$125,000 Settlement for Motor Vehicle Accident

In August 2016 Plaintiff was the front seat passenger of a motor vehicle when Defendant negligently failed to maintain a reasonable safe following distance, failed to make proper observations and/or otherwise failed to take evasive action when he struck the rear of the vehicle in which Plaintiff was a passenger. The force of impact was so great that Plaintiff's vehicle was subsequently pushed forward and struck the rear of the vehicle in front of them, resulting in a second impact.

Initially, Plaintiff did not present to the hospital as he was under the mistaken impression that he was merely suffering from some minor soreness. It soon became evident, however, that his pain was increasing both in terms of severity and frequency with each passing hour. As such, a few hours following this accident, Plaintiff presented to a chiropractor where he was examined and commenced a course of conservative treatment consisting of chiropractic care and physical modalities. During the course of his treatment, he was referred for a series of diagnostic testing in order to better ascertain the nature and extent of his injuries.

Plaintiff underwent x-ray testing of his cervical and lumbar spine. The results of these radiographs were unremarkable for fractures. In November, Plaintiff presented to MRI testing of his lumbar and cervical spine. The MRI of his lumbar spine demonstrated a (1) subacute central and right-sided disc herniation at L4-5 with compressive deformity of the dural sac and right neural foraminal stenosis; and (2) subacute right disc herniation at L5-S1 with right lateral recess and neural foraminal stenosis. With respect to the cervical spine, the MRI revealed a (1) central disc herniation at C2-3; (2) central disc herniation at C3-4; and (3) central and left paracentral focal disc herniation at C5-6 with associated encroachment of the anterior aspect of the spinal canal. Plaintiff commenced acupuncture treatment.

During the course of his treatment, he was referred to a pain management specialist and was indicated for injection therapy. He concluded his course of chiropractic treatment, physical therapy and acupuncture therapy in December 2016. Plaintiff did not undergo additional treatment for his cervical spine.

When the course of conservative treatment failed to alleviate his pain, he proceeded with a lumbar epidural steroid injection at L4-5 in February 2017. Unfortunately, the injection only temporarily relieved his low back pain and his symptoms returned shortly thereafter. It was thereafter recommended that he undergo electrodiagnostic testing to his lower extremities. In March 2017, Plaintiff underwent the recommended EMG/NCV test which revealed evidence of left L5 radiculopathy.

Since the injection failed to alleviate his pain, in April 2017 he consulted a neurosurgeon. Based on that examination and after reviewing his films, he was recommended for and ultimately underwent a L5-S1 discectomy as follows: Left L5 hemilaminectomy, facetectomy and foraminotomy with decompression of nerve roots; Left lateral recess decompression and foraminotomy with decompression of nerve root; Open L5-S1 discectomy; Harvesting and placement of fat graft; Use of microscope for microdissection; Fluoroscopic guidance for localization; Placement of left On-Q anesthetic catheter. Plaintiff met with his neurosurgeon for two post-operative visits and was discharged in August 2017.

The case settled for $147,000.00 prior to the scheduling of a trial.

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