

Kouame v Muhammad
2015 NY Slip Op 31662(U)
January 2, 2015
Supreme Court, Bronx County
Docket Number: 305960/11
Judge: Mark Friedlander
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**NEW YORK SUPREME COURT-COUNTY OF BRONX
PART IA-25**

KOUTOUA KOUAME,

Plaintiff,

-against-

ASIF MUHAMMAD and RAJ SHARMA,

Defendants.

**MEMORANDUM
DECISION/ORDER**
Index No.: 305960/11

HON. MARK FRIEDLANDER

Defendants, Asif Muhammad. ("Muhammad") and Raj Sharma ("Sharma"), move for an order, pursuant to CPLR§3212 and Insurance Law §§5102(d) and 5104(d), granting defendants summary judgment dismissing plaintiff's complaint on the ground that the injuries claimed do not satisfy the "serious injury" requirements of the Insurance Law.

This action arises out of a motor vehicle accident that occurred on December 17, 2010, between a motor vehicle owned by defendant Sharma and operated by defendant Muhammad, and a motor vehicle operated by plaintiff.

Plaintiff claims in his bill of particulars, dated January 6, 2012(Exhibit C), that, as a result of this accident, he sustained the following:

- Right shoulder full-thickness rotator cuff tear requiring arthroscopic surgery on November 18, 2011;
- Right shoulder full-thickness rotator cuff tear involving the supraspinatus with partial tear of the long head of the biceps tendon requiring arthroscopic surgery on November 18, 2011;
- Central and left paracentral disc herniation at L5-S1 level;
- Disc bulge at L4/L5 level impinging upon the thecal sac with encroachment into the bilateral neural foraminal stenosis with right paracentral disc herniation;
- Disc bulge at L3/L4 level impinging upon the thecal sac with encroachment into the neural

foraminal bilaterally;
Anterolisthesis of L3 on L4 and L4 on L5;
Sprain/strain of the cervical spine;
Straightening of the cervical lordosis;
Internal derangement, left knee;
Joint effusion of the left knee; and
Joint effusion of the right knee.

The burden rests on defendants to establish by evidentiary proof, in admissible form, that plaintiff has not suffered a serious injury (*Lowe v. Bennet*, 122 AD2d 728 [1st Dept. 1986], aff'd 69 NY2d 701 [701]). When defendants' evidence is sufficient to make out a *prima facie* case that a serious injury has not been sustained, the burden shifts, and it is then incumbent upon plaintiff to produce sufficient evidence in admissible form to raise a triable issue of fact as to whether plaintiff sustained a serious injury (see *Licari v. Elliot*, 57 NY2d 230 [1982]).

Defendants submit the affirmed reports of: Jacquelin Emmanuel, M.D., an orthopedist, who examined plaintiff at defendants' request on January 28, 2013 (Exhibit H); Jean-Robert Desrouleaux, M.D., a neurologist, who examined plaintiff at defendants' request on January 28, 2013 (Exhibit I); plaintiff's Emergency Room Record from Jacobi Medical Center (Exhibit K); as well as a photocopy of the transcript of the deposition testimony of plaintiff, taken on December 5, , 2013 (Exhibit J).

Dr. Emmanuel conducted range of motion testing of plaintiff's cervical spine and lumbar spines, right shoulder, left and right knees. With respect to the right shoulder, he reported normal range of motion. There were healed entry portals. There was no deltoid atrophy. There was no tenderness on palpation of the acroiclavicular joint or over the greater tuberosity. Various enumerated test were negative. There was no winging of the scapula. There was no sensory loss to light touch or pinprick. With respect to plaintiff's knees, he reported normal and complete range of motion. There was no

redness, swelling or increased temperature. There was no tenderness above the joint line or bony structures, medial or lateral joint lines. McMurray Test was negative. There was no ligamentous instability. There was no evidence of atrophy. Muscle tone and bulk were normal.

With respect to the cervical spine, Dr. Emmanuel reported normal range of motion. Examination of the neck revealed no tenderness to palpation of the cervical paraspinal musculature. No muscle spasm was noted. Cervical compression was negative. The neurological examination revealed no motor or sensory deficits in the upper extremities. Deep tendon reflexes in the biceps and triceps were present and equal bilaterally. Muscle strength in each range was 5/5. There was firm grasping power in both hands.. There was no radiation of pain or parasthesia. Dr. Israel concluded that plaintiff's alleged injuries to his right shoulder, left hip and left knee had all resolved. He further opined that alleged fusion of the cervical spine had healed.

With respect to the lumbosacral spine, Dr. Emmanuel reported normal range of motion. Plaintiff had a normal gait and toe/heel walk. The lordotic curve was normal. There was no spasm or tenderness noted over the paraspinal musculature on palpation. Sitting lasegue testing was negative to 80 degrees. Straight leg raising was negative to 75 degrees in both the seated and supine positions. The neurological examination revealed patellar and Achilles deep tendon reflexes to be normal at 2+. There was no sensory deficit. Muscle strength of the lower extremities at graded at normal (5/5). There was no atrophy noted in the muscles of the lower extremities. There was no radiation of pain, numbness or tingling. Dr. Emmanuel concluded that plaintiff had sprain/strain of the cervical and lumbar spines and sprain/contusion of bilateral knees, all of which had resolved. Dr. Emmanuel further found that "resolved right shoulder arthroscopic surgery."

Dr. Desrouleaux's examination of the plaintiff revealed that the HEENT, cranial nerves, cortical functions, muscle strength, reflexes and sensation tests were all normal. His gait was normal and he was able to perform heel, toe, and tandem walking normally. There was no tenderness of the cervical and lumbar spines. No associated spasm was noted. Straight t leg raising was possible up to 90 degrees (normal) bilaterally in the sitting position. There was no complaints of pain or muscle spasms. Range of motion for the cervical and lumbar spines was normal. Dr. Desrouleaux concluded that plaintiff's cervical and lumbar sprain/strain had resolved and that there is currently no neurologic disability due to the accident in question.

Based upon the above, defendants have made out a *prima facie* case that plaintiff's injuries did not meet the threshold requirements for serious injury as regards the categories of loss of use, permanent consequential limitation or significant limitation.

As to plaintiff's 90/180 claim as well, defendants have made a *prima facie* case. Pursuant to plaintiff's deposition testimony, he returned to work three to four weeks subsequent to the accident (Exhibit J, pg. 64). This fails to raise a triable issue of fact. *Borja v. Delarose*, 90 A.D.3d 407 (1st Dept. 2011); *Perez v. Coor*, 84 A.D.3d 646 (1st Dept. 2011). Plaintiff's contention that his deposition transcripts is inadmissible, as it was not signed, is without merit, as the accuracy of the transcript was not challenged and it is certified by the stenographic reporter. *Martin v. City of New York*, 82 A.D.3d 653 (1st Dept. 2011).

Since defendant has made out a *prima facie* case that a serious injury has not been sustained, the burden shifts, and it is incumbent upon plaintiff to produce sufficient evidence in admissible form to raise a triable issue of fact as to whether plaintiff sustained a serious injury.

In opposition to the motion, plaintiff submits the affirmations and reports of Susan Azar, M.D. and Sanjay Gupta, M.D., radiologists, of Radiological Diagnostic Medical Associates, P.C. (Bainbridge ave MRI), of the MRIs taken of plaintiff's lumbar spine and right shoulder on December 29, 2010 and January 3, 2011 (Exhibit B); the affirmations and reports of Emmanuel Hostin, M.D., an orthopedist (Exhibit C), Gautam Khakhar, M.D., (Exhibit D), and Vijay Sidhwani, M.D., physiatrists (Exhibit E); and plaintiff's affidavit.

Dr. Azar's review of plaintiff's MRI films of the lumbar spine, revealed bulging and/or herniated discs. Dr. Gupta's review of plaintiff's MRI films of the right shoulder revealed, *inter alia*, a full thickness tear of the supraspinatus tendon of the right shoulder. Dr. Sidhwani conducted range of motion testing of plaintiff's cervical spine, lumbar spine, right shoulder and right and left knees, from December 20, 2010 through August 10, 2011, and quantified significant restrictions to thereto, which he causally related to plaintiff's accident of December 17, 2010. In addition thereto, Dr. Khakhar conducted range of motion of plaintiff's cervical spine, lumbar spine, right shoulder and right and left knees, on September 16, 2013, and quantified significant restrictions to thereto, which he causally related to plaintiff's accident of December 17, 2010. These reports raise an issue of fact as to whether plaintiff sustained a permanent consequential limitation of use of a body organ or member or a significant limitation of use of a body function or system, with respect to the cervical and lumbar spines, right shoulder and left and right knees. The gap in plaintiff's treatment is satisfactorily explained by the termination of non-fault benefits, as stated in plaintiff's affidavit and Dr. Sidhwani's affirmation.

Defendants' motion is granted with respect to plaintiff's 90/180 claim as plaintiff has failed to raise a triable issue of fact. *Borja v. Delarose, supra; Perez v. Coor, supra*. The remainder of

defendants' motion is denied in its entirety.

The foregoing constitutes the Decision and Order of the Court.

Dated: 1/2/15



MARK FRIEDLANDER, J.S.C.