
CANADA / JUDGMENT

Gignac v. Rozylo

2011 BCSC 237

COURT

Supreme Court of British Columbia

DECIDED

25 February 2011

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2011 BCSC 237 Gignac v. Rozylo

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Gignac v. Rozylo,

2011 BCSC 237

Date: 20110225

Docket: 06-4867

Registry: Victoria

Between:

Robert Abraham Gignac

Plaintiff

And:

Allen Rozylo, Henry Alexander Rozylo and

The Estate of Henry Alexander Rozylo

by its unknown personal representative

Defendants

And:

Insurance Corporation of British Columbia

Third Party

Before: The Honourable Mr. Justice R. D. Wilson

Reasons for Judgment

Counsel for the Plaintiff:

C. D. Starkey and H. Wiltse

Counsel for the Defendant

Henry Alexander Rozylo and

the Third Party:

J. M. Young

Place and Date of Trial/Hearing:

Victoria, B.C.

February 11, 2011

Written Submissions Received:

February 14 and 16, 2011

Place and Date of Judgment:

Victoria, B.C.

February 25, 2011

I.

[1] The plaintiff's action was a claim for personal injury damages. On 29 April 2010, following the trial of the action, among other heads of damage, I assessed \$115,975 for costs of future care, and \$15,755 for special damages.

[2] These reasons address the application by the third party for an order:

For an estimate of the statutory deductions the plaintiff may be entitled to receive under Part 7 of the Regulations to the Insurance (Motor Vehicle) Act and that a deduction be made pursuant to s. 25 of the Insurance (Motor Vehicle) Act from the damages award for special damages and future costs of care.

II.

[3] In support of his claim for special damages, the plaintiff filed a schedule of special damages. Included in that schedule were expenditures said to have been made for medications, physiotherapy and massage therapy.

[4] In support of his claim for costs of future care, the plaintiff led the evidence of an occupational therapist and rehabilitation consultant. A compendium of the goods and services said to attract an award for costs of future care was filed. Present values for each item were calculated by an economist. The assessment is a total of those individual present value calculations.

[5] The applicant submits that from the special damages claim, the following attract consideration for reduction from the special damage award:

Medications \$ 109.51

Physiotherapy \$1,760.50

Massage Therapy \$ 414.25

TOTAL \$2,284.26

[6] The applicant further argues that from the future care costs, the following entries attract consideration for reduction from the assessment:

Wall Bar \$ 119.00

Hot/cold packs \$ 365.00

Medications \$ 1,814.00

Physiotherapy \$ 1,175.00

Orthopedic Therapy[1] \$ 8,162.00

Massage Therapy \$ 5,895.00

Pool Program \$ 8,162.00

Psychological Support \$ 3,337.00

Household accessories \$ 3,790.00

TOTAL \$32,819.00

[7] In recognition of the admonition in Schmitt v. Thomson[2] that, "Trial judges may be cautious in their approach to the s. 24(5) estimate inasmuch as the deduction results in a lessening of the award in the tort action considered proper on the evidence by the trial judge", the applicant submits that an appropriate reduction, to recognize the "uncertainties" involved, would be approximately 20% of the total of \$35,103.26 said to be subject to a s. 25 analysis, and the assessment at trial reduced by \$25,000. And the plaintiff is entitled to enter judgment on this head of damage for \$90,975.

[8] The plaintiff contends that no deduction should be made from the assessment, on a number of grounds, including:

(i) he is not entitled to receive benefits from the corporation for the goods and services asserted by the applicant, by reason of his having a primary insurer; or the goods and services are not rehabilitative;

(ii) his entitlement to the benefits are so uncertain as to render impossible any estimate.

III.

[9] For the purposes of this application, the material words in the statute are:

1 (1) "benefits" means the prescribed benefits.

25 (1) In this section "benefits" means a payment that is or may be made under a plan established under this Act, [3]

25 (2) A person who has a claim for damages and who is entitled to receive benefits is deemed to have released the claim to the extent of the benefits.

25 (4) In an action in respect of bodily injury the amount of benefits to which the claimant is or would have been entitled, must not be referred to

25 (5) After assessing the award of damages the amount of benefits referred to in [subsection 4, above] must be disclosed to the court [and] if the amount of benefits has not been ascertained, the court must estimate it

25 (6) If, it is necessary to estimate the value of future payments that the corporation is authorized or required to make under a plan the value must be estimated according to the value on the date of the estimate of a deferred benefit

[10] For the purposes of this application, the material words in Part 7 of the Regulation are:

78 "rehabilitation" means the restoration, in the shortest practical time, of an injured person to the highest level of gainful employment or self sufficiency that, allowing for the permanent effects of his injuries, is, with medical and vocational assistance, reasonably achievable by him;

88 (1) Where an insured is injured in an accident for which benefits are provided under this Part, the corporation shall, subject to subsections (6), pay as benefits all reasonable expenses incurred by the insured as a result of the injury for necessary medical, surgical, dental, hospital, ambulance or professional nursing services, or for necessary physical therapy, chiropractic treatment, occupational therapy or speech therapy or for prosthesis or orthosis.

88 (2) Where, in the opinion of the corporation's medical advisor, provision of any one or more of the following is likely to promote the rehabilitation of an insured who is injured in an accident for which benefits are provided under this Part, the corporation may provide any one or more of the following:

(f) funds for any other costs the corporation in its sole discretion agrees to pay.

88 (6) The corporation is not liable for any expenses paid or payable to or recoverable by the insured under a medical, surgical, dental or hospital plan or law, or paid or payable by another insurer.

88 (7) The maximum amount payable by the corporation under this section for medical, surgical, dental, nursing or physical therapy services or for chiropractic treatment, occupational therapy or speech therapy listed in the payment schedules established by the Medical Services Commission under the Medicare Protection Act is the amount listed in the payment schedules for that service, treatment or therapy.

88 (8) The corporation is not liable to pay for more than 12 physical therapy treatments for an insured for each accident unless, before any additional treatment is given, the corporation's medical advisor or the insured's medical practitioner certifies to the corporation in writing that, in his opinion, the treatment is necessary for the insured.

IV.

[11] Manifestly, the inquiry on this application is not into what payments the corporation will or may, in the future, make for covered benefits; nor is it restricted to a simple determination of what coverages are available to the insured.

[12] This is a conventional application in a civil proceeding and the conventional burden and standard of proof is applicable.

[13] In my view, the issue for determination on this application is -- has the applicant established, to the civil standard, that the plaintiff is a person entitled to receive benefits, under the plan, which the corporation (Insurance Corporation of British Columbia) is authorized or required to make under the plan? And, if so, then what is the estimated present value of those benefits.

[14] In support of the application, the applicant has filed the affidavit of Ms. Anne Lewko, sworn 20 January 2011. Ms. Lewko is an insurance examiner employed by the corporation. She is the examiner assigned to handle the plaintiff's claim.

[15] In the affidavit, Ms. Lewko provides the following evidence:

7. Pursuant to section 88 of the Regulations pursuant to the Insurance (Motor Vehicle) Act there are both mandatory and permissive benefits. The benefits that are mandatory must be for expenses which are reasonable and necessary.
8. Section 88 sets out various medical expenses which are mandatory for payment.
9. ICBC claims handling procedures include reasonable expenses for necessary medication as part of the mandatory benefits under section 88(1) even though medication is not specifically listed in section 88(1).

10. Permissive benefits pursuant to section 88(2) may be provided in the discretion of the assigned examiner. Section 88(2) sets out various kinds of permissive benefits as well as "other" benefits which may be paid. The "other" benefits are not defined.
13. Psychological services are not a specific listed permissive benefit. It would fall under the "other" category. ICBC policy is that typically psychological services is a permissive benefit under section 88(2).
14. Massage therapy is not a specific listed permissive benefit. It would fall under the "other" category. ICBC policy is that typically massage therapy is a permissive benefit. According to the current ICBC claims handling policies, with a GP referral, ICBC will pay for a maximum of 12 visits within the first eight weeks from the date of loss.
- [16] I have presumed that the words "mandatory" and "permissive", used by Ms. Lewko, are synonymous with the statutory language of "required" and "authorized". I have further presumed that Ms. Lewko's reference to "other" refers to s. 88(2)(f), referred to above.
- [17] In response to the application, the plaintiff has filed an affidavit sworn 9 February 2011. Attached to the affidavit are copies of on-line printouts of a Pacific Blue Cross Extended Health Care Plan. This plan is available to the plaintiff's wife as an employee of the Province of British Columbia. The plaintiff is a named insured on that policy.
- [18] The plaintiff says that Blue Cross is the primary insurer and the corporation is the secondary insurer. Therefore, it is argued, the plaintiff is not entitled to benefits by reason of s. 88(6) of the Regulation.
- [19] In the reply argument, the applicant contends that the material provided by the plaintiff is inadequate for a determination of the plaintiff's entitlement under the Blue Cross plan.
- [20] I am not persuaded that this is so. The material provided by the plaintiff sets out an inventory of the plan benefits. It is certainly far more detailed than is to be found in either of s. 88(1) or (2). I am satisfied that Blue Cross would be the primary insurer for physiotherapy, orthopaedic therapy, massage therapy, psychological support and medications.
- [21] However, as the applicant points out, the Blue Cross plan does not reimburse the plaintiff for 100% of his expense. For example, according to the evidence at trial, the plaintiff was paying \$60 per visit for physiotherapy, and \$37.50 per visit for massage therapy. The Blue Cross plan provides \$10 per visit for physiotherapy and, for massage therapy, \$10 per visit for 8 visits, with a maximum of \$750 per year. The plaintiff would be entitled to benefits under the plan for the excess of his expenditure over the Blue Cross contribution, up to the maximum allowed under the plan.
- [22] I find the plaintiff entitled to those benefits. There is a risk of double recovery for the future costs of medications, physiotherapy and orthopaedic therapy. I assess the present day value of the plaintiff's entitlement for those items at \$2,000. The assessment on costs of future care will be reduced accordingly.

V.

- [23] As I understand Ms. Lewko, if a benefit is not "specifically listed", then, an insured's entitlement to the benefit is dependent upon "ICBC claims handling procedures", or "ICBC claims handling policies", or "ICBC policy".
- [24] Legislative support for this approach is s. 88(2)(f), the "other" category, referred to above.
- [25] The statute does not direct me to determine entitlement to benefits pursuant to ICBC policy; the direction is to determine entitlement pursuant to the plan.
- [26] Section 88(2)(f) is subject to the opinion of the corporation's medical advisor that an expenditure is likely to promote the rehabilitation of an insured.
- [27] The opinion of that medical advisor is a necessary condition before resort may be had to s. 88(2)(f) of the Regulation. Absent the necessary condition, the corporation is not authorized to pay benefits.
- [28] Rehabilitation means restoration. This plaintiff's debilitating condition is chronic pain. Current medical science has no cure for this condition. I find it improbable that a medical advisor would opine that any of the goods and services contained in the assessment of future care costs, would promote the rehabilitation of this plaintiff. Those goods are services were recommended by the occupational therapist as necessary to enable this plaintiff to maintain an optimum level of functioning, now and in the future, and to maximize independence and prevention of further disability.
- [29] Alternatively, if I am wrong in my interpretation of the legislation, and ICBC policy is a relevant factor, then the applicant has not persuaded me that it is more likely than not that this plaintiff is entitled to the benefits in controversy. The scales are evenly balanced. Policy may authorize the benefit or it may not. According to Ms. Lewko:
11. It is ICBC policy that the exercise of discretion for permissive benefits must be rationally connected to the relevant factors governing an objective assessment of the entitlement to the benefit.

That is a level of abstraction which does not allow for a determination of entitlement on a balance of probability.

- [30] In result, the cost of future care assessment is reduced by \$2,000.

"R. D. Wilson, J."

The Honourable Mr. Justice R. D. Wilson

- [1] In an affidavit made 20 January 2011, the occupational therapist, Ms. Mair Edwards, deposed that, "Orthopedic Therapy is a form of physical therapy".
- [2] (1995), 18 B.C.L.R. (3d) 153 (B.C.C.A.) at para. 19.

- [3] The "plan established" is Part 7 of the Insurance (Motor Vehicle) Regulation, B.C. Reg. No. 447/83.
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