In the
Missouri Court of Appeals
Western District

S&B HAULING & CONSTRUCTION AND UTAH BUSINESS INSURANCE COMPANY OF AMERICA,	)	
Appellants,	)	**WD88030**
v.	)	**OPINION FILED: DECEMBER 2, 2025**
CENTER FOR SURGICAL SPECIALTIES, P.C.,	)	
Respondent.	)	

Appeal from The Labor and Industrial Relations Commission

Before Division Two: Edward R. Ardini, Jr., Presiding Judge, Karen King Mitchell, Judge and Cynthia L. Martin, Judge

S&B Hennen Hauling and Construction, LLC ("Employer") and Utah Business Insurance Company of America ("Insurer") (collectively "Appellants") appeal from a final award by the Labor and Industrial Relations Commission ("Commission") that resolved a medical fee dispute filed by The Center for Surgical Specialties, P.C.

("Surgical Specialties").[1] The Appellants argue that, because the General Assembly amended the Workers' Compensation Law[2] in 2005 to require strict construction of its provisions, the Commission erroneously applied section 287.140 to shift the burden to the Appellants to prove that the charges for medical services provided by Surgical Specialties were unreasonable and unfair. The Appellants further assert that there was not sufficient competent evidence in the record to support the award of $8,196.48 to Surgical Specialties. Finding no error, we affirm.

Factual and Procedural History[3]

Employer's employee was injured at work on July 7, 2020, and suffered a complex medial meniscus tear in his right knee. On July 29, 2020, Insurer, on behalf of Employer, authorized Surgical Specialties to perform arthroscopic surgery to repair employee's knee. Dr. M., Surgical Specialties' owner and a board-certified orthopedic surgeon, successfully performed the surgery on August 7, 2020. Surgical Specialties billed the

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[1]The Commission's final award identifies Employer as "S&B Hauling & Construction," but the Appellants' brief identifies Employer as "S&B ***Hennen*** Hauling & Construction, LLC." This discrepancy is not material to the disposition of the Appellants' appeal. Accordingly, we have elected to retain the Commission's identification of the parties for our caption, but we have used the Appellants' identification of Employer in the Opinion itself.

[2]Section 287.010 *et seq.* All statutory references are to RSMo 2016 as supplemented through July 7, 2020, the date of the employee's injury, unless otherwise indicated. *See Farmer-Cummings v. Personnel Pool of Platte Cnty.*, 110 S.W.3d 818, 821 n.7 (Mo. banc 2003) (observing that the version of the Workers' Compensation Law in effect at the time of the injury controls any dispute as to the payment of fees and charges for treatment).

[3]We view the evidence objectively and not in the light most favorable to the Commission's decision. *Bohanna v. United Fruit & Produce Co.*, 716 S.W.3d 275, 277 n.1 (Mo. App. W.D. 2025).

Appellants $19,763 for the medical services that were rendered. The Appellants paid Surgical Specialties $11,566.52, but refused to pay the remaining balance of $8,196.48.

In April 2021, Surgical Specialties filed an application with the Workers' Compensation Division seeking payment of the unpaid balance from the Appellants pursuant to section 287.140. The Appellants filed an answer which argued that the amount already paid to Surgical Specialties represented the usual and customary rate for the medical services provided.

At the hearing before an administrative law judge ("ALJ"), the parties stipulated that Employer's employee had suffered a compensable workplace injury, and that Surgical Specialties, through Dr. M., was authorized to perform surgery to repair employee's knee. Surgical Specialties admitted into evidence without objection certified medical and billing records for employee's medical treatment. The only issue to be determined at the hearing was whether the medical bills submitted by Surgical Specialties were fair and reasonable and entitled to payment according to section 287.140.3.

The ALJ heard testimony from Surgical Specialties' business manager ("business manager"), who testified that 99 percent of Dr. M.'s practice at Surgical Specialties is comprised of workers' compensation referrals. In the instant case, the employee was referred to Surgical Specialties by a nurse case manager working on behalf of the Appellants. The nurse case manager directed and authorized Surgical Specialties to perform arthroscopic surgery to repair the complex tear to the employee's medial meniscus. The business manager testified that the bill issued to the Appellants totaling

$19,763 reflected the charges and fees that Surgical Specialties routinely bills for the particular surgery performed in this case, regardless of who is billed for the procedure.

The ALJ also heard testimony from Dr. Q., a physician and the chief executive officer of WellRithms, a company that contracts with workers' compensation insurers to assume legal and financial exposure in exchange for payment based upon a percentage of liability assumed. Dr. Q. testified that Insurer paid WellRithms 25 percent of $8,196.48--the amount in dispute--in exchange for WellRithms' assumption of the risk of financial responsibility for the outstanding amount. Dr. Q. conducted a review of Surgical Specialties' billing in the instant case and testified that Surgical Specialties did not code its bill in the standard fashion that complied with Medicare scheduled billing. Dr. Q. testified that, based on this review of the bill, Surgical Specialties should have been paid $11,566.52 based on standard billing and reimbursement practices.[4]

The ALJ issued its award ("ALJ" Award") on February 23, 2024. The ALJ Award, relying on *Esquivel v. Day's Inn of Branson*, 959 S.W.2d 486 (Mo. App. S.D. 1998),[5] found that Surgical Specialties had the burden of proof regarding the

[4]Dr. Q. also testified that he completed a second review of Surgical Specialties' bill and found two additional errors: (1) payment had been issued based on procedure codes that were not included in the medical notes; and (2) the bill included codes for procedures performed in an outpatient hospital rather than an ambulatory service center. According to Dr. Q., if Surgical Specialties would have properly billed the Appellants for a surgery conducted in an ambulatory service center, WellRithms would have recommended that the reimbursement amount should be $5,545.25 instead of $11,566.52.

[5]Our Supreme Court overruled *Esquivel*, insofar as *Esquivel* noted that appellate review of the Commission's award requires a court to view the record and all reasonable inferences drawn therefrom in the light most favorable to the award, in *Hampton v. Big Boy Erection*, 121 S.W.3d 220 (Mo. banc 2003).

reasonableness of its medical charges, and that its evidence and testimony sustained this burden. The ALJ Award found that it thereafter became Appellants' burden to establish that Surgical Specialties' charges were unreasonable or unfair, and that the evidence offered through Dr. Q. failed to sustain this burden. The ALJ Award thus found that Surgical Specialties had sustained its burden of proof to establish that its charges were fair and reasonable, and ordered Appellants to pay the sum of $8,196.48. However, in the conclusion portion of the ALJ Award, Appellants were ordered to pay Surgical Specialties the amount of $9,016.13.

The Appellants sought review of the ALJ Award from the Commission. Relevant to this appeal, the Appellants asserted that the ALJ erred in: (1) "finding that the presented medical bills were fair and reasonable" because Surgical Specialties used improper billing practices; (2) misconstruing "receives," as used in section 287.140.3; (3) awarding $9,016.13 when the amount in dispute was $8,196.48; and (4) shifting the burden of proof from Surgical Specialties to the Appellants.

On April 2, 2025, the Commission issued its final award ("Final Award"), which affirmed and adopted the ALJ Award to the extent it was not inconsistent with the Final Award. The Final Award first acknowledged Surgical Specialties' request that the proceedings before the Commission be dismissed because the attorney representing the Appellants was retained by WellRithms, a non-party, so that the Commission had no statutory authority to consider the Appellants' appeal. The Final Award rejected Surgical Specialties' request, noting that the attorney who signed the application for review indicated that he was doing so on behalf of the Appellants. The Final Award then

addressed the Appellants' argument that the burden-shifting analysis employed by the ALJ was not compliant with section 287.140.3, and concluded that the ALJ Award "properly determined that [Surgical Specialties] met its burden of proof and then shifted the burden to [the Appellants] as directed in *Esquivel*." Finally, the Final Award acknowledged that the ALJ Award erroneously ordered the Appellants to pay Surgical Specialties $9,016.13, and modified the order to require the Appellants to pay Surgical Specialties $8,196.48.

The Appellants appeal.[6]

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[6]Surgical Specialties elected not to file a respondent's brief. However, Surgical Specialties did file two motions, both of which have been taken with the case. Surgical Specialties filed a motion to dismiss the appeal for lack of standing, asserting that the appeal is being prosecuted by WellRithms, Inc., a non-party to the underlying medical fee dispute. Surgical Specialties also filed a motion to remand for further proceedings to conduct discovery or, in the alternative, to dismiss the appeal for lack of standing. The second motion also argues that WellRithms is prosecuting the appeal and adds a request to conduct "comprehensive discovery" about the relationship between Employer, Insurer, and WellRithms "to determin[e] the true party in interest, the authority of WellRithms, Inc., and compliance of Insurer with its statutory duties."

These motions rely on the same contention set forth in the motion to dismiss that Surgical Specialties filed before the Commission. The Commission denied that motion, and noted that by signing the application for review, the attorney represented to the Commission that he was a Missouri attorney in good standing and was representing the Appellants.

Here, the attorneys who signed the Appellants' brief have thus represented that they are attorneys for the Employer and the Insurer. "Counsel of record are presumed, without any further showing, to be authorized to file papers on behalf of the party they represent and, more importantly, to bind that party to the arguments and facts contained therein." *Naylor Senior Citizens Hous., LP v. Side Const. Co.*, 423 S.W.3d 238, 248 (Mo. banc 2014). "The appearance in court of an attorney carries with it the presumption of authority to appear and act for his clients." *State ex rel. A.M.T. v. Weinstein*, 411 S.W.2d 267, 272 (Mo. App. 1967). Surgical Specialties' motions do not rebut these presumptions. Both motions are denied.

Standard of Review

Article V, section 18 of the Missouri Constitution provides for judicial review of a final award issued by the Commission to determine whether the decision is "authorized by law" and is "supported by competent and substantial evidence upon the whole record." Section 287.495.1 provides further guidance:

> The court, on appeal, shall review only questions of law and may modify, reverse, remand for rehearing, or set aside the award upon any of the following grounds and no other:
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> (1) That the commission acted without or in excess of its powers;
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> (2) That the award was procured by fraud;
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> (3) That the facts found by the commission do not support the award;
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> (4) That there was not sufficient competent evidence in the record to warrant the making of the award.

"[A]n award is said to be supported by sufficient competent and substantial evidence *unless* it is 'contrary to the *overwhelming* weight of the evidence.'" *Hasselbring v. Macon Cnty. Nursing Home Dist.*, 717 S.W.3d 218, 222 n.3 (Mo. App. W.D. 2025) (quoting *Pace v. City of St. Joseph*, 367 S.W.3d 137, 145 (Mo. App. W.D. 2012)). "When determining whether the Commission's award is supported by sufficient competent evidence, we consider the record as a whole, viewing it objectively and not in the light most favorable to the award." *Fernandez v. Smithfield Foods, Inc.*, 689 S.W.3d 499, 507 (Mo. App. W.D. 2024). However, if the Commission has made credibility determinations, we are bound by such determinations. *Id.* With respect to its interpretation and application of the law, we offer no deference to the Commission and employ *de novo* review. *Id.* "To the extent that the Commission affirmed and adopted

the findings and conclusions of the ALJ, [we] review[] the ALJ's findings and conclusions for error." *Balliu v. Treasurer of State*, 704 S.W.3d 751, 758 (Mo. App. W.D. 2025) (quoting *Steinbach v. Maxion Wheels, Sedalia, LLC*, 667 S.W.3d 188, 195 (Mo. App. W.D. 2023)).

Analysis

The Appellants two points on appeal challenge the Commission's application of section 287.140.3 to order the Appellants to pay Surgical Specialties $8,196.48 in outstanding medical fees. The Appellants' first point on appeal asserts that the Commission misapplied section 287.140.3 by employing a burden-shifting mechanism that required the Appellants to prove that the medical fees were unfair and unreasonable ("Point One"). The Appellants' second point on appeal argues that there was not sufficient competent evidence in the record to establish that the medical fees awarded to Surgical Specialties were fair, reasonable, and no more than the usual and customary fee it receives for the same services when the payor is a private individual ("Point Two"). We discuss the points on appeal in order.

"Medical aid is one component of the compensation an injured worker is entitled to receive" under the Workers' Compensation Law. *Erwin v. Midway Arms, Inc.*, 710 S.W.3d 548, 554 (Mo. App. W.D. 2025) (quoting *Abt v. Miss. Lime Co.*, 420 S.W.3d 689, 704 (Mo. App. E.D. 2014)). Section 287.140.1 requires an employer to provide its injured employee treatment for compensable injuries and describes the employer's obligation as follows:

> In addition to all other compensation paid to the employee under this section, the employee shall receive and the employer shall provide such medical, surgical, chiropractic, and hospital treatment, including nursing, custodial, ambulance and medicines, as may reasonably be required after the injury or disability, to cure and relieve from the effects of the injury.

Section 287.140.3 concerns the determination of compensable fees and charges associated with medical treatment reasonably required to cure or relieve the effects of a compensable injury. It provides:

> All fees and charges under this chapter shall be fair and reasonable, shall be subject to regulation by the division [of workers' compensation of the department of labor and industrial relations] or the commission, or the board of rehabilitation in rehabilitation cases. A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier. The division or the commission, or the board of rehabilitation in rehabilitation cases, shall also have jurisdiction to hear and determine all disputes as to such charges. A health care provider is bound by the determination upon the reasonableness of health care bills.

Section 287.140.3.

By its express terms, section 287.140.3 governs the resolution of all disputes concerning such fees and charges, whether an employee or a health care provider is pursuing reimbursement. *Esquivel*, 959 S.W.2d at 488-89. Since its 1993 amendment, section 287.140.3 has required the claimant to prove that the fees and charges sought are "fair and reasonable," a phrase that is used in conjunction with the statutory prohibition against fees and charges that are "greater than the usual customary fee the provider receives for the same treatment or service when the payor for such treatment or service is

a private individual or a private health insurance carrier."[7] Missouri courts have held that a claimant presents sufficient evidence to satisfy this burden of proof by "present[ing] testimony and evidence relating medical bills to an injury and plac[ing] in evidence the accompanying medical bills and records." *Esquivel*, 959 S.W.2d at 489 (holding in the context of a health care provider seeking payment for outstanding medical fees and charges); *see also Martin v. Mid-Am. Farm Lines, Inc.*, 769 S.W.2d 105, 111-12 (Mo. banc 1989) (holding the same in the context of an employee seeking payment for medical fees and charges billed to the employee but not yet paid). "[W]hen such testimony accompanies the bills, which the [provider] identifies as being related to and the product of [the employee's] injury, and when the bills relate to the professional services rendered as shown by the medical records in evidence, a sufficient factual basis exists for the [C]omission to award compensation." *Martin*, 769 S.W.2d at 111-12.

Notwithstanding the Appellant's contention to the contrary, neither *Martin* nor *Esquivel* announced that the "burden of proof" imposed by section 287.140.3 shifts to an employer or insurer to prove the unfairness and unreasonableness of unpaid medical bills. Rather, both *Martin* and *Esquivel* applied black-letter principles of law related to the burden of going forward with evidence once a party who bears the burden of proof has sustained its burden of production by presenting testimony and evidence that is sufficient to make a prima facie case that would support a judgment in their favor. "'[P]rima facie evidence' means such evidence which, in law, is sufficient to satisfy the burden of proof

[7]Prior to the 1993 amendment, section 287.140.3 required proof that the fees and charges be "fair and reasonable for similar treatment of other similarly injured persons."

to support a verdict in favor of the party by whom it is introduced ***when not rebutted by other evidence***." *State ex rel. State Dep't of Pub. Health & Welfare v. Ruble*, 461 S.W.2d 909, 913 (Mo. App. 1970) (emphasis added). Though prima facie evidence satisfies the initial burden of production possessed by the party who bears the burden of proof, it is not controlling on the burden of persuasion. "Prima facie evidence . . . is not conclusive evidence, and while it suffices to support a judgment upon a fact so established, it does not require or demand a verdict for the party whose contention it supports." *Id.*

Instead, the "[c]laimant's 'burden of proof is made up of two separate burdens, the burden of persuasion and the burden of production.'" *March v. Treasurer of Mo.*, 649 S.W.3d 293, 299 (Mo. banc 2022) (quoting *Annayeva v. SAB of TSD of City of St. Louis*, 597 S.W.3d 196, 200 n.8 (Mo. banc 2020)). The burden of production references the claimant's burden to "introduce[] competent and substantial evidence on the whole record sufficient to support a finding on each of the facts necessary to that award." *Id.* at 300 (quoting *Annayeva*, 597 S.W.3d at 200 n.8). The burden of persuasion is separate. It requires a claimant "'actually to convince the fact-finder to view the facts in a way that favors' them." *Id.* (quoting *Annayeva*, 597 S.W.3d at 200 n.8). "[T]he burden of persuasion is met when, after a careful consideration and weighing of both parties' evidence, a fact-finder decides in favor of the party who carried the burden of proof on those issues." *Wax v. Vickers*, 701 S.W.3d 903, 908 (Mo. App. S.D. 2024) (quoting *Smith v. Capital Region Med. Ctr.*, 458 S.W.3d 406, 417 (Mo. App. W.D. 2014)).

As applied to claims for unpaid medical bills pursuant to section 287.140.3, once a provider or employee has sustained the burden of production with respect to the fairness

and reasonableness of outstanding medical bills by presenting testimony and evidence relating medical bills to an injury and placing in evidence the accompanying medical bills and records, "[t]he employer [or insurer], of course, may challenge the reasonableness or fairness of these bills or may show that the medical expenses incurred were not related to the injury in question." *Martin*, 769 S.W.2d at 112. Thus, "where a health care provider presents testimony and evidence relating medical bills to an injury and places in evidence the accompanying medical bills and records, ***the burden of going forward*** with the evidence shifts to the employer or insurance carrier to prove that such medical bills were unreasonable and unfair." *Esquivel*, 959 S.W.2d at 489 (emphasis added). This "shift," however, does not relieve the provider or employee seeking recovery under section 287.140.3 of the burden of proof. "While . . . the burden of going forward with the evidence may shift during the progress of the trial of a case, the burden of proof does not shift but remains with the party having the affirmative of an issue until the termination of the case." *Brown v. Sloan's Moving & Storage Co.*, 274 S.W.2d 310, 313 (Mo. 1954); *see also Frank v. Wabash R.R. Co.*, 295 S.W.2d 16, 22 (Mo. 1956) ("While the burden of going forward with the evidence may shift during the progress of the case, the burden of proof, ***absent a statutory provision to the contrary***, remains with the party having the affirmative of the issue . . . until the termination of the case.") (emphasis added) (citation omitted). In other words, the claimant always bears the risk of non-persuasion. *In re Request for Increase in Sewer Operating Revenues of Emerald Pointe Util. Co.*, 438 S.W.3d 482, 490 (Mo. App. W.D. 2014) ("While the burden of producing evidence may

shift from one party to the other and back again, the burden of persuasion does not.") (citing *Brinker v. Dir. of Revenue*, 363 S.W.3d 377, 380 (Mo. App. E.D. 2012)).

Here, when the Commission found that the "burden shifted" to the Appellants to prove the unfairness or unreasonableness of the unpaid medical bills presented into evidence by Surgical Specialties, it was not holding that the burden of proof imposed by section 287.140.3 had shifted. Instead, it was simply recognizing that the evidence and testimony submitted by Surgical Specialties was sufficient to sustain its burden of production, and to support the entry of judgment should the evidence be deemed credible (the burden of persuasion), such that it became the Appellants' obligation to assume the burden of coming forward with competing evidence. However, the burden of persuasion, and thus the ultimate burden of proof that its unpaid fees and charges were fair and reasonable, remained squarely on Surgical Specialties.

We therefore reject the premise that is essential to the Appellants' first point on appeal, which confuses the provider or employee's burden of proof with a shift in the burden of coming forward with evidence once a prima facie case has been made by the party with the burden of proof. *See Frank*, 295 S.W.2d at 22 (holding that the burden of coming forward with competing evidence should not be confused with the burden of proof). *Martin* and *Esquivel* properly concluded that a sufficient factual basis exists to support a judgment in favor of a provider or employee pursuant to section 287.140.3 if medical bills related to a compensable work injury, and related to professional services reflected in medical records, are admitted into evidence. In so holding, *Martin* and *Esquivel* identified the nature of the evidence that is sufficient to make a prima facie case

that medical bills reflect "fair and reasonable" fees and charges as required by section 287.140.3, though such judgment is not compelled, as it remains subject to the burden of persuasion.

Martin and *Esquivel* did not reach their conclusions tethered to reliance on liberal construction required of the Workers' Compensation Law then in effect.[8] Instead, *Martin* and *Esquivel* reached their conclusions by applying universal principles of law relating to the burden of proof, and the burden of going forward with competing evidence once a prima facie case sufficient to sustain the burden of proof has been made. It follows that the amendment to the Workers' Compensation Law in 2005 requiring strict construction of its provisions did not alter the fundamental holdings in *Martin* and *Esquivel*. In fact, since 2005, Missouri cases have continued to cite favorably to *Martin* and *Esquivel*, and have continued to conclude that the burden to prove the fairness and reasonableness of medical fees and charges is sustained by evidence that medical bills relate to treatment for a compensable injury as demonstrated in medical records. *See, e.g., Ritchie v. Silgan Containers Mfg. Corp.*, 625 S.W.3d 787, 799 (Mo. App. W.D. 2021) (holding that an employee satisfies burden of proof permitting recovery of medical expenses by introducing medical bills into evidence, by testifying that the bills are related to the work

[8]The Appellants claim that *Martin* relied on liberal construction of the Workers' Compensation Law to reach its conclusion about the evidence that is sufficient to support a finding that outstanding medical fees and charges are fair and reasonable. We disagree. The Supreme Court in *Martin* found simply that no purpose would be served by requiring greater evidence to prove that outstanding medical bills are fair and reasonable than is required to prove that paid medical bills are unfair and unreasonable. *Martin*, 769 S.W.2d at 111-112.

injury, and by establishing that the bills relate to services rendered as shown by medical records); *Cook v. Mo. Highway & Trans. Comm'n*, 500 S.W.3d 917, 929 (Mo. App. S.D. 2016) (holding that "sufficient factual basis exists for the Commission to award compensation for past medical expenses" if claimant introduces medical bills, testifies that the bills are related to the work injury, and establishes that the bills relate to professional services shown by medical records admitted into evidence). "When these elements are met, the burden [of coming forward] shifts to the employer [or insurer] to prove some reason the award of past medical expenses is inappropriate." *Cook*, 500 S.W.3d at 929 (citing *Farmers-Cummings v. Pers. Pool of Platte Cnty.*, 110 S.W.3d 818, 823 (Mo. banc 2003)).

The Commission did not improperly shift the burden of proof to the Appellants to prove that Surgical Specialties' unpaid medical bills were unfair or unreasonable.

Point One is denied.

The Appellants' second point on appeal challenges the sufficiency of the evidence to support the Commission's Final Award ordering them to pay Surgical Specialties $8,196.48 in outstanding medical fees because Surgical Specialties "did not put on evidence to establish that its charges were fair, reasonable, and no more than the usual and customary fee it receives for the same treatment or service when the payor is a private individual or insurance carrier as required by [s]ection 287.140.3 and strict construction."

We have already explained why the Appellants' reliance on "strict construction" as controlling or influential in assessing the evidence required to sustain a provider's burden

of proof under section 287.140.3 is without merit. In the absence of consideration of this erroneous premise, the record plainly reflects that Surgical Specialties admitted evidence sufficient to sustain its burden of proof that its unpaid charges were fair and reasonable, and that those charges are not "greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier."

With respect to whether the charges billed were fair and reasonable, the record reflects that Surgical Specialties admitted the relevant medical bills, testimony relating the bills to a compensable workplace injury, and medical records establishing that the bills were incurred in connection with services reflected in those records. Surgical Specialties' business manager testified that the Employer's employee was referred to Surgical Specialties by a nurse case manager working on behalf of the Appellants, and that the nurse case manager "direct[ed] and authorize[d]" Surgical Specialties to perform an operation on the employee's right knee in order "to cure and relieve [the employee] from the effects of" a workplace injury. The business manager testified that Dr. M. performed an arthroscopic surgery to repair a complex tear to employee's medial meniscus, and identified copies of the post-operative report and itemized billing statement related to employee's surgery, both of which were entered into evidence. The post-operative report included a detailed description of the procedure itself. The business manager testified that the itemized billing statement set forth the costs associated with the surgery performed to repair the workplace injury that the employee suffered. The itemized billing statement included the surgical fee as well as charges for a surgical

implant, surgical supplies, anesthesia, and pharmaceuticals used during the surgery. The business manager testified that the bill issued to the Appellants totaling $19,763 reflected the charges and fees that Surgical Specialties bills for the arthroscopic surgery to repair a complex tear to a medial meniscus. The business manager testified that Surgical Specialties received payment from the Appellants in the amount of $11,566.52, leaving $8,196.48 outstanding in unpaid fees and charges. This evidence satisfied Surgical Specialties' burden of production because, as discussed, *supra*, the nature of the evidence was sufficient to support an award in its favor that its unpaid fees and charges were fair and reasonable. Surgical Specialties also sustained its burden of persuasion, as the Final Award included a finding that the business manager's testimony was "credible and persuasive." We are bound by the Commission's credibility determination. *See Fernandez*, 689 S.W.3d at 507.

The Appellants argue that the above described evidence was not sufficient to sustain Surgical Specialties' burden to prove its unpaid charges and fees were fair and reasonable because the business manager's testimony failed to provide "substantive evidence" that the charges contained in itemized billing statements adhered to standard billing practices or were generated by an independent billing service or software. These arguments, which were largely advanced by the evidence and testimony offered by the Appellants through Dr. Q. are reflective of "competing" evidence on the issue of the fairness and reasonableness of Surgical Specialties unpaid medical bills. But, the evidence and testimony offered through Dr. Q. was not controlling, and was obviously

not accepted by the Commission as sufficient to defeat Surgical Specialties' burden of persuasion.

The Appellants also argue that Surgical Specialties failed to put on any evidence to establish that its charges were no more than the usual and customary fee it receives for the same treatment or service when the payor is a private individual or insurance carrier. It is true that section 287.140.3 tempers what will be considered a recoverable "fair and reasonable" fee or charge by noting that the fee charged by a provider for treatment and care cannot be "greater than the usual and customary fee ***the provider*** receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier." (Emphasis added.)

Here, Surgical Specialties' business manager testified that 99 percent of Dr. M.'s practice at Surgical Specialties is comprised of workers' compensation referrals, and that every time Dr. M. performs the surgery performed on Employer's employee, Surgical Specialties bills $19,763, regardless of who is billed for the procedure. As we have already noted, the Commission found the business manager's testimony to be "credible and persuasive." Though the Appellants argue that this evidence "lacks sufficient probative force" that the amounts routinely charged by Surgical Specialties for the procedure performed on Employer's employee are actually "received" when the payor is a private carrier, we disagree. "The fee or charge is the amount the healthcare provider actually requires the employee to pay, initially or thereafter, for the service provided." *Farmer-Cummings*, 110 S.W.3d at 821. That is particularly so here, when Surgical Specialties' business manager testified that 99 percent of Dr. M.'s services are provided to

workers' compensation claimants, and not to private payors. This evidence was sufficient to sustain Surgical Specialties' burden of production and persuasion.

Sufficient evidence supports the Commission's Final Award ordering the Appellants to pay Surgical Specialties $8,196.48 in outstanding medical fees and charges.

Point Two is denied.

Conclusion

The Final Award is affirmed.

Cynthia L. Martin, Judge

All concur