pain. The chiropractor's records set forth her objective findings of plaintiff's injuries based upon palpation over several visits.

ii. Medical examinations and/or records post-dating the actual 180-day period are irrelevant. Rouch v. Betts, 71 A.D.3d 977 (2d Dept. 2010); Strilcic v. Paroly, 75 A.D.3d 542 (2d Dept. 2010).

6. **Preexisting, Degenerative changes**

a. In order to raise this issue, the defendant must provide more than a conclusory statement by a medical professional that a preexisting condition or degenerative changes are present. Pommmells v. Perez, 4 N.Y.3d 566 (2005).

b. Once the defendant presents objective evidence of a preexisting injury or degenerative changes, the plaintiff is required to provide "evidence addressing defendant's claimed lack of causation." Pommmells v. Perez, 4 N.Y.3d 566 (2005); Ostroll v. Nargizian, 97 A.D.3d 1076, 1077 (3d Dept. 2012).

c. The defendant is entitled to summary judgment where the plaintiff fails to submit admissible evidence on the issue of causation. Agard v. Bryant, 24 A.D.3d 182 (1st Dept. 2005); Alvarez v. NYLL Mgt. Ltd., 120 A.D.3d 1043 (1st Dept. 2014); Kendig v. Kendig, 115 A.D.3d 438 (1st Dept. 2014) (holding plaintiff's reports failed to address defendant's prima facie showing that her cervical and lumbar spine conditions were degenerative, preexisting and arthritic).

    i. In Macdelinne v. Jimenez, 126 A.D.3d 549 (1st Dept. 2015), the defendant established that plaintiff suffered no permanent, consequential or significant limitation of use of her spine and shoulders. The defendant relied on her radiologist's opinion that the MRIs performed on plaintiff's cervical spine, lumbar spine, and shoulders showed changes, including disc desiccation, osteophytes, and tendinosis, that were degenerative in nature, with no evidence of traumatic injury. The defendant also submitted an orthopedist's report who found full range of motion in the cervical spine and voluntary or exaggerated limitations in the lumbar spine and shoulders that did not correlate with objective evidence of injury. The court held that plaintiff failed to raise a triable issue of fact as to causation, since she did not submit evidence addressing the cause of her injuries and her own medical evidence acknowledged degenerative changes in the cervical spine.

d. The plaintiff's proof must include objective evidence to distinguish aggravation of the preexisting condition from the preexisting condition itself. Lindow v. Smith, 998 N.Y.S.2d 306 (Sup. Co. Broome Co. 2014) (citing Dabiere v. Yager, 297 A.D.2d 831 (3d Dept. 2002)).

    i. In Sanchez v. Draper, 123 A.D.3d 492 (1st Dept. 2014), the defendant argued that the plaintiff's injuries were not significant or permanent and relied on the affirmed reports of an orthopedist and neurologist who found full range of motion and no signs of nerve damage in support of their motion for summary judgment. The defendant also submitted a radiologist's affirmed report opining that the MRI of the 55-year-old plaintiff's cervical spine showed degenerative changes that preexisted the accident and opined there was no herniation. In response, the plaintiff raised an issue of fact by submitting the affirmed narrative report of his treating neurologist, who set forth the plaintiff's history of progressively worsening symptoms, including limitations in range of motion

expressed as a percentage of normal and described his qualitative impairments. The assessment was supported by objective medical evidence, including affirmed MRI reports finding herniated discs in the cervical spine and bulging discs in the lumbar spine, observations of muscle spasm and an abnormal EMG and nerve conduction test.

ii. In Lindow v. Smith, 998 N.Y.S.2d 306 (Sup. Co. Broome Co. 2014), the plaintiff was previously diagnosed with a 20% loss of normal use of her cervical and lumbar spines resulting from a 1991 car accident The defendant moved for summary judgment on the serious injury threshold, relying on his expert that opined "to a reasonable degree of medical certainty," as a result of the subject car accident, plaintiff sustained only minor or mild soft tissue injuries to her neck and shoulders that temporarily aggravated a preexisting condition leaving no permanency. The burden then shifted to plaintiff to establish by objective medical proof that the subject accident aggravated her preexisting injury. The plaintiff did not meet her burden where her expert's report failed to set forth any diagnostic tests that supported an aggravation of her pre-existing injuries above and beyond the previously diagnosed 20% loss of normal use.

7. Chiropractor

a. Chiropractor's opinions are entitled to the same weight as other experts. Mulligan v. City of New York, 120 A.D.3d 1155 (1st Dept. 2014). A chiropractor's report must be submitted as an affidavit. See CPRL §2106.

i. In Levinson v. Mollah, 105 A.D.3d 644 (1st Dept. 2013), the court held that the plaintiff failed to raise an issue of fact of a serious injury where the only sworn evidence proffered was an affidavit from his chiropractor who, following an examination conducted shortly after the one performed by defendant's neurologist, acknowledged that both body parts at issue exhibited a full range of motion in every plane, and offered no qualitative assessment of any limitations.

ii. In Ostroll v. Nargizian, 97 A.D.3d 1076 (3d Dept. 2012), summary judgment dismissal was warranted where plaintiff's chiropractor failed to allege that he ever performed any objective medical tests of plaintiff's range of motion or any other diagnostic tests. The chiropractor's affidavit was also devoid of evidence distinguishing the plaintiff's current limitations from those that predated the subject accident.

iii. In Heller v. Jansma, 103 A.D.3d 1160 (4th Dept. 2013), the court held that the chiropractor's affidavit was insufficient to raise a triable issue of fact where the

most recent examination of plaintiff predated the affidavit by more than three years.

iv. In Pantojas v. Lajara Auto Corp., 117 A.D.3d 577 (1st Dept. 2014) the court held that plaintiff raised a triable issue of fact where the chiropractor's affidavit set forth his findings of range of motion limitations, spasms, and positive Kemp's and straight leg raising tests. The plaintiff also submitted his orthopedist's observation of range of motion limitations.

v. In Diaz v. Cruz, 125 A.D.3d 552 (1st Dept. 2015), the plaintiff raised an issue of fact by submitting the affirmed report of the radiologist who interpreted plaintiff's MRIs of the cervical and lumbar spines, and found herniated discs at several levels. The plaintiff also submitted an affidavit from his treating chiropractor. The chiropractor's affidavit found deficits in ranges of motion in the cervical and lumbar spines, shortly after the accident and at the examination, and causally connected the deficits to the accident. The chiropractor also opined they were unrelated to plaintiff's age or any prior trauma.

vi. In Mulligan v. City of New York, 120 A.D.3d 1155 (1st Dept. 2014), the plaintiff raised a triable issue of fact where the chiropractor's affidavit set forth the range of motion limitations measured shortly after the accident and averred that the limitations continued throughout the course of the treatment, and again two and a half years later. Plaintiff also submitted MRI reports of the cervical spine revealing bulging discs.

8. Case Law Update

a. Summary Judgment Dismissal Warranted

i. In Gomez v. Salmeron, 46 Misc.3d 1219(A) (Sup. Ct. Nassau Co. 2015) the plaintiff failed to meet her burden where her treating physician's report failed to provide specifics regarding her bulging disc, and instead simply provided a "terse statement" that "the patient has permanent partial disability in regards to neck, lower back, left knee, and shoulder."

ii. In O'Gorman v. Prus, ---N.Y.S.3d--- (2015), No. 56640/11 2015 WL 1442643 (March 31, 2015), the plaintiff failed to meet her burden where her medical records and reports were not certified and were unsworn. The court noted that although it appeared some range of motion testing was conducted, it was not clear how the testing was done, nor was there adequate comparison of plaintiff's range of motion with normal values.

iii. In Thompson v. New York City Transit Auth., 5 N.Y.S.3d 330 (Sup. Ct. New York Co., 2014), the defendant met its burden where the orthopedic surgeon's affirmed reports indicated normal ranges of motion in plaintiff's cervical spine and lumbar spine. The plaintiff's reliance on his radiologist's finding of a herniated disc, in itself, was insufficient to establish a serious injury, and additional objective medical evidence of significant physical limitations resulting from the herniation was required.

b. Triable Issue of Fact

i. In Yoo Ha Park v. Zhong Rong Zhu, 988 N.Y.S.2d 526 (Sup. Ct. Queens Co. 2014), the plaintiff raised an issue of fact by submitting the affirmed medical reports of his examining physicians, attesting to the fact that plaintiff had significant limitations in range of motion of the cervical and lumbar spine both contemporaneous to the accident and in a recent examination, and concluding that plaintiff's limitations were significant and permanent and resulted from trauma causally related to the accident.

ii. In Herrera v. Dulisee, 988 N.Y.S.2d 523 (1st Dept. 2014), the defendant failed to establish entitlement to judgment as a matter of law, where included in defendant's motion papers were plaintiff's medical records showing a bulging disc and a 20% loss of use of his cervical spine shortly after the accident, and continuing range of motion defects three years later. The court noted that even assuming defendant met his initial burden, the plaintiff's submissions were sufficient to defeat the motion, where the affirmed report of plaintiff's examining neurologist showed recent quantified range of motion limitations, positive tests, and permanency. The court also noted that the reports indicating plaintiff felt "much better" and experienced "no pain" were not fatal to her claim, stating

"injuries can become significantly more or less severe as time passes."

iii. In Fludd v. Pena, 122 A.d.3d 436 (1st Dept. 2014), the plaintiff raised a triable issue of fact as to whether she sustained serious injury to the lumbar spine, where her treating orthopedist confirmed that plaintiff exhibited limitations in range of motion in her lumbar spine when she was examined shortly after her accident and again when she was examined after defendant moved for summary judgment. Plaintiff's expert also affirmed that he reviewed the MRI taken of plaintiff's lumbar spine less than two months post-accident and it showed bulging discs, and he opined that the injuries were causally related to the accident.

iv. In Boateng v. Yiyan, 119 A.D.3d 424 (1st Dept. 2014), the plaintiff raised a triable issue of fact even though she relied in part on unsworn contemporaneous MRI reports and medical evaluations. The court noted the MRI reports and evaluations were also reviewed by defendant's experts in preparing their reports.