

11-1299

CIRCUIT COURT
IN THE CIRCUIT COURT OF OHIO COUNTY, WEST VIRGINIA

2011 AUG 17 AM 11 00

WHEELING HOSP., INC., BRENDA L. MILLER

Petitioner,

v.

Civil Action No. 10-CAP-15
Hon. Martin J. Gaughan

CRAIG A. GRIFFITH, West
Virginia State Tax Commissioner,

Respondent.

ORDER

The question before this Court is whether Wheeling Hospital (hereafter "the Hospital"), having been paid for the use of its facility, staff, equipment, drugs and supplies as inpatient and outpatient services, may now be taxed on those receipts at the lower rate applicable to services classified as physician services. The Hospital originally reported, and paid tax on, the gross receipts for these services as inpatient and outpatient services. It now seeks to amend its return to report them as physician services, thereby obtaining a refund. There is no evidence that any payer has sought return of any portion of their payments based on a claim that these services were not properly classified as inpatient or outpatient services. Rather, the Hospital's claim appears to arise solely from its changed view of the law.

The Office of Tax Appeals held an administrative hearing, reviewed the parties' stipulations and concluded that the services at issue were properly classified as inpatient and outpatient services. Therefore, the refund request of Wheeling Hospital was denied. Wheeling Hospital made a timely appeal to this Court. Both Wheeling Hospital and the Tax Commissioner filed written briefs in this

matter, and oral argument was held on June 24, 2011.

STANDARD OF REVIEW

A taxpayer seeking a refund bears the burden of proof. W. Va. Code §11-10-9(a) states in pertinent part, "If the hearing is on a petition for refund or credit, the petitioner shall also have the burden of proof." Similarly, the Taxpayer carries the burden in this Court to demonstrate a legal error made by the OTA.¹

W. Va. Code § 11-10A-19(f) provides that appeals from OTA shall be governed by the standard set forth in the Administrative Procedures Act. In turn, the Administrative Procedures Act provides that:

(g) The court may affirm the order or decision of the agency or remand the case for further proceedings. It shall reverse, vacate or modify the order or decision of the agency if the substantial rights of the petitioner or petitioners have been prejudiced because the administrative findings, inferences, conclusions, decision or order are:

- (1) In violation of constitutional or statutory provisions; or
- (2) In excess of the statutory authority or jurisdiction of the agency; or
- (3) Made upon unlawful procedures; or
- (4) Affected by other error of law; or
- (5) Clearly wrong in view of the reliable, probative and substantial evidence on the whole record; or
- (6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.²

While "[i]nterpreting a statute or an administrative rule or regulation presents a purely legal

¹See, e.g., *Johnston-Willis, Ltd. v. Kenley*, 369 S.E.2d 1, 6 (Va. App. 1988) ("The burden is upon the party complaining of the agency action to demonstrate an error of law subject to review.").

²W. Va. Code § 29A-5-4(g).

question subject to *de novo* review[.]”³ “[a]n inquiring court, even a court empowered to conduct *de novo* review, must examine a regulatory interpretation of a statute by standards that include appropriate deference to agency expertise and discretion.”⁴ And, even if an administrative tribunal errs in the basis of its decision, if the decision is correct on any legal basis, a reviewing court should affirm it.⁵

FINDINGS OF FACT

1. Wheeling Hospital, Inc. (hereinafter “the Hospital”) is a licensed West Virginia hospital located at 1 Medical Park, Wheeling, West Virginia 26003. See Stipulation No. 1.

2. Certain of the Hospital’s revenues are subject to the privilege taxes imposed under the West Virginia Health Care Provider Tax Act codified at W. Va. Code § 11-27-1 *et seq.*, with each such tax being designated therein as an annual broad-based health care related tax. See Stipulation No. 3.

3. For the years in question, West Virginia taxed ambulatory surgical centers, chiropractic services, dental services, emergency ambulance services, independent laboratory X-ray services, *inpatient hospital services*, intermediate care facility services for the mentally retarded, nursing facility service, other than services of intermediate care facilities for the mentally retarded, nursing services, opticians’ services, optometric services, *outpatient hospital services*, *physicians’ services*, podiatry services, psychological services, and therapists’ services. W. Va. Code § 11-27-4 through § 11-27-19.

4. From the passage of the health care provider tax statute (hereinafter, “HCPT”) in

³Syl. Pt. 1, *Appalachian Power Co. v. State Tax Dep’t*, 195 W. Va. 573, 466 S.E.2d 424 (1995).

⁴*Id.* at 582, 466 S.E.2d at 433.

⁵*See, e.g., U.S. Steel Min. Co. v. Helton*, 219 W. Va. 1, 3 n.3, 631 S.E.2d 559, 561 n.3 (2005) (quoting *GTE South, Inc. v. Morrison*, 199 F.3d 733, 742 (4th Cir. 1999) (“if the administrative order reaches the correct result and can be sustained as a matter of law, we may affirm on the legal ground even though the agency relied on a different rationale.”)).

1993, the taxes were imposed on the gross receipts of inpatient services, outpatient services and physician services.

5. In 2010, the HCPT on physician services was eliminated after a gradual reduction in the rate which began in 2000. *See* W.Va. Code §11-27-36(j). However, in 2003-2006, the years in dispute, physician services were subject to the Health Care Provider Tax.

6. In enacting the HCPT, the Legislature found that participation in the Medicaid program was necessary to ensure (1) that West Virginia's citizens who are not physically, mentally or economically able to provide for their basic healthcare receive medical care; and (2) that health care providers are adequately compensated to ensure the provision of these medical services. *See* W.Va. Code §11-27-1.

7. The revenue received from the provider taxes is deposited into the special revenue fund created in the State Treasurer's Office and known as the Medicaid State Share Fund. *See* W.Va. Code §11-27-32.

8. This revenue, along with other State funds, is used as the State's share that is required in order to receive funds from the federal government. *See* W.Va. Code §11-27-33.

9. Since the enactment of the health care provider taxes, the rate of tax on physician services has been less than the rate for hospital services.

10. Hospitals have always been taxed at 2.5% of their gross receipts for inpatient and outpatient services, while physicians were originally taxed at 2% of their gross receipts.

11. The Hospital originally reported the services at issue as inpatient and outpatient services. *See* Stipulation No. 16.

12. At the time of the original filing of its Broad Based Health Care returns, the rate of tax imposed on the gross receipts attributable to physician services was declining from 1.8% to 0.8%. *See* W.Va. Code § 11-27-36.

13. At the time of the original filing of the Hospital's Broad Based Health Care tax

returns, the rate of tax imposed on the gross receipts of the inpatient and outpatient service remained constant at 2.5%.

14. The Hospital's original filing of Broad Based Health Care tax returns reported gross receipts for the inpatient and outpatient services it later reclassified.

15. On October 27, 2006, the Hospital filed an amended Broad Based Health Care Tax return for fiscal year 2003, requesting a refund of \$484,188. *See Stipulation No. 6.*

16. On December 14, 2006, the Hospital filed amended Broad Based Health Care Tax returns for fiscal years 2004 and 2005, requesting refunds of \$687,101 and \$800,986 respectively. *See Stipulation No. 7.*

17. Following receipt of the amended returns, auditors from the Tax Department performed a field audit for the years in question. *See Stipulation No. 11.*

18. The field audit resulted in a reduction in the Hospital's refund request and an agreement that a portion of the Hospital's claim for a refund was allowed based upon the information received. *See Stipulation Nos. 12 and 13.*

19. The refund claims not granted, which are the subjects of this appeal, are related to the Hospital's reclassification of certain services from inpatient/outpatient services to physician services. *See Stipulation No. 16.*

20. The Hospital reclassified "the revenue the Hospital received. . . relat[ing] to the use of its facility, staff, equipment, drugs, supplies and other necessary overhead" as physician services. *See Petitioner's Brief in Support of Petition for Appeal of Administrative Decision , Page 2.*

21. There is no dispute that when a physician performs a procedure, in the Hospital or a facility owned by the Hospital, the tax imposed on the performance of this procedure is properly taxed as a physician service because the physician received payment for the procedure. *See Stipulation Nos. 98 and 103 (payment for reading and interpretation of laboratory reports), 191a (payment for outpatient breast biopsies and other procedures performed at Women's Health*

Center/Breast Center), 216a (payment for outpatient cardiac catheterization), 242a (payment for inpatient dialysis provided at Wheeling Hospital), 243a (payment for outpatient dialysis provided at freestanding renal dialysis facilities), 283a (payment for outpatient surgical procedures) and 298a (payment for inpatient surgical procedures).

22. With regard to the physician's provision of service for hospital or clinic visits, the physician was properly taxed at the physician rate because the physician received income. *See* Stipulation Nos. 190a (payment to physician for Women's Health Center/Breast Center visits), 197a and 198a (payment to physicians for Wound Care Center visits), 204a and 205a (payment to physician for treatment provided at Oncology Center/Nuclear Medicine) and 210a (payment to physicians for Sleep Lab visits).

23. When a patient visits any facility owned by the Hospital for any type of service, the registration process includes admission as a patient of the Hospital. Furthermore, admission is required in order for the Hospital to bill any charges with respect to the patient. *See* Stipulation No. 69.

24. Form CMS-1500 is the standard form used by non-institutional providers, including physicians. However, it is also sometimes used by hospitals. *See* Stipulation No. 20.

25. Form UB-92 is the form used by hospitals and other institutional health care providers to bill services. *See* Stipulations Nos. 17 and 18.

26. Some insurers, including Medicare and Medicaid, pay for services provided to inpatients based on the patient's diagnosis. The amount paid for services in connection with that diagnosis is based on the usual amount and type of services required for treatment. If services or other items are required beyond what is normal, those things are paid for separately, if covered. *See* Stipulation No. 75a.

27. Some insurers, including Medicare, pay for services provided to outpatients by categorizing procedures and services according to similarities in costs and clinical characteristics.

The category or group determines the amount of reimbursement for a specific service. *See* Stipulation No. 75b.

28. Every service, supply, and drug provided by a hospital or other health care provider has a charge description master code (hereinafter "CDM code") unique to that health care provider. *See* Stipulation No. 37.

29. The amount listed as the CDM for each service includes a mark-up over the original cost of providing the service. *See* Stipulation No. 39.

30. The chargemaster is a compilation of all CDM codes used by the particular hospital or provider and maps the CDM for use in billing and accounting systems. *See Stipulation No. 38.* That is, it states the book price of each service, supply, or drug – the price that would be paid by a patient paying cash for the services – as well as the discounted prices made applicable by reason of insurer-negotiated agreements. *See* Stipulation No. 75.

31. Some commercial payers reimburse a percentage of the charge listed on the chargemaster for services provided both to inpatients and outpatients. *See* Stipulation No. 75c.

32. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are *primarily* used to identify medical services and procedures furnished by physicians and other health care professionals. *See* Stipulation No. 26.

33. Hospitals use CPT codes, when applicable, in the grouping of hospital charges included on a hospital bill. *See* Stipulation No. 33.

34. CPT codes are therefore not exclusive identifiers of physician services. *See* Stipulation No. 26 and Stipulation No. 33.

35. The Hospital uses CPT codes on its bill to reflect the overhead the Hospital provides that is associated with a service or procedure provided by a physician. *See* Stipulation Nos. 33, 190b, 191b, 197b, 198b, 204b, 205b, 210b, 216b, 242b, 283b and 298b.

36. On form UB-92, CPT codes are listed if the insurer requires them. *See Stipulation No. 74.*

37. On the physician's fee schedule, the practice expense component reflects the physician's overhead including facility, clinic staff, incidental drugs and supplies and medical equipment. *See Stipulation No. 53.*

38. When the Hospital provides the overhead, as it has in the disputed services, and bills on the UB-92, the Hospital instead of the physician receives payment as is reflected in the findings set forth herein. The stipulations use the term "practice expense" to describe the overhead provided by the Hospital. However, the use of the term "practice expense" does not transform the Hospital's provision of inpatient and outpatient services into a physician's service.

39. The Women's Health Center/Breast Center (hereinafter "Women's Health Center") is located at a Medical Office Building. *See Stipulation No. 186.*

40. When the physician provided services or performed a procedure at the Women's Health Center, the physician billed for his work and malpractice component on CMS-1500 using CPT codes. Because the visit and/or procedure occurred at the Hospital's facility, the physician did not receive compensation for all of the overhead associated with the visit. *See Stipulation Nos. 190a and 191a.*

41. Because Wheeling Hospital provided the facility and overhead related to the clinic visits and/or procedures at the Women's Health Center, it billed for its provision of services on a UB-92 using the same CPT codes utilized by the physician. The Hospital received payment for the overhead expense along with related drugs and supplies. *See Stipulation Nos. 190b and 191b.*

42. The Wound Care Center is located at a Medical Office Building. *See Stipulation No. 193.*

43. When the physician provided services or performed a procedure at the Wound Care Center, the physician billed for his work and malpractice component on CMS-1500 using CPT

codes. Because the visit and/or procedure occurred at the hospital's facility, the physician did not receive compensation for all of the overhead associated with the visit. *See Stipulation Nos. 197a, 198a.*

44. Because Wheeling Hospital provided the facility and overhead related to the clinic visit and/or procedure at the Wound Care Center, it billed for its provision of services on a UB-92 using the same CPT codes utilized by the physician. The Hospital received payment for the overhead expense along with related drugs and supplies. *See Stipulation Nos. 197b, 198b.*

45. Patients visit physicians at the Oncology Center for cancer treatments. The Oncology Center provides radiation and nuclear medicine therapy treatments. *See Stipulation No. 200.*

46. The radiation and nuclear medicine therapy treatments are provided at the Hospital. *See Stipulation No. 203.*

47. When a physician provided services or performed a procedure at the Oncology Center, the physician billed for his work and malpractice component on CMS-1500 using CPT codes. Because the visit and/or procedure occurred at the Hospital's facility, the physician did not receive compensation for all of the overhead associated with the visit. *See Stipulation Nos 204a, 205a*

48. Because Wheeling Hospital provided the facility and overhead related to the clinic visit and/or procedure performed at the Oncology Center, it billed for its provision of services on a UB-92 using the same CPT codes utilized by the physician. The Hospital received payment for the overhead expense along with related drugs and supplies. *See Stipulation Nos. 204b, 205b.*

49. The Sleep Lab is located at the Hospital and provides treatment for sleep disorders. *See Stipulation No. 207.*

50. When the physician provided treatment at the Sleep Lab, the physician billed for his work and the malpractice component on form CMS-1500 using CPT codes. Because the treatment occurred at the Hospital's facility, the physician did not receive compensation for all of the overhead

associated with the visit. *See* Stipulation No. 210a.

51. Because the Hospital provided the facility and overhead related to treatment provided at the Sleep Center, it billed for the remainder of the overhead expense on form UB-92 using the same CPT codes used by the physician on form CMS-1500. The Hospital received the payment for the remaining overhead expense along with related drugs and supplies. *See* Stipulation No. 210b.

52. When the physician performed a cardiac catheterization at an outpatient location, the physician billed for his work and the malpractice component on form CMS-1500 using CPT codes. Because the treatment occurred at a Hospital facility, the physician did not receive compensation for all of the overhead associated with the visit. *See* Stipulation No. 216a.

53. Because the Hospital provided the facility and overhead related to the cardiac catheterization, it billed for the remainder of the overhead expense on form UB-92 using the same CPT code used by the physician on form CMS-1500. The Hospital received the payment for the remaining overhead expense along with related drugs and supplies. *See* Stipulation No. 216b.

54. For the tax years in question the Hospital employed pathologists. *See* Stipulation No. 227.

55. The Hospital's billing for pathology services differs depending upon the payer. When Medicare was the payer, the Hospital billed for the physician services and malpractice component on a CMS-1500 while it also billed for some services on the UB-92. *See* Stipulation No. 228.

56. Because the pathologists are employed by the Hospital, most non-Medicare payers require that all three components – physician services/work, malpractice and practice expense – be billed on a UB-92. *See* Stipulation No. 230.

57. Because the pathologists are Hospital employees, the Hospital received the entire payment for all three components of the physician fee schedule. *See* Stipulation No. 231.

58. The Hospital has a joint venture with a group of physicians who provide renal dialysis treatments. *See* Stipulation No. 234.

59. The joint venture is a separate entity and provides the facility, equipment, staff, drugs and supplies necessary to provide renal dialysis treatments. *See* Stipulation No. 235.

60. The physicians providing renal dialysis services are not employed by the joint venture, nor are they employed by the Hospital. *See* Stipulation No. 236.

61. Wheeling Hospital's inpatients receive renal dialysis treatment from physicians working for the joint venture. *See* Stipulation No. 240.

62. The joint venture bills the Hospital for the renal dialysis treatment provided, and the Hospital bills the patient. *See* Stipulation No. 241.

63. The physician who provides dialysis bills Wheeling Hospital's inpatients for the work and malpractice components. *See* Stipulation No. 242a.

64. The Hospital, as part of the dialysis joint venture, provided the equipment, supplies, staff, and other overhead for the procedure.

65. Because the Hospital provided the facility and overhead related to dialysis treatment, it billed for the remainder of the overhead expense on form UB-92 using the same CPT codes used by the physician on form CMS-1500. The Hospital received the payment for the remaining overhead expense along with related drugs and supplies. *See* Stipulation No. 242b.

66. In this case, the Hospital both reported the billing for overhead and paid the tax owed on it, although it was the dialysis joint venture that actually owed the tax.

67. Lithotripsy is a medical procedure that uses shock waves to break up stones that form in the kidney, bladder, ureters or gallbladder. *See* Stipulation No. 218.

68. The Hospital has a contract with a company that provides the staff and equipment to perform the lithotripsy service to patients of the Hospital at the Hospital. *See* Stipulation No. 220.

69. The physicians who perform the lithotripsy procedures are not employed by either the Hospital or the company with which the Hospital contracts. *See* Stipulation No. 221.

70. The lithotripsy company does not bill insurance companies or patients directly. Instead, it bills the Hospital, and the Hospital bills the patient. *See* Stipulation No. 222.

71. When the physician provided lithotripsy services to the patients at the Hospital, the physician billed for the work and the malpractice components of services on form CMS-1500 using CPT codes. *See* Stipulation No. 223a.

72. Although the lithotripsy company provided the equipment, supplies, staff, and other overhead for the procedure, the Hospital billed for these services on a UB-92 using the same CPT codes used by the physician. *See* Stipulation No. 223b.

73. When, as here, the Hospital bills for the services of a third party that has provided services using its own equipment and supplies on the Hospital's premises, the Hospital is obligated to report the billing and the name of the third party to which the gross receipts will be paid. *See* TAA96-004, *supra*. Because the Hospital has paid the gross receipts that arose from use of the third party's equipment and supplies to the third party, that party is responsible for paying the HCPT on those gross receipts. *Id.*

74. In this case, the Hospital both reported the billing for overhead and paid the tax owed on it, although it was the lithotripsy company who actually owed the tax. For that reason, the Tax Commissioner agreed to provide a refund to the Hospital in connection with its billing for lithotripsy services.

75. The Hospital does not contend that the equipment, supplies, and other overhead associated with skilled nursing services and therapist services should fall within the physician services classification. Clearly, it could not reasonably make such a claim because such services are not furnished by physicians; therefore, there can be no billing for physician services.

76. During some periods related to this case, emergency room services were provided by hospital-employed physicians. At other times, the physicians were independent. *See* Stipulation No. 253.

77. When emergency room physicians are employed by the Hospital, billings differ depending on whether the payer is Medicare or non-Medicare. *See* Stipulation No. 259.

78. Medicare requires two billings. Part of the billing is on form CMS-1500. The remainder of the billing is on form UB-92. Both billings include the CPT codes. *See* Stipulation No. 261.

79. When emergency room physicians are employees of the Hospital, most non-Medicare payers require that the entire billing occur on form UB-92. *See* Stipulation No. 262.

80. When employee physicians provide emergency room services, the Hospital receives the payment for all three components of the physician fee schedule and for related drugs and supplies. *See* Stipulation No. 264.

81. When independent physicians provide emergency room services, the physician bills and is paid for the services by billing on form CMS-1500. *See* Stipulation No. 265.

82. The Hospital bills with the same CPT codes used on the physician billing on form UB-92. The Hospital receives payment for the support services and supplies provided to the patient being seen by the physician. *See* Stipulation No. 266.

83. In order to bill anesthesia services, a number of variables need to be considered before a CPT code can be assigned. The number of codes that can apply is too large to reasonably include in the chargemaster. *See* Stipulation No. 277.

84. Accordingly, anesthesia services do not have CPT codes listed on the chargemaster. *See* Stipulation No. 278.

85. For anesthesia services, related drugs and supplies are billed by the Hospital on form UB-92 with drug and supply revenue codes. *See* Stipulation No. 279.

86. Many surgical procedures are performed at the Hospital on patients who are admitted to the Hospital but who are not inpatients. *See* Stipulation No. 69 and 281.

87. For outpatient surgeries, the physician bills and receives payment for the work and

malpractice components by billing on form CMS-1500 using CPT codes in the Surgery series of codes. *See* Stipulation No. 283a.

88. For outpatient surgeries, the services provided by the Hospital in order for the physician to perform the procedure are billed by the Hospital on form UB-92 using the same CPT code used by the physician on form CMS-1500. *See* Stipulation No. 283b.

89. Some surgical procedures are so complex and risky they must be performed on an inpatient basis. *See* Stipulation No. 296.

90. At the OTA hearing the Hospital's witness admitted that the equipment and facility provided by the Hospital is not always something that a physician can or will provide outside a hospital setting. *See* OTA Tr. at 21,22. Ms. Anderson testified that hospitals, rather than physicians, typically purchase expensive technology. *Id.* The Hospital is most likely to purchase a "high investment-low return on investment" piece of equipment, while physicians consider purchase of "high investment-high return" equipment. *Id.*

91. For inpatient surgery services, the physician bills for the work and malpractice component on form CMS-1500 using CPT codes. *See* Stipulation No. 298a.

92. The inpatient services provided by the Hospital in order for the physician to perform the procedure are billed by the Hospital on form UB-92. Most payers do not require that a CPT code be included on the bill. When it is required, the same CPT code used by the physician on form CMS-1500 is also used on the UB-92. *See* Stipulation No. 298b.

CONCLUSIONS OF LAW

1. Wheeling Hospital bears the burden of proof to establish that its reclassification of services from inpatient and outpatient services to physician services for which it seeks a refund is proper. *See* W.Va. Code § 11-10-9(a).

2. Article 27 of Chapter 11 of the West Virginia Code is referred to as the "West

Virginia Health Care Provider Tax Act of 1993". *See* W.Va. Code § 11-27-2.

3. Wheeling Hospital's original Broad Based Health Care tax returns listed the services in question as inpatient and outpatient services for tax years 2003 – 2006 establishing that the statutes in question are plain and unambiguous.

4. There is no evidence in the record that the Hospital's 2003–2006 returns were amended because entities or persons who paid the Hospital for inpatient and outpatient services sought a return of any portion of their payment based on a claim that the services were, in fact, physician services. Simply stated, the Hospital received gross receipts for the disputed services as inpatient and outpatient services, but now seeks to reclassify the services on its Broad Based Healthcare tax returns in order to obtain a tax refund. Thus, the ambiguity asserted by the Hospital arises solely from the Hospital's change in its legal theory.

5. Additionally, the Hospital's amended returns were not filed due to a statutory ambiguity: the language imposing the tax had not changed from the enactment of the statute in 1993 through the time of the filing of the disputed Broad Based Health Care Provider returns, and the Hospital conceded as much at oral argument.

6. In 2009, the Legislature passed a clarifying statute defining "physician services." *See* W.Va. Code § 11-27-16, effective July 10, 2009.

7. The statute by its terms clarified the definition of physician services; therefore, no change in the law occurred.

8. This Court has not applied the statutory enactment of 2009 clarifying the definition of physician services.

9. With regard to the imposition of the Health Care Provider Tax on providers, the tax on inpatient services, outpatient services and physician services, are all imposed on the gross receipts of the provider. In pertinent part, the common definition for gross receipts subject to taxation states, "'Gross receipts' means the amount received or receivable, whether in cash or in kind, from patients,

third-party payors and others for [inpatient, outpatient or physician services]. . . furnished by the provider. . .” See W.Va. Code § 11-27-9, § 11-27-15 and § 11-27-16.

10. Physician services, inpatient services, and outpatient services are separate categories of medical assistance, which Congress intended states to treat as distinct for coverage, payment, and other program purposes. See *Virginia, Dept. Of Medical Assistance Services v. Johnson*, 609 F. Supp.2d 1, 5 (D.D.C. 2009).

11. Physicians’ services are defined as those services that are physicians’ services for purposes of Section 1903(w) of the Social Security Act. See W.Va. Code § 11-27-16(c) (pre-2010). Section 1903(w) is part of subchapter XIX of the Social Security Act.

12. Under section 1396d(a)(5)(A), which provides definitions for all of subchapter XIX, physicians’ “services are services furnished by a physician.” See *California Ass’n of Rural Health Clinics v. Maxwell-Jolly*, 748 F.Supp.2d 1184, 1197(E.D. Cal. 2010) (quoting 42 U.S.C. § 1396d(a)(5)(A)). A physician is defined as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such functions or actions. See 42 U.S.C. § 1396d(a)(5)(A).

13. A physician service is defined as one rendered by a physician within the scope of practice of medicine or osteopathy as defined by State law or by someone under that physician’s personal supervision. See 42 C.F.R. § 440.50(a)(1) & (2).

14. West Virginia has a long-standing and broad prohibition against the corporate practice of medicine. See D.Cameron Dobbins, A Survey of State Laws Relating to the Corporate Practice of Medicine, 9 No. Health Law. 18, 23 (1997). Only a natural person, not a legislative one, can practice medicine in West Virginia. See, e.g., W.Va. Code § 30-3-10(b) (license to practice medicine limited to males and females). See Accord 41 C.J.S. Hospitals § 38 (“A hospital, as an entity, cannot practice medicine, diagnose illness or establish a course of treatment”). Consequently, anything done or furnished by a hospital, and not its employed physicians, is not the practice of medicine and

cannot be a physician service.

15. An inpatient service is one that is rendered to an inpatient by the hospital at the direction of a physician. *See* 42 C.F.R. § 440.10(a)(1-3).

16. An outpatient service is one by or under the direction of a physician. *Id.* § 440.20.

17. Because personal supervision and direction are two different terms, then what the doctor does and what the hospital does (and provides to the doctor) must be considered, construed, and treated as two different things. *See* Ohio Dep't of Hum. Serv., Docket No. 84-233 (Dec. No. 659)(Dep't HHS, Dept' App. Bd. June 18, 1985).

18. The Court concludes the Hospital staff that assists the physician when he performs a procedure are employees of the Hospital, who are under the physician's direction but not under his supervision. Therefore, the Hospital's provision of staff, facility, supplies and equipment is not a physician service.

19. The Court concludes that none of the services at issue were furnished by a physician or under his supervision as required under federal law to qualify as a physician service.

20. The Court concludes that while CPTs are used for physician reimbursement, that is not their only purpose. CPT codes describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation or management services of physicians, hospitals, and other health care providers. *See John V. Jacobi, Canaries in the Coal Mine: the Chronically Ill in Managed Care*, 9 Health Matrix 79, 138 n.24 (1999) and *John Dewar Gleissner, Proving Medical Expenses: Time for a Change*, 28 Am. J. Trial Advoc. 649, 651 (2005).

21. The CPT code is also used to indicate the service performed and *the amount of resources the hospital provides to the physician to perform the medical procedure*. Hence, the same code, may convey different information to the payer. *See United States ex rel. Woodruff v. Hawaii Public Health*, 560 F. Supp.2d 993, 988(D. Haw. 2008). The CPT reflects, therefore, not only *what* was done, but the hospital resources necessary to *do* it. *See Ohio Hosp. Ass'n v. Shalala*, 201 F.3d

418, 420 (6th Cir. 1999). As the CMS has, *inter alia*, explained:

•The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designated to reasonably relate the resources to the different levels of effort represented by the code.

See Melinda S. Stegman, Are National Evaluation & Management Codes for Emergency Department and Clinic Visits Really Necessary, 9 No. 5 J. Health Care Compliance 65, 76 (2007).

22. The Court concludes that CPT codes are not exclusive identifiers of physician services and are used to describe services provided by the Hospital as well as other medical practitioners. *See Stipulation No. 26, Stipulation No. 33.*

23. The Court concludes that when a CPT code is on the hospital bill for services, it describes the inpatient and outpatient services associated with a physician service or procedure, but that does not transform these services into physician services.

24. The UB-92 requests reimbursement for a hospital's technical charges, including room and board, equipment costs, nursing costs, laboratory costs, and medical supplies. *See United States ex rel. Woodruff v. Hawaii Pacific Health, 560 F. Supp.2d 988, 993 (D. Haw. 2008).*

25. The Court concludes that the Hospital's provision of its facility, drugs, supplies and equipment was not services furnished by the physician and therefore these services are inpatient and outpatient services.

26. In terms of reimbursement by Medicaid programs, physicians and hospitals are not treated alike. Separate and distinct formulas exist to determine reimbursement to physicians and hospitals respectively, indicating that Congress deliberately determined that there are distinctions between services provided by physicians and services provided by hospitals; therefore, hospital services and physician services are not equivalent. *See Tammy Lundstrom, Note, Under-reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services, Wayne L. Rev. 1243, 1249-50 (2005).*

27. West Virginia Medicaid treats hospital services and physician services differently:

(1) physicians are reimbursed (*i.e.*, make gross revenues) on a fee schedule based on a CPT code; (2) hospitals are reimbursed (*i.e.*, make gross revenues) for inpatient services based on a lump sum payment generated by the patient's categorization with a Diagnostic Related Group; and, (3) hospitals are reimbursed (*i.e.*, make gross revenues) for outpatient services based on a fee for service. *See* W.Va. State Medicaid Plan, Attachment 4.19-A; 4.19-B.2.a; 4.19-B.5.a.

28. The Court concludes that all of the services at issue were performed following admission to the Hospital.

29. The Court concluded that some of the services, *i.e.*, inpatient surgeries, are only performed at the Hospital.

30. The Court concludes that in 1991, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (hereinafter "MVCPSST") *See* Pub. L. No. 102-234, 105 Stat. 1793 (1991) which provided that for a state tax dedicated to funding a state Medicaid program to be permissible, the tax must be (1) broad-based; (2) uniformly imposed; and (3) must not hold taxpayers harmless for the costs of the tax. *See* 42 U.S.C. §§ 1396b(w)(3)(B); 1396(w)(3)(D); 1396b(w)(4).

31. If a health care tax fails any of these three tests the amount of federal matching funds will be reduced. *See Id.*, § 1396b(w)(1)(A).

32. The general purpose of the MVCPSST is to prevent states from increasing payments to providers, drawing down the federal share of the increase, and then neutralizing the provider's financial burden. *See* 2 Mark H. Gallant, Health L. Prac. Guide § 27:2 (2010).

33. A provider tax is broad based if imposed on "all items or services" in a class. *See* 42 U.S.C. § 1396b(w)(3)(B)(i).

34. A provider tax is uniform if imposed at a uniform rate "for all items and services . . . in the class." *See Id.* § 1396b(w)(3)(C)(i)(III).

35. The Taxpayer starts from a flawed premise, that the Hospital reimbursements for

overhead are actually reimbursements for physicians' services. As shown above, they are not: they are for inpatient and outpatient services. As such, the HCPT taxes all services in classes equally, all Hospital services were taxed equally, and all physicians' services were taxed equally.

36. The Court concludes that the Hospital's reliance on the Resource Based Relative Value Scale (hereinafter "RBRVS") system, which determines Medicaid reimbursement to a physician for physician services is irrelevant because the services at issue were not furnished by physicians. Furthermore, West Virginia's healthcare provider taxes are uniformly imposed on providers, which imposition has been approved by the federal government since 1993. The difference in the tax rate for physicians and inpatient and outpatient services has been approved by the release of federal matching funds to the State since the inception of the healthcare provider taxes.

37. Furthermore, the Court concludes that CMS is the federal agency charged with ensuring that State plans comply with all federal requirements prior to authorizing release of federal funding to the states. Specifically, 42 C.F.R. § 430.10 states:

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

38. The Hospital's suggestion that uniformity requires that all the disputed services should be classified as physician services because some of the procedures or visits could have occurred at a private physician's office is erroneous: (a) the services occurred at the Hospital's facility and were furnished by Hospital, and (b) none of the services occurred at a private office. Furthermore, the Court will not assume, in the absence of evidence, that some of the Hospital admissions were unnecessary.

39. The Court concludes that the Hospital's billing of a portion of the disputed services as inpatient and outpatient services to the State is especially significant. The Bureau of Medical Services (hereinafter "BMS") pays hospitals and physicians for the basic medical care provided to

our citizens who physically, medically or economically are unable to provide for their own care. As the agency responsible for ensuring proper administration of the health care of the State's disadvantaged citizens, the State of West Virginia through BMS paid the Hospital for inpatient and outpatient services that it now seeks to reclassify as physician services. BMS's payment of these services as inpatient and outpatient services is entitled to deference. See Syl. Pt. 1, *Appalachian Power, supra* and *State of Louisiana Dept. Of Health and Human Resources v. Sullivan*, 895 F.2d 809 (D.C. Cir. 1990)(Table). The Hospital's billing of the disputed services as inpatient and outpatient services and BMS's payment of the services as they were billed demonstrates that the services were Hospital services.

40. In *Children's Hospital v. State, Dept. of Health and Human Resources*, 768 N.W.2d 442 (Neb. 2009), the State and Children's Hospital disputed the amount of payment for services provided. Children's Hospital wanted the services reimbursed as a hospital service in order to obtain reimbursement on a cost-to-charge ratio rather than the fixed charge of the physician fee schedule. The Court finds *Children's Hospital* to support the Tax Commissioner's position because (1) the dispute, unlike here, occurred at the time of reimbursement; (2) the Court found the services to be hospital services because, like this case, the staff, facilities, equipment and supplies for the disputed services were provided by the hospital; (3) billing for the services was on an institutional bill form; and (4) the evidence that the services were pursuant to a hospital admission is conclusively established here while only inferred in *Children's*. Therefore, the Court concludes that the services in dispute here were hospital services.

41. The Hospital contends that because the Commissioner agreed to a refund related to lithotripsy, the Court should order the same result as to the other requests for refund. The Tax Commissioner agreed to provide this refund to the Hospital based on the fact that the Hospital had paid tax that was, in fact, owed by the lithotripsy company. The Commissioner's agreement to provide a refund under those facts does not persuade the Court that the other requested refunds are justified because the facts as to those other services are distinguishable. As to lithotripsy, the Hospital

billed for use of the third party provider's equipment and supplies, received payment, and then passed that payment along to that provider, which owed the tax. The other refund requests relate to factual situations in which the Hospital billed for the use of its own equipment, supplies, facilities, and personnel, received payment for it, and retained that payment. Thus, the Hospital was responsible for the payment of those taxes.

42. The January 5, 2000 and November 17, 2006 letters to Debra Anderson of Anderson & Roers, LLC, on which the Hospital relies, do not support Wheeling Hospital's claim for reclassification. The only type of binding opinion issued by the Tax Department is a Technical Assistance Advisory. See W.Va. Code § 11-10-5r. These letters are not Technical Assistance Advisories. Furthermore, the November 17, 2006 letter states the following: "For purposes of the Health Care Provider Tax, physicians' services are taxable at the 'physicians' services' rate to the extent they are not billed as a part of another taxable service."

43. The letter goes on to say:

Health care services provided by a physician or through outpatient clinics which provide health care services under the direct supervision and responsibility of a physician, are health care services taxable under the physicians' services classification to the extent that they are billed separately as physicians' services.

44. The Court concludes that inasmuch as the Hospital was paid gross receipts based upon its classification of the disputed services as inpatient and outpatient services, its request for reclassification of these services to be taxed on these same services as physician services resulting in a refund is contrary to the facts and the applicable laws.

45. The Court concludes that because OTA reached the correct result, this Court, consistent with *U.S. Steel Min. Co. v. Helton*, 219 W.Va. 1,3, n.3, 631 S.E.2d 559, 561 n.3 (2005) affirms the OTA decision although this Court's Order is in part grounded upon a different basis.

Entered this 15th day of August, 2011.

ENTERED IN CIVIL
ORDER BOOK 1405
PAGE 31
as dated on Order

Brenda X. Miller

CLERK OF THE CIRCUIT
COURT OF OHIO COUNTY, WV

[Signature]
Honorable Martin J. Gaughan

A copy, Teste:

Brenda X. Miller
Circuit Clerk

8/17/11
A.H.