$265,000 Settlement for Motor Vehicle Accident

In January 2016 Plaintiff was fully stopped in traffic when Defendant negligently failed to maintain a reasonably 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 without warning. Her vehicle was subsequently pushed forward into the rear of the vehicle directly in front of her, resulting in a second impact.

Following the accident, Plaintiff presented via ambulance to the hospital where she complained of pain to her neck, bilateral shoulders and thighs. A physical examination demonstrated tenderness in her neck and back. She was prescribed pain medication and discharged with instructions to follow-up with a doctor. Five days later, she presented to a chiropractor and immediately commenced a course of conservative treatment consisting of chiropractic care and physical modalities. Pursuant to her treatment she was referred for additional diagnostic testing in order to better ascertain the nature and extent of her injuries. An MRI of her cervical spine revealed the following: (1) central disc herniation at C3-4 which impresses upon the anterior thecal sac and abuts the anterior cervical cord; (2) central/right paracentral disc herniation at C4-5 which effaces the anterior thecal sac and abuts the anterior cervical cord, resulting in central canal stenosis; and (3) central disc herniation at C7-T1 which indents upon the anterior thecal sac. As a result, she presented to an orthopedist and a physical examination demonstrated a diminished range of motion in Plaintiff's neck as well as tenderness across her low back. The doctor recommended she engage in a course of physical therapy. Consistent with the doctor's recommendation, she commenced a plan of treatment which consisted of supervised exercises and modalities until she was discharged after she reached a plateau in progress. She thereafter returned to her orthopedist, at that time, she reported low back pain, which was accompanied by the constant sensation of needles and also reported neck pain. Plaintiff immediately commenced a course of aquatic and physical therapy to address these complaints. During the course of her treatment, she underwent additional diagnostic studies. In November 2016, she underwent an EMG/NCV study which revealed abnormal evidence consistent with right S1 radiculopathy and right C5-6 radiculopathy. In December 2016 she underwent a lumbar MRI which revealed a central disc herniation at L5-S1 with left foraminal narrowing. When her pain persisted, in March 2017, she

consulted a neurosurgeon and was recommended that she undergo a second cervical MRI which revealed a C4-C5 posterior disc herniation asymmetric to the right with mass effect on the ventral aspect of the spinal cord. There was also a posterior C6-C7 disc herniation causing mass effect on the ventral aspect of the spinal cord with central canal narrowing and moderate right and moderate to severe left foraminal narrowing at this level.

Given the severity of her injuries and failure to respond to the conservative course of treatment, cervical discectomy and fusion surgery was recommended. In June 2017, Plaintiff underwent the recommended surgery which consisted of C4-C5 interbody arthrodesis and discectomy with decompression of spinal cord and nerve roots; C5-C6 interbody arthrodesis and discectomy with decompression of spinal cord and nerve roots; C6-C7 interbody arthrodesis and discectomy with decompression of spinal cord and nerve roots; C4-C5, C6-C7 anterior instrumentation; Placement of C4-C5 intervertebral PEEK cage; Placement of C5-C6 intervertebral PEEK cage; Placement of C6-C7 intervertebral PEEK cage; Application of cranial tongs; Harvesting of right structural anterior iliac crest autograft; Harvesting of right morselized anterior iliac crest autograft; Reconstruction of ilium; Harvesting of local bone autograft; Placement of i-FACTOR allograft; Bone marrow harvesting for transplantation; Use of microscope for microdissection and discectomy; Placement of right iliac crest On-Q local anesthetic catheter. Plaintiff met with her operating neurosurgeon for three post-operative visits and was discharged in December 2017.

The case settled as to Defendant for the $100,000.00 policy limit, prior to the scheduling of a trial. Plaintiff also possessed an insurance policy with Defendant, USAA Insurance Company with a limit of liability for underinsured motorist benefits in the amount of one million dollars. The case settled as to Defendant USAA for $165,000.00, prior to the scheduling of a trial.

As such, the case settled for a total of $265,000.00.