IN THE MISSOURI COURT OF APPEALS
WESTERN DISTRICT

[redacted],	)	
Appellant,	)	[redacted]
v.	)	
	)	**OPINION FILED:**
	)	**January [redacted] 2021**
[redacted] **and** [redacted],	)	
Respondents.	)	

Appeal from the Labor and Industrial Relations Commission

Before Division Two: Lisa White Hardwick, Presiding Judge, and Thomas H. Newton and Karen King Mitchell, Judges

[redacted]

([redacted] appeals from the decision of the Labor and Industrial Relations Commission dismissing [redacted] medical fee dispute as time barred. [redacted] raises seven points on appeal. In its first three points, [redacted] argues that the Commission erred in dismissing its medical fee dispute because genuine issues of material fact exist as to whether the payment explanation provided to [redacted] is a notice of dispute. For its remaining points, [redacted]

raises constitutional challenges to the medical fee dispute statute and regulation and their application to this case. Finding no error, we affirm.

Background[1]

On April [redacted] 2013, an employee of [redacted] (Employer) was injured when a refrigerator he was moving fell on him. The employee filed a Claim for Compensation with the Missouri Division of Workers' Compensation on June [redacted] 2013. On December [redacted] 2015, [redacted] provided authorized medical services to the employee and billed Employer $125,184.60 for those services.[2] On May [redacted] 2016, [redacted] sent [redacted] a check for $50,629.23 along with an Explanation of Bill Review, and [redacted] deposited the check on June [redacted] 2016. The Explanation itemized each procedure and showed the reduction applied to each charge. Each reduction had a code in the column labeled "Negotiated/Discount" that corresponded to a key at the bottom of the page titled, "Explanation of Reason Codes for Detail Lines," which stated,

> v279 Reduction due to [redacted] review. For questions[,] please contact [redacted] at [redacted]. . . .
> z652 Recommendation of payment has been based on th[ese] procedure code[s], 490 [and 278], which best describe[] services rendered. . . .
> v140 CV: Allowance is recommended at fair and reasonable rate for implant charges that are supported by the submitted documentation. . . .

The Explanation identified [redacted] as the payor, included a box for the "TPA Claim Number," and identified Employer and its insurer [redacted] by name. The check identified "[redacted] as Agent for [redacted]."

[1] Consistent with the medical fee dispute procedures discussed *infra*, we consider the undisputed material facts set forth by employer/insurer, as well as [redacted] response to those facts and any additional disputed material facts offered by [redacted]

[2] Employer's insurer authorized the services on December [redacted] 2015.

On August [redacted] 2017, [redacted] filed an Application for Payment of Additional Reimbursement of Medical Fees, asserting that [redacted] is entitled to the additional $74,555.37 for the authorized medical services rendered to the employee. In response, Insurer filed a Request for Award on Undisputed Facts, asking the Division to deny [redacted] Application as untimely under § 287.140.4(2).[3] Insurer's Request included the following relevant facts: (1) the date of service was December [redacted] 2015, and the amount billed was $125,184.60; (2) a check in the amount of $50,629.93 along with the Explanation was mailed by or on behalf of [redacted] to [redacted] (3) the Explanation was in writing and had Reason Codes to explain the basis for disputing the charged amounts; (4) [redacted] cashed or deposited the check on or before June [redacted] 2016; and (5) [redacted] Application was filed on or about August [redacted] 2017.

To support these facts, Insurer submitted the affidavit of [redacted] a Claims Team Lead at [redacted] along with copies of the Explanation, the check for $50,629.93, and the deposit record. Based on his personal knowledge and a review of the pertinent business records, [redacted] testified that the Explanation "along with" the check for $50,629.93 were mailed by or on behalf of [redacted] as the third-party administrator for Employer/Insurer, to [redacted] on or about May [redacted] 2016, and the check cleared on June [redacted] 2016. [redacted] also testified that [redacted] sent [redacted] a letter in February 2017, well within the limitations period, to request that the claim be reprocessed. In the letter, [redacted] threatened to initiate a medical fee dispute if the parties could not agree on an additional reimbursement amount.

[redacted] filed a response to the Request for Award in which it admitted Insurer's undisputed facts, except [redacted] denied that (1) the Explanation and check were mailed together; (2) the Explanation constituted a notice of dispute; and (3) [redacted] received the

[3] All statutory references are to the Revised Statutes of Missouri, as updated through the 2014 Supplement.

Explanation on or before June [redacted] 2016. [redacted] response also included the following additional material facts: (1) Insurer did not provide [redacted] with "any bill, demand, request or opinion disputing [[redacted]'s] medical fee or as to what [Insurer] believed to be a fair and reasonable fee for the services provided"; (2) the Explanation did not "indicate it was created or provided by [Insurer] or that the medical charges are being disputed or explain the basis for the dispute"; and (3) neither Insurer nor its designated representative sent [redacted] a notice of dispute. [redacted] did not provide any additional evidence in support of its additional material facts or in support of its denials.

On September [redacted] 2019, an administrative law judge with the Division issued Findings of Fact and Rulings of Law denying [redacted] Application. The ALJ made the following findings of fact: (1) [redacted] filed the Application on August [redacted] 2017; (2) the medical services at issue were rendered on December [redacted] 2015; (3) Insurer mailed the Explanation and the check to [redacted] on May [redacted] 2016; (4) the Explanation was in writing and contained the basis for disputing portions of the amount charged; (5) [redacted] deposited the check on June [redacted] 2016; and (6) [redacted] received the Explanation and check no later than June [redacted] 2016. Based on its findings, the ALJ determined that there were no genuine issues of material fact as to the notice of dispute or the fact that [redacted] Application was time barred. Following [redacted] timely request for review, the Commission issued a Final Award adopting the ALJ's findings and award and concluding that Employer/Insurer is not liable to [redacted] for additional reimbursement of medical fees.

This appeal follows.

Standard of Review

When reviewing a final award on undisputed facts by the Commission in a medical fee dispute, we determine whether, based on the undisputed facts set forth by the employer/insurer, the health care provider's response to those facts, and any additional disputed material facts set forth by the health care provider, there are sufficient material facts to support the Commission's award and whether any genuine issues of material fact remain. 8 C.S.R. § 50-2.030(1)(P) (2014).

Analysis

Before analyzing [redacted] points on appeal, we review the workers' compensation statutes and regulations governing medical fee disputes.

In pertinent part, § 287.140 provides,

> 3. All fees and charges under this chapter shall be fair and reasonable [and] shall be subject to regulation by the division or the commission . . . . 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 . . . 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.
>
> 4. The division shall, by regulation, establish methods to resolve disputes concerning the reasonableness of medical charges, services, or aids. This regulation shall govern resolution of disputes between employers and medical providers over fees charged, whether or not paid, and shall be in lieu of any other administrative procedure under this chapter. The employee shall not be a party to a dispute over medical charges, nor shall the employee's recovery in any way be jeopardized because of such dispute. *Any application for payment of additional reimbursement, as such term is used in 8 CSR 50-2.030, as amended, shall be filed not later than:*
>
> *(1) Two years from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered before July 1, 2013; and*
>
> *(2) One year from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered after July 1, 2013.*

> *Notice shall be presumed to occur no later than five business days after transmission by certified United States mail.*

The italicized text was added in 2013 and became effective January 1, 2014.

Pursuant to § 287.140, the Commission promulgated 8 C.S.R. § 50-2.030, which sets forth procedures for resolving medical fee disputes. In relevant part, 8 C.S.R. § 50-2.030 states,

> (1) Procedures Pertaining to Applications for Payment of Additional Reimbursement of Medical Fees (Reasonableness Disputes).
>
> (A) If an employer or insurer disputes the reasonableness of a medical fee or charge, the employer or insurer shall notify the health care provider in writing that the medical charge is being disputed and shall explain the basis for the dispute. The employer or insurer may tender partial payment and the health care provider may accept payment of the amount tendered without prejudice to the filing of an application for payment of additional reimbursement of medical fees. Upon receiving the written notice of the dispute, the health care provider may contact the insurer or employer to attempt to resolve the dispute.
>
> . . . . .
>
> (P) Requesting and Issuing Awards on Undisputed Facts.
>
> 1. . . . The employer or insurer may file a request for an award on undisputed facts in regard to the application for payment of additional reimbursement of medical fees on the ground that same was not filed within the limitation period set forth in section 287.140.4, RSMo, or on the ground that the charges have been paid in full, or on any ground which would fully negate any liability for further payment, and upon which ground the facts are not in dispute. . . . The request for an award on undisputed facts shall state with particularity each material fact as to which the employer or insurer claims there is no genuine issue, with specific references to the contents of the application for payment of additional reimbursement of medical fees, deposition testimony, affidavits, and documents that demonstrate the lack of a genuine issue as to such facts. Each request for an award on undisputed facts shall have attached thereto the affidavits, portions of deposition transcripts, and other documents relied upon in the request.
>
> 2. Within thirty (30) days after a request for an award on undisputed facts is filed with the division, the health care provider shall file its response thereto. The response shall admit or deny each of the factual statements contained in the request. A denial may not rest upon mere allegations or general denials. Rather, the response shall support each denial with specific references to the depositions, documents, or affidavits that demonstrate specific facts showing that there is a genuine issue to be decided at an evidentiary hearing. Attached to the response shall be a copy of the affidavits, deposition transcripts (or portions thereof), and

other documents upon which the response relies. The response may also set forth, in detail, additional material facts that remain in dispute.

3. Upon timely filing of the response, the administrative law judge assigned to the case shall proceed to ruling on the request for an award on undisputed facts. . . . If the request for an award on undisputed facts and response show that there is no genuine issue as to any material fact and that the application for payment of additional reimbursement of medical fees should be denied in full, the administrative law judge shall issue an award on undisputed facts denying the application for payment of additional reimbursement of medical fees in full. Such award shall be a final reviewable award in the case as to the application for payment of additional reimbursement of medical fees.

4. The health care provider may file an application for review with the Labor and Industrial Relations Commission within twenty (20) days from the date of the award of the administrative law judge. This review shall be subject to review and appeal in the same manner as provided for other awards in Chapter 287, RSMo.

5. If the request for an award on undisputed facts and response show that there is a genuine issue as to any material facts, the administrative law judge shall issue an order denying the request for an award on undisputed facts. An order denying the request for an award on undisputed facts is not a final award as to any issue, and is not subject to review or appeal.

With this legal framework in mind, we turn to [redacted] seven points on appeal. In its first three points, [redacted] argues that the Commission erred in dismissing its medical fee dispute because genuine issues of material fact exist as to whether the Explanation was a notice of dispute, whether it was sent by an agent of Employer/Insurer, and whether it was received by [redacted] more than one year before the Application was filed. For its remaining points, [redacted] claims the Commission erred in dismissing the dispute because § 287.140 and 8 C.S.R. § 50-2.030 violate [redacted] constitutional rights.

I. There is no genuine issue of material fact as to whether the Explanation constituted a notice of dispute sent on behalf of Employer/Insurer and received by [redacted] more than one year before [redacted] filed its Application (Points I-III).

In its first three points, [redacted] asserts that the Commission erred in dismissing [redacted] Application because the Commission's finding that the Explanation is a "notice of

dispute" within the meaning of § 287.140 and 8 C.S.R. § 50-2.030(1)(A) sent on behalf of Employer/Insurer and received by [redacted] more than one year before [redacted] Application was filed was not supported by competent and substantial evidence.[4] We disagree.

Section 287.140 directs the division to establish methods to resolve medical fee disputes between employers/insurers and health care providers. Pursuant to that section, the Commission promulgated 8 C.S.R. § 50-2.030(1)(A), which directs an employer or insurer that disputes the reasonableness of a medical fee to notify the health care provider in writing that the medical charge is being disputed and explain the basis for the dispute. Here, the Explanation was in writing and identified [redacted] Employer, and Insurer. The Explanation contained reduced fee amounts for those charges that were disputed and "Reason Codes" for each reduction in benefits. Specifically, the Explanation stated that the reductions were based on three factors: (1) application of a [redacted] review; (2) use of procedure codes that best describe the medical services rendered; and (3) the "fair and reasonable rate for implant charges that are supported by the submitted documentation." Because the Explanation contained all elements required by 8 C.S.R. § 50-2.030(1)(A), the Explanation was a notice of dispute within the meaning of that rule.

In its first three points, [redacted] raises three challenges to the Commission's finding that the Explanation constituted a notice of dispute. In Point I, [redacted] argues that genuine issues of material fact exist as to whether the Explanation "explains the basis for a dispute." But Insurer's Request for Award included the facts that the Explanation was in writing and had Reason Codes to explain the basis for disputing the charged amounts, and Insurer supported those facts by attaching the Explanation itself, which belies [redacted] argument. The Explanation reflected

[4] [redacted] frames its first three points in terms of whether the Commission's findings are supported by competent and substantial evidence. While that is sufficient to raise the issues on appeal, the standard of review we apply here is consistent with the procedures specific to medical fee disputes, as discussed more fully *supra*.

the reduction in benefits for each procedure and explained the reason(s) for each reduction. In response, [redacted] offered only a general denial that the Explanation is a notice of dispute but did not provide any additional evidence to support its denial. *See* 8 C.S.R. § 50-2.030(P)(2) ("A denial may not rest upon mere allegations or general denials. Rather, the response shall support each denial with specific references to the depositions, documents, or affidavits that demonstrate specific facts showing that there is a genuine issue . . . ."). Additionally, [redacted] February 2017 letter to [redacted] evidences [redacted] understanding that the amounts it charged for the services had been disputed. Thus, we agree with the Commission's finding that, based on the undisputed facts and the response thereto, the Explanation was a notice of dispute.

For Point II, [redacted] claims that there are genuine issues of material fact as to whether the Employer or Insurer (as opposed to [redacted] disputed the medical charges. The affidavit submitted by Insurer in support of its Request for Award listed the Employer and Insurer and identified [redacted] as the third-party administrator at the time of the relevant payments in the underlying workers' compensation case. The Explanation identified [redacted] as the payor, included a box for the "TPA Claim Number," and identified Employer and Insurer. And the check identified "[redacted] as Agent for [redacted]" [redacted] offered no evidence challenging [redacted]'s authority to act on behalf of Insurer, and [redacted] suggestion that [redacted] lacked such authority is mere speculation. Thus, we agree with the Commission's finding that, based on the undisputed facts and the response thereto, the Explanation is a notice of dispute by Employer/Insurer within the meaning of § 287.140 and 8 C.S.R. § 50-2.030(1)(A).

Finally, in Point III, [redacted] asserts that there are genuine issues of material fact as to whether it received the Explanation more than a year before the Application was filed. Insurer's

Request for Award included the fact that the check was mailed to [redacted] along with the Explanation and that [redacted] deposited the check on June [redacted], 2016. In support, Insurer offered [redacted] affidavit that, on or about May [redacted], 2016, the Explanation "along with" the check were mailed to [redacted] by or on behalf of [redacted]

First, [redacted] argues that [redacted] statements are hearsay and do not provide evidence that would be admissible in a hearing and that therefore the affidavit cannot establish the lack of a genuine issue as to any material fact. We disagree. In his affidavit, [redacted] stated that he is "personally acquainted with the facts stated herein," which clearly distinguishes [redacted] affidavit from the one this court reviewed and ruled inadmissible in *May & May Trucking, L.L.C. v. Progressive Northwestern Insurance Co.*, 429 S.W.3d 511, 515-16 (Mo. App. W.D. 2014) (finding affidavit that did not declare it was based on personal knowledge or otherwise indicate a basis for personal knowledge to be inadmissible hearsay). Second, [redacted] admits that it deposited the check on June [redacted] 2016, but denies receipt of the Explanation by that date and argues that [redacted] statement that the Explanation was mailed "along with" the check does not clearly indicate that the Explanation and check were mailed together, that the affidavit merely creates an inference that the Explanation and check were mailed together, and that such an inference cannot be made in favor of the employer/insurer. But, in this context, the plain meaning of the statement in the affidavit that the Explanation was mailed "along with" the check is that the Explanation and the check were mailed together. No inference is needed, and [redacted] offers no evidence in the form of "specific references to the depositions, documents or affidavits that demonstrate specific facts showing that there is a genuine issue" regarding when [redacted] received the Explanation. 8 C.S.R. § 50-2.030(P)(2). Again, "mere allegations or general denials" are

insufficient. *Id.* Thus, we agree with the Commission's finding, based on the undisputed facts and the response thereto, that [redacted] received the Explanation on or before June [redacted] 2016.[5]

Points I, II, and III are denied.

II. [redacted] constitutional challenges to the medical fee dispute statute and regulation lack merit (Points IV-VII).

In its remaining points, [redacted] raises constitutional challenges to § 287.140.4 and 8 C.S.R. § 50-2.030 and their application to this case. In Point IV, [redacted] challenges the alleged retroactive application of the one-year limitations period in § 287.140.4 to its claim for reimbursement. In Point V, [redacted] argues that 8 C.S.R. § 50-2.030(1)(P)(2) violates due process because that section requires [redacted] to admit or deny Insurer's material facts but does not require Insurer to admit or deny [redacted] additional material facts. For Point VI, [redacted] claims that § 287.140.4 is unconstitutionally vague because it fails to describe what constitutes a notice of dispute. And, in Point VII, [redacted] asserts that the one-year limitations period in § 287.140.4 "is unreasonable, arbitrary, capricious and is not related to a legitimate state interest and it interferes with [[redacted]'s] right to contract for the payment of its services."

"Under Article V, section 3 of the Missouri Constitution, the Missouri Supreme Court has exclusive jurisdiction in all cases involving the validity of a statute." *State ex rel. Mo. Highways*

[5] In Point III, [redacted] makes two additional arguments that we also reject as meritless. First, [redacted] argues that there is a genuine issue of material fact as to when it received the Explanation because [redacted] Insurer did not send the Explanation and check by registered or certified mail. Although § 287.140.4 provides that notice of a dispute "shall be presumed to occur no later than five business days after transmission by certified United States mail," a notice of dispute is not required to be sent by certified mail and, here, there is other proof of the date of receipt by [redacted] Likewise, [redacted] reliance on § 287.520.1 is misplaced. That section states, in relevant part, "Any notice required under this chapter shall be deemed to have been properly given and served when sent by registered or certified mail properly stamped and addressed to the person or entity to whom given." Like § 287.140.4, § 287.520.1 describes when a notice is deemed to have occurred, but does not require that the notice be sent by specific means.

Second, [redacted] claims that, under 8 C.S.R. § 50-2.030(1)(A), it was allowed to accept partial payment without prejudice to its right to file the Application. While that is true, [redacted] right to file the Application was not foreclosed by acceptance of partial payment but rather by [redacted] failure to timely file the Application, as discussed *infra*.

& Transp. Comm'n v. Greenwood, 269 S.W.3d 449, 458 (Mo. App. W.D. 2008). "The mere assertion that a statute is unconstitutional, however, does not deprive the court of appeals of jurisdiction." *Id.* "The constitutional issue must be real and substantial [and] not merely colorable." *Id.* (quoting *Glass v. First Nat. Bank of St. Louis, N.A.*, 186 S.W.3d 766, 766 (Mo. banc 2005)). "In determining whether a constitutional claim is merely colorable, a preliminary inquiry is made as to whether the claim presents a contested matter of right that involves fair doubt and reasonable room for disagreement." *Id.* at 458-59. "If such inquiry reveals that the claim is so legally and factually insubstantial as to be plainly without merit, the claim may be deemed merely colorable." *Id.* at 459.

Here, our initial inquiry reveals that [redacted] constitutional claims are not real and substantial but are, instead, merely colorable. Accordingly, we have jurisdiction to review them.

We begin with [redacted] arguments regarding the one-year limitations period in § 287.140.4 (Points IV and VII). That section states, in pertinent part, "Any application for payment of additional reimbursement . . . shall be filed not later than . . . [o]ne year from the date the first notice of dispute of the medical charge was received by the health care provider if such services were rendered after July 1, 2013." As [redacted] correctly points out, this limitations period was added to § 287.140.4 in 2013 and became effective January 1, 2014. The parties agree that the claimant's underlying injury occurred on April [redacted] 2013, the workers' compensation claim was filed on June [redacted] 2013, and the medical services at issue were rendered on December [redacted] 2015. Thus, on the face of the statute, the one-year limitations period bars [redacted] Application because the underlying medical services were rendered after July [redacted] 2013.

[redacted] responds that, in Missouri, workers' compensation claims are governed by the law in effect when the injured employee's claim was filed. Because the one-year limitations period

in § 287.140.4 was not in effect when the employee's underlying claim was filed (2013), the limitations period does not apply to the Application,[6] and the Commission's finding to the contrary violates the constitutional prohibition on retrospective application of laws. But application of the one-year limitations period in this case is not retrospective because the medical services for which [redacted] seeks reimbursement were provided on December [redacted] 2015, nearly two years after the limitations period went into effect. A law is retrospective if it "'creates a new obligation, imposes a new duty, or attaches a new disability with respect to transactions or considerations already past' or '[gives] to something already done a different effect from that which it had when it transpired.'" *Accident Fund Ins. Co. v. Casey*, 550 S.W.3d 76, 81 (Mo. banc 2018) (quoting *State ex rel. Schottel v. Harman*, 208 S.W.3d 889, 892 (Mo. banc 2006)). "A law is not retrospective merely because it 'relates to prior facts or transactions but does not change their legal effect, or because some of the requisites for its action are drawn from a time antecedent to its passage, or because it fixes the status of an entity for the purpose of its operation.'" *Id.* at 81-82 (quoting *Schottel*, 208 S.W.3d at 892).

The one-year statute of limitations affects only the rights and duties of health care providers, such as [redacted] Here, the medical services at issue had not yet been provided and, as a result, the issue regarding reimbursement had not yet arisen when the statutory amendment

[6] For purposes of this case, we need not address [redacted] claim about the law applicable to workers' compensation claims generally because here the legislature was clear about when the one-year limitations period for medical fee disputes would apply. And "the primary rule of statutory interpretation is to give effect to legislative intent as reflected in the plain language of the statute at issue." *Karney v. Dep't of Labor and Indus. Rels.*, 599 S.W.3d 157, 162 (Mo. banc 2020) (quoting *Parktown Imports, Inc. v. Audi of Am., Inc.*, 278 S.W.3d 670, 672 (Mo. banc 2009)). There is no ambiguity in the plain language of § 287.140.4. "Without ambiguity, [we are] bound to give effect to the intent reflected in the statute's plain language and cannot resort to other means of interpretation." *Id.* Section 287.140.4 plainly states that, where, as here, medical services were rendered after July 1, 2013, an application for additional reimbursement for such services must be filed within one year of the date the first notice of dispute was received. The undisputed facts show that [redacted] received the Explanation, which constituted a notice of dispute, no later than June [redacted] 2016. [redacted] filed the Application on August [redacted] 2017, more than a year later. Thus, there is no genuine dispute that the Application was time barred under § 287.140.4.

took effect. Therefore, the statutory amendment created no new obligation, duty, or disability associated with a transaction that had already transpired. Prior to the amendment to § 287.140.4, the only events related to this case that had transpired were those related to the injured employee, but § 287.140.4 expressly states that it has no effect on the employee's right to recover and that he is not a party to the dispute over the medical charges. Here, the only parties affected by the one-year statute of limitations are [redacted] and the Employer/Insurer, the transaction at issue was the provision of approved medical services in December 2015, and the one-year limitations period went into effect on January 1, 2014. This case does not involve the retrospective application of a statute.

In Point VII, [redacted] asserts that the one-year limitations period in § 287.140.4 "is unreasonable, arbitrary, capricious and is not related to a legitimate state interest and it interferes with [[redacted]'s] right to contract for the payment of its services." But "statutes of limitation will not be held unconstitutional as denying due process unless the time allowed for commencement of the action and the date fixed when the statute commences to run are clearly and plainly unreasonable." *Ross v. Kan. City Gen. Hosp. and Med. Ctr.*, 608 S.W.2d 397, 400 (Mo. banc 1980). We fail to see how a one-year limitations period that commences to run when the first notice of dispute of the medical charge is received is clearly and plainly unreasonable. This is especially true where the filing required to occur within that year is a form supplied by the Commission and copies of documentation that should already exist. And, as to [redacted] contention that the one-year limitations period unreasonably interfered with its ability to contract with Insurer to provide the medical services at issue, we again note that, when the parties contracted for those services, the one-year limitations period had been in place for nearly two

years. Thus, we fail to see how the limitations period affected the parties' ability to contract for those services.

Points IV and VII are denied.

In Point VI, [redacted] claims that § 287.140.4 is unconstitutionally vague because it fails to describe what constitutes a notice of dispute. "It is a basic principle of due process that an enactment is void for vagueness if its [requirements] are not clearly defined." *Cocktail Fortune, Inc. v. Supervisor of Liquor Control*, 994 S.W.2d 955, 957 (Mo. banc 1999). "The void for vagueness doctrine ensures that laws give fair and adequate notice of [required] conduct and protects against arbitrary and discriminatory enforcement." *Id.* "The test in enforcing the doctrine is whether the language conveys to a person of ordinary intelligence a sufficiently definite warning as to the [required] conduct when measured by common understanding and practices." *Id*. "However, neither absolute certainty nor impossible standards of specificity are required in determining whether terms are impermissibly vague." *Id*. "Moreover, it is well established that 'if the law is susceptible of any reasonable and practical construction which will support it, it will be held valid, and . . . the courts must endeavor, by every rule of construction, to give it effect.'" *Id.* (quoting *State v. Duggar*, 806 S.W.2d 407, 408 (Mo. banc 1991)).

In pertinent part, § 287.140.4 directs the division to "establish[, by regulation] methods to resolve disputes concerning the reasonableness of medical charges, services, or aids. This regulation shall govern resolution of disputes between employers and medical providers over fees charged." Accordingly, the Commission issued 8 C.S.R. § 50-2.030(1)(A), which states in relevant part, "If an employer or insurer disputes the reasonableness of a medical fee or charge, the employer or insurer shall notify the health care provider in writing that the medical charge is being disputed and shall explain the basis for the dispute." Thus, a notice of dispute must (1) be

in writing; (2) indicate that the employer/insurer disputes the medical charge; and (3) explain the reason(s) for the dispute. Because a person of ordinary intelligence would easily understand those elements and "impossible standards of specificity" are not required, we find nothing impermissibly vague about the notice of dispute requirements in § 287.140.4 and 8 C.S.R. § 50-2.030(1)(A). And, in the context of this case, the Commission's conclusion that the Explanation constituted a notice of dispute was based on the undisputed facts.[7]

Point VI is denied.

Finally, in Point V, [redacted] argues that 8 C.S.R. § 50-2.030(1)(P)(2) violates due process because that section requires [redacted] to admit or deny Insurer's material facts but does not require Insurer to admit or deny [redacted] additional material facts. But [redacted] did not offer any additional material facts that were supported by "specific references to the depositions, documents or affidavits" as required by 8 C.S.R. § 50-2.030(1)(P)(2). So, while [redacted] is correct that 8 C.S.R. § 50-2.030(1)(P)(2) does not require an employer or insurer to respond to additional material facts offered by a health care provider, in this case there was nothing for Insurer to respond to because [redacted] did not offer any properly supported additional material facts. Thus, [redacted] claim of a due process violation assumes a fact—submission of properly supported additional material facts by the health care provider—that is absent here. In other words, [redacted] argument is based on a hypothetical fact. And any opinion rendered on hypothetical facts is advisory. "An opinion is advisory if there is no justiciable controversy, such as if . . . the decision is based on hypothetical facts." *State v. Giles*, 583 S.W.3d 533, 536 n.5 (Mo. App. W.D. 2019) (quoting *State ex rel. Heart of Am. Council v. McKenzie*, 484

[7] While [redacted] is correct that, under 8 C.S.R. § 50-2.030(1)(A), it could accept partial payment without prejudice to its right to file the Application, the issue here is whether the Application was timely filed and not whether [redacted] had a right to file an application in the first place.

S.W.3d 320, 324 n.3 (Mo. banc 2016)). "A court may not issue advisory opinions." *Dunn v. Dunn*, 536 S.W.3d 304, 311 (Mo. App. W.D. 2017) (quoting *Mitchell v. Residential Funding Corp.*, 334 S.W.3d 477, 488 (Mo. App. W.D. 2010)).

Point V is denied.

Conclusion

Because Insurer's Request for Award and [redacted] response showed that there is no genuine issue as to any material fact, that [redacted] Application should be denied in full, and that [redacted] constitutional challenges lack merit, the Commission's award is affirmed.

Karen King Mitchell, Judge

Lisa White Hardwick, Presiding Judge, and Thomas H. Newton, Judge, concur.