$749,000 Settlement for Motor Vehicle Accident

In April 2016 Plaintiffs A.R. and D.S. were traveling in an easterly direction in the right lane on Route 10 in Hanover Township. Plaintiff D.S. was a front seat passenger in the vehicle operated by Plaintiff A.R. At the aforesaid time and place, the Defendant was traveling in an easterly direction in the left lane on Route 10 in Hanover Township when he negligently, carelessly, and recklessly attempted to make a lane change to the right lane. Defendant failed to take evasive actions, failed to maintain the proper following distance and make proper observation causing him to strike Plaintiffs' vehicle in the rear, seriously injuring both Plaintiff A.R. and Plaintiff D.S. As contained in the business record of the police report, the responding Police Officer, attributed this accident to Defendant for unsafe speed and following too closely. Defendant was issued a citation for careless driving. The property damage to the vehicle was $16,784.02.

As to Plaintiff, D.S.:

Following the accident, Plaintiff D.S. was immediately transported via ambulance to the hospital. She complained of pain to her lower back and right arm and underwent x-rays. She was prescribed medication and was released with the instructions to follow-up with a doctor. She consulted a chiropractor and commenced a course of conservative care consisting of chiropractic treatment, physical therapy and acupuncture. During that time, she also consulted an orthopedic for her orthopedic injuries, including the injuries to her right arm and wrist. She was prescribed medication and recommended a wrist brace and was advised to continue with her conservative course of treatment. While undergoing treatment, she was referred for a series of diagnostic testing in order to greater ascertain the nature and extent of her injuries. In June 2016, she underwent an MRI of her lumbar spine which revealed a posterolateral disc herniation at L5-S1 on the left side and associated left L5-S1 neural foraminal stenosis. She also underwent an MRI to her cervical spine which revealed a central herniation of the intervertebral disc extending inferior to the disc space with encroachment of the anterior aspect of the spinal canal at C5-6. In addition to the foregoing, she also underwent EMG/NCV studies of her upper extremities which revealed radiculopathy at left S1, right C5, C6, C7 and left C5-6

radiculopathy.

Plaintiff D.S. later consulted a pain management doctor and due to the nature of her injuries, she was recommended lumbar and cervical epidural steroid injections. During this time, she also consulted a neurosurgeon who also recommended epidural injections. In July 2016 she underwent a cervical epidural steroid injection and a lumbar epidural steroid injection.

When her pain failed to resolve following the injections, she went back to her neurosurgeon on In August 2016 and was recommended lumbar discectomy surgery. In September 2016, she underwent the following surgery; (a) left L5 hemilaminectomy, facetectomy and foraminotomy with decompression of nerve roots; (b) left S1 lateral recess decompression and foraminotomy with decompression of the nerve root; (c) open L5-S1 discectomy and (d) harvesting and placement of fat graft. After one month following her surgery, she noted recurrent pain in her left buttock, left posterior thigh and left calf with paresthesias. She was recommended injections and went forward with two lumbar injections. These injections only alleviated her pain temporarily. Thereafter, she consulted an orthopedic surgeon who recommended she undergo another MRI which demonstrated some degenerative changes at L2-3 disc level and it also showed a recurrent disc herniation to the left at the L5-S1 level. Based on those results, she was recommended for a decompression. In September 2017, she underwent a revision left sided L5-S1 laminectomy foraminotomy discectomy surgery. She followed up postoperatively and was doing well.

With regard to her cervical injuries, since her treatment failed to alleviate her pain, she was recommended for and ultimately underwent C3-4, C4-5, C5-6 and C6-7 left sided laminoforaminotomy.

The case settled as to Plaintiff D.S. for the $250,000.00 policy limit prior to the scheduling of a trial.

As to Plaintiff A.R.:

Following the accident, Plaintiff A.R. was immediately transported via ambulance to the hospital. He complained of pain to his neck and lower back. He underwent x-rays and was prescribed medication

and was released with the instruction to follow-up with a doctor. He then I sought treatment with a physiatrist who performed an examination, prescribed medication and referred him to an orthopedist.

Plaintiff A.R. presented to a chiropractor and commenced a course of conservative care consisting of chiropractic treatment, physical therapy and acupuncture. During the course of his treatment, he underwent diagnostic studies. According to his cervical spine MRI report, he sustained the following injuries: (1) a central disc herniation causing dural compression at C3-4; (2) a central disc herniation at C4-5 abutting the ventral aspect of the cord; and (3) a right paracentral disc herniation cuasing mild right deformity of the cord at C5-6. As to his lumbar spine, the MRI indicated the following: (1) right paracentral superiorly extruded disc herniation causing moderate ventral flattening of the thecal sac at T12-L1; (2) a broad-based central disc herniation at L1-2 causing mild ventral flattening of the thecal sac; (3) a left paracentral disc herniation causing mild left paracentral ventral flattening of the thecal sac at L2-3; (4) central disc herniation with a broadbase causing mild ventral flattening of the thecal sac at L3-4; and (5) right paracentral disc herniation with mild right paracentral ventral flattening of the thecal sac. After review of his diagnostic studies, Plaintiff A.R. was referred to a neurosurgeon which he consulted in July 2016.

During this time and in response to the failure to his injuries to respond to physical modalities, he was referred to a pain management specialist. He related to the doctor that he was experiencing persistent neck pain radiating down to his shoulders and upper right arm. He also advised the doctor that he was suffering from lower back pain. He was recommended a cervical epidural steroid injection, which was performed in July 2016, which provided little to no relief. A second cervical epidural injection was performed in August 2016, which also did not significantly improve his pain. As to his lumbar spine, he underwent lumbar epidural steroid injections in July and September 2016, with minimal improvement for approximately one week, but the symptoms soon returned.

When the injections failed to alleviate his pain, he returned to his neurosurgeon, who recommended that he undergo a two (2) level anterior cervical discectomy and fusion surgery at C4-5 and C5-6. In September 2016, he underwent a two-level anterior cervical discectomy and fusion surgery at C4-5 and C5-6 with arthrodesis and decompression of the spinal cord and nerve roots as well as the harvesting of bone marrow, the right structural anterior iliac crest and the right morselized anterior iliac

crest along with placement of Actifuse and placement of an intervertebral PEEK cage at C4-5 and C5-6.

With regard to Plaintiff A.R.'s lumbar injuries, in addition to chiropractic treatment and multiple lumbar injections, he also underwent a right L3, L4 and L5 medial branch clock in January 2017, a left L3, L4, L5 medial branch blocks in February 2017 and bilateral L3, L4 and L5 medial branch radiofrequency ablations in April 2017. When plaintiff's pain persisted following the injections and procedures, he followed up with his neurosurgeon and was recommended L5-S1 discectomy. In August 2017, he ultimately underwent L5-S1 dicectomy and right sided foraminotomies. He followed up post operatively and was discharged five weeks later with a good result following the surgery.

Plaintiff A.R.'s case settled as to Defendant for the $250,000.00 policy limit. Additionally, Plaintiff A.R., possessed an underinsured policy with Defendant, NJM, in the amount of $500,000.00 and in July 2018 the case settled with Defendant NJM for $499,000.00.

As such, this matter settled for a total amount of $749,000.00 ($250,000.00 for Plaintiff D.S. and $499,000.00 for Plaintiff A.R. prior to the scheduling of a trial.