$125,000 Settlement for Motor Vehicle Accident

In March 2016, Plaintiff was fully stopped in traffic waiting to merge onto New Road from Route 280 West in Parsippany, New Jersey when Defendant 1 negligently failed to maintain a reasonable safe following distance, failed to make proper observations and/or otherwise failed to take evasive action when she struck Plaintiff's vehicle in the rear suddenly and without warning. Subsequent to the initial impact, a vehicle owned by Defendant 2, negligently struck the rear of Defendant 1's vehicle, propelling it forward, resulting in a second impact to the rear of Plaintiff's vehicle.

Following the accident, Plaintiff presented via ambulance to the hospital and underwent a series of diagnostic testing, including a CT-scan of her cervical spine and an x-ray test of her lumbar spine. These radiographs proved unremarkable for fractures and/or subluxations. She was diagnosed with a cervical and lumbar sprain. Thereafter, she was prescribed pain medication and discharged with instructions to follow up with a doctor.

She subsequently presented to a chiropractor and complained of severe pain, stiffness and tightness in her neck. She also complained of low back pain radiating to her left leg. Given her complaints, she immediately commenced a course of conservative treatment consisting of chiropractic care and physical therapy. Plaintiff underwent MRI testing to her cervical and lumbar spine. The MRI report of cervical spine revealed a posterior disc herniation at C3-4 abutting the ventral cord margin. As to her lumbar spine, the MRI report demonstrated a broad posterior subligamentous disc herniation at L4-5 with thecal sac impression and peripheral disc encroachment into the foramen, with associated central spinal stenosis. During the course of her treatment, she underwent an EMG/NCV study which revealed evidence of right-sided L5 radiculopathy. When her pain failed to respond to the course of conservative treatment, she consulted a pain management doctor and in November 2016, underwent a lumbar epidural steroid injection at L4-5.

The injection only temporarily relieved her pain. She continued to experience severe and constant pain and ultimately consulted a neurosurgeon in September 2017 to discuss additional treatment options.

In April 2018, she underwent medial branch nerve blocks at L3-L4, L4-L5, and L5-S1, without success. Plaintiff returned to her surgeon complaining of constant, severe lower back pain radiating throughout her left lower extremity with numbness and tingling in her feet bilaterally. He recommended that she undergo a lumbar discography with post discogram CT to identify her pain generator which she did. She followed up with the neurosurgeon in May 2018 and he recommended and she elected to proceed with L4-5 discectomy in hopes of relieving her pain and preventing further neurologic injury. In June 2018, Plaintiff underwent left L4 hemilaminectomy, facetectomy and foraminotomy with decompression of nerve roots; open L4-5 discectomy; harvesting and placement of fat graft; use of microscope for microdissection; fluoroscopic guidance for localization; and placement of left On-Q local anesthetic catheter. She followed up postoperatively and no additional treatment was recommended.

Defendant 1 was insured by MetLife Insurance Company with a $100,000.00 policy limit. Defendant 2 was insured by AllState Insurance Company with a $25,000.00 policy limit.

The case settled for a total amount of $125,000.00 prior to the scheduling of a trial.

No lost wage claim asserted. No defenses with respect to liability or damages. Plaintiff was governed by a verbal threshold.