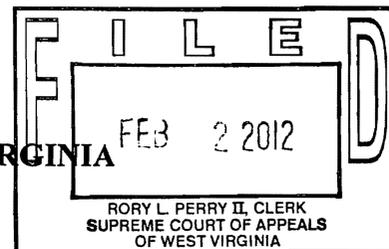


IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

NO. 11-1299



**WHEELING HOSPITAL, INC.,**

**Petitioner,**

**v.**

**CRAIG A. GRIFFITH, WEST VIRGINIA  
TAX COMMISSIONER,**

**Respondent.**

---

**BRIEF OF THE RESPONDENT CRAIG A. GRIFFITH,  
WEST VIRGINIA STATE TAX COMMISSIONER**

---

**DARRELL V. McGRAW, JR.  
ATTORNEY GENERAL**

**KATHERINE A. SCHULTZ  
SENIOR DEPUTY ATTORNEY GENERAL  
State Bar No. 3302  
CHARLI FULTON  
SENIOR ASSISTANT ATTORNEY GENERAL  
State Bar No. 1314  
State Capitol Complex  
Building 1, Room W-435  
Charleston, West Virginia 25305  
(304) 558-2522  
[kas@wvago.gov](mailto:kas@wvago.gov)  
[ccf@wvago.gov](mailto:ccf@wvago.gov)**

**TABLE OF CONTENTS**

	<b>Page</b>
I. STATEMENT OF THE CASE .....	1
A. Related cases .....	1
B. Procedural history of the case .....	2
C. Statement of facts .....	4
1. The Health Care Provider Tax, W. Va. Code § 11-27-1 et seq. ....	4
2. Standardized billing procedures for Health Care Providers .....	5
3. Billing procedures of Wheeling Hospital .....	8
II. SUMMARY OF ARGUMENT .....	15
III. STATEMENT REGARDING ORAL ARGUMENT .....	17
IV. ARGUMENT .....	18
A. Standard of review .....	18
B. The circuit court applied, rather than ignored W. Va. Code § 11-27-16, and the federal definition of “physicians’ services” by considering whether the disputed services were (1) “furnished by a physician,” (2) “[w]ithin the scope of practice of medicine or osteopathy as defined by State law,” and (3) “[b]y or under the personal supervision of an individual licensed . . . to practice medicine or osteopathy,” 42 C.F.R. 440.50(a). ....	19
1. The disputed items and services cannot be physicians’ services because they were not furnished by physicians .....	19
2. Congress intended physicians’ services, inpatient services and outpatient services to be separate and distinct and West Virginia Medicaid treats them as such .....	25

3. CPT codes are a short-hand billing tool and not an exclusive identifier of physician services ..... 32

4. The 2000 and 2006 informal letters do not support the Hospital’s position ..... 34

C. The circuit court’s order does not violate federal uniformity requirements because the disputed services are not physician services and are properly classified as inpatient and outpatient hospital services ..... 36

D. The circuit court’s order was correct; therefore, its affirmance will not have disastrous consequences for the West Virginia Medicaid program ..... 38

VII. CONCLUSION ..... 40

## TABLE OF AUTHORITIES

<b>FEDERAL CASES</b>	<b>Page</b>
<i>Krauss v. Oxford Health Plans, Inc.</i> , 517 F.3d 614 (2nd Cir. 2008) . . . . .	32
<i>Ohio Hospital Association v. Shalala</i> , 201 F.3d 418 (6th Cir.1999) . . . . .	32
<i>U.S. ex rel. Woodruff v. Hawaii Pacific Health</i> , 560 F. Supp.2d 988 (D. Hawaii 2008) . . . .	32
<i>Virginia, Department of Medical Assistance Services v. Johnson</i> , 609 F. Supp.2d 1 (D.D.C.2009) . . . . .	25
<i>Wilder v. Virginia Hospital Association</i> , 496 U.S. 498 (1990) . . . . .	36
 <b>STATE CASES</b>	
<i>Children's Hospital v. State of Nebraska, Department of Health and Human Services</i> , 768 N.W.2d 442 (Neb. 2009) . . . . .	23, 24
<i>Chrystal R.M. v. Charlie A.L.</i> , 194 W. Va. 138, 459 S.E.2d 415 (1995) . . . . .	18
<i>Davis Memorial Hospital v. West Virginia State Tax Commissioner</i> , 222 W. Va. 677, 671 S.E.2d 682 (2008) . . . . .	18
<i>In the Interest of Tiffany Marie S.</i> , 196 W. Va. 223, 470 S.E.2d 177 (1996) . . . . .	19
<i>Weaver v. Ritchie</i> , 197 W. Va. 690, 478 S.E.2d 363 (1996) . . . . .	19
 <b>STATUTES</b>	
42 C.F.R. § 430.10 . . . . .	36, 38
42 C.F.R. § 433.56 . . . . .	19, 25,37
42 C.F.R. § 440.10(a) . . . . .	20
42 C.F.R. § 440.20(a) . . . . .	21
42 C.F.R. 440.50(a) . . . . .	passim
42 C.F.R. § 498.80 . . . . .	20
42 U.S.C. § 1396b(w) . . . . .	19, 36

W. Va. Code § 11-10-3(a) .....	18
W. Va. Code § 11-10-5d(a) .....	2
W. Va. Code § 11-10-9(a) .....	18
W. Va. Code § 11-27-1 .....	4, 5, 37
W. Va. Code § 11-27-3 .....	30, 31
W. Va. Code § 11-27-4 .....	4
W. Va. Code § 11-27-9(c)(3) .....	20, 37
W. Va. Code § 11-27-15 .....	21, 37
W. Va. Code § 11-27-16 .....	passim
W. Va. Code § 11-27-19 .....	4
W. Va. Code § 11-27-32 .....	5
W. Va. Code § 11-27-33 .....	5
W. Va. Code § 11-27-36 .....	3, 5
W. Va. Code § 30-3-10(b) .....	29
<b>OTHER</b>	
2 Mark H. Gallant, <i>Health L. Prac. Guide</i> § 27:2 (2010) .....	36
41 C.J.S. <i>Hospitals</i> § 38 .....	29
American Heritage College Dictionary (3d ed. 1997) .....	22
Black's Law Dictionary (rev. 4 <sup>th</sup> ed. 1999) .....	22, 26
D. Cameron Dobbins, <i>A Survey of State Laws Relating to the Corporate Practice of Medicine</i> , 9 NO. 5 Health Law 18 .....	29
John Dewar Gleissner, <i>Proving Medical Expenses: Time for a Change</i> , 28 Am. J. Trial Advoc. 649 (2005) .....	32

John V. Jacobi, <i>Canaries in the Coal mine: the Chronically Ill in Managed Care</i> , 9 Health Matrix 79 (1999) .....	32
Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (MVCPST), Pub. L. No. 102-234, 105 Stat. 1793 (1991) .....	36
<i>Ohio Dep't of Hum. Serv.</i> , Docket No. 84-233 (Dec. No. 659) (Dep't HHS, Dep't App. Bd. June 18, 1985) .....	20
Tammy Lundstrom, Note, <i>Under-reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services</i> , Wayne L. Rev. 1243 (2005) ....	25
Rev. R.A.P. 20 .....	17

**IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA**

**NO. 11-1299**

**WHEELING HOSPITAL, INC.,**

**Petitioner,**

**v.**

**CRAIG A. GRIFFITH, WEST VIRGINIA  
TAX COMMISSIONER,**

**Respondent.**

**BRIEF OF THE RESPONDENT CRAIG A. GRIFFITH,  
WEST VIRGINIA STATE TAX COMMISSIONER**

**I. STATEMENT OF THE CASE**

**A. Related cases**

This case raises the legal issue of whether hospital-provided services previously reported on Health Care Provider Tax (hereinafter HCPT) returns as inpatient and outpatient services (and billed and reimbursed as such) may lawfully be reclassified on amended tax returns as physicians' services, thereby reducing the applicable tax rate and resulting in substantial refunds to hospitals. Wheeling Hospital's Notice of Appeal states that there are no related cases currently pending in the Supreme Court or in a lower tribunal. In fact, however, there are numerous claims pending at the Office of Tax Appeals (hereinafter OTA) and the Tax Department that raise the same issue as is presented in this case. The same consultant that advised Wheeling Hospital that it could amend its tax returns to reclassify the services provided the same advice to other hospitals. App. R. vol. 1, p. 133 ("This letter accompanies amended tax returns our firm is filing on behalf of a number of hospitals we work with in West Virginia, advising them regarding their Broad Based Tax Return.")

Because W. Va. Code § 11-10-5d(a) makes tax returns and return information confidential, detailed information about the status of each case cannot be provided. However, the following general information may be provided: fourteen (14) hospitals have filed amended tax returns seeking refunds based on reclassification of inpatient and outpatient hospital services to physicians' services. The 59 amended returns thus far received seek refunds that total \$34.4 million, excluding interest.<sup>1</sup> The interest that would be due on these refunds is approximately \$8.0 million as of February 1, 2012.

The outcome of the instant case will decide all these claims. The hospitals with claims pending at OTA have all agreed to be bound by the outcome of this case. Similarly, the Tax Department is holding the remaining claims in abeyance and will decide whether or not to provide refunds based on this Court's decision in the instant case. Because refunds may be claimed for three years after filing, additional claims covering the 2009 through 2011 tax years may still be filed.

**B. Procedural history of the case<sup>2</sup>**

Wheeling Hospital, Inc. (hereinafter the Hospital) is a licensed West Virginia hospital located at 1 Medical Park, Wheeling, West Virginia 26003. App. R. vol. 2, 1311, ¶ 1. Certain of the Hospital's revenues are subject to the taxes imposed under the HCPT. App. R. vol. 2, 1311, ¶ 2. Revenues subject to the tax are reported on a form called the Broad Based Health Care tax return.

---

<sup>1</sup> This amount includes the \$2,185,937 refund that Wheeling Hospital seeks in the instant case. Stipulation 15, App. R. vol. 1, p. 90.

<sup>2</sup> The facts in this section are taken from the circuit court's findings of fact, which are not disputed by the Hospital.

App. R. vol. 2, 1312-13, ¶ 13. The Hospital now disputes the HCPT for the years 2003 through 2006. App. R. vol. 2, 1312, ¶ 5.

The Hospital originally reported gross receipts for the disputed services as inpatient and outpatient services on its Broad Based Health Care tax returns. App. R. vol. 2, 1312-13, ¶¶ 11, 14. During those years, the tax rate on the gross receipts of inpatient and outpatient service remained constant at 2.5%; however, the tax rate on the gross receipts for physicians' services declined from 1.8% to 0.8% during that period.<sup>3</sup> App. R. vol. 2, 1312-13, ¶¶ 12, 13.

In October 2006, the Hospital filed an amended Broad Based Health Care Tax return for fiscal year 2003, requesting a refund of \$484,188. App. R. vol. 2, 1313, ¶ 15. Two months later, the Hospital filed amended returns for fiscal years 2004 and 2005, requesting refunds of \$687,101 and \$800,986 respectively. App. R. vol. 2, 1313, ¶ 16. In these returns, 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 physicians' services. App. R. vol. 2, 1313, ¶ 20.

After receiving the amended returns, the Tax Department performed a field audit for the years in question. App. R. vol. 2, 1313, ¶ 17. 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. App. R. vol. 2, 1313, ¶ 18. 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. App. R. vol. 2, 1313, ¶ 19.

---

<sup>3</sup> W. Va. Code § 11-27-36.

The Hospital appealed this decision to OTA, which affirmed the Tax Department's decision. App. R. vol. 2, 933-57. Thereafter, the Hospital appealed OTA's decision to the Circuit Court of Ohio County, which affirmed on different grounds. App. R. vol. 2, 1309-30.

**C. Statement of facts**

**1. The Health Care Provider Tax, W. Va. Code § 11-27-1 et seq.<sup>4</sup>**

The West Virginia Health Care Provider Tax Act (HCPT) is codified at W. Va. Code § 11-27-1 *et seq.*, with each tax therein designated as an annual broad-based health care related tax. App. R. vol. 2, 1311, ¶2. For the years at issue in this case, 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 services 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.<sup>5</sup> App. R. vol. 2, 1311, ¶ 3. From 1993, when the HCPT was enacted through 2010, the taxes had been imposed on the gross receipts of inpatient services and outpatient services; from 1193 to 2010 they were imposed on the gross receipts of physician services. App. R. vol. 2, 1311-12, ¶ 4.

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

---

<sup>4</sup> The facts in this section are taken from the Circuit Court's Findings of fact, which are not disputed by the Hospital.

<sup>5</sup> W. Va. Code § 11-27-4 through § 11-27-19.

providers are adequately compensated to ensure the provision of these medical services.<sup>6</sup> App. R. vol. 2, 1312, ¶ 6. The revenue received from the HCPT is deposited into a special revenue fund in the State Treasurer's Office known as the Medicaid State Share Fund.<sup>7</sup> App. R. vol. 2, 1312, ¶ 7. 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.<sup>8</sup> App. R. vol. 2, 1312, ¶ 7.

Since the enactment of the HCPT, the rate of tax on physician services has always been lower than the rate for hospital services. App. R. vol. 2, 1312, ¶ 9. 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. App. R. vol. 2, 1312, ¶ 10. Beginning in 2000, there was a gradual reduction in the tax rate on physician services until the tax on physician services was completely eliminated in 2010.<sup>9</sup> App. R. vol. 2, 1312, ¶ 5.

## **2. Standardized billing procedures for Health Care Providers<sup>10</sup>**

Standardized forms are used by health care providers to bill services to third party payers, including Medicare, Medicaid, and insurance payers. Stipulation 17, App. R. vol. 1, 91. Form UB-92, developed by the National Uniform Billing Committee, is the standard billing form that is used nationwide by institutional health care providers such as hospitals and nursing homes. App. R. vol.

---

<sup>6</sup> W. Va. Code §11-27-1.

<sup>7</sup> W. Va. Code §11-27-32.

<sup>8</sup> W. Va. Code §11-27-33.

<sup>9</sup> W. Va. Code § 11-27-36(j).

<sup>10</sup> The facts in this section are taken from the Circuit Court's Findings of Fact, App. R. vol. 2, 1311-22, which are not disputed by the Hospital, and the Joint Stipulations of Fact, App. R. vol. 1, 87-123.

1, 91, Stipulations 18, 19; App. R. vol. 2, 1314, ¶ 25. Form CMS-1500, maintained by the National Uniform Claim Committee, is the standard billing form designed to be used by non-institutional health care providers, including physicians. App. R. vol. 2, 1314, ¶ 24. However, it is also used by hospitals for some billings. *Id.*

**CPT Codes:** The Centers for Medicare & Medicaid Services (CMS), a federal agency, is responsible for maintaining a coding system for the processing of Medicare and Medicaid health care claims. App. R. vol. 1, 91, Stip. 22. The coding system, Current Procedural Terminology (CPT), consists of descriptive terms and identifying codes that are *primarily* used to identify medical services and procedures furnished by physicians and other health care professionals. App. R. vol. 2, 1315, ¶ 32 (emphasis in original). CPT codes are used throughout the United States by other third party payers as the preferred method of coding and describing health care services. Stipulation 29, App. R. vol. 1, 92. CPT codes cover only professional health care services and related items. Stipulation 30, App. R. vol. 1, 92. Hospitals use CPT codes when applicable in grouping hospital charges included on a hospital bill. App. R. vol. 2, 1315, ¶ 33. Thus, CPT codes are not exclusive identifiers of physician services. App. R. vol. 2, 1315, ¶ 34.

**CDM Codes:** Every service, supply, and drug provided by a hospital or other health care provider has a charge description master code (CDM code) unique to that health care provider. App. R. vol. 2, 1315, ¶ 28. The amount listed as the CDM for each service includes a mark-up over the original cost of providing the service. App. R. vol. 2, 1315, ¶ 29. 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. App. R. vol. 2, 1315, ¶ 30. 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. *Id.* On the chargemaster, the CDM codes that require the service to be performed or directly supervised by a physician have related CPT codes, except for surgical procedures. Stipulation 40, App. R. vol. 1, 93. Because there are so many potential types of surgical procedures, hospital medical coding departments add the CPT codes when the payer requires this level of detail in billing. *Id.*

**Physician’s Fee Schedule:** The Centers for Medicare & Medicaid Services annually prepare and publish the Physician’s Fee Schedule, which establishes the amount that Medicare will reimburse for each type of service provided by physicians. Stipulation 46, App. R. vol. 1, 94. The Schedule lists the physician services by CPT code. *Id.* The three resources used to compute a physician service’s reimbursable value are (1) the work required, (2) the practice expense (non-facility or facility), and (3) malpractice insurance expense. Stipulation 51, App. R. vol. 1, 94.

The practice expense component reflects the physician’s overhead, including facility, clinic staff, incidental drugs and supplies, and medical equipment. Stipulation 53, App. R. vol. 1, 94. The Physician’s Fee Schedule contains two columns for the practice expense component—a facility column and a non-facility column. Stipulation 54, App. R. vol. 1, 94. The facility column covers services provided in a hospital or skilled nursing facility; the non-facility column covers services provided in a physician’s office. Stipulation 55, App. R. vol. 1, 94.

In many cases, when a physician service is provided in a hospital or other facility rather than in the physician’s office, the practice expense/overhead component is reduced because the hospital or other facility bears all or some of the practice expense/overhead costs incurred from the provision of that physician service. Stipulation 56, App. R. vol. 1, 95. When the physician service is provided

in a facility owned by a hospital, by a physician who is employed by the hospital, the hospital bills and receives payment for the work and malpractice components of the physician fee. Stipulation 59, App. R. vol. 1, 95. Correspondingly, when the physician service is provided in a facility owned by a hospital, by a physician who is not employed by the hospital, the physician bills and receives payment for the work and malpractice components of the physician fee. Stipulation 60, App. R. vol. 1, 95.

### **3. Billing procedures of Wheeling Hospital<sup>11</sup>**

When a patient visits any facility owned by Wheeling Hospital for any type of service, the registration process includes admission as a patient of the Hospital. App. R. vol. 2, 1314, ¶ 23. Admission is required in order for the Hospital to bill any charges with respect to the patient. *Id.* All disputed services in this case were provided pursuant to hospital admissions, and there is no evidence that the hospital admissions were inappropriate or that the services furnished during these admissions were not ordinarily furnished in hospital settings. App. R. vol. 1, 526.

Some insurers, including Medicare and Medicaid, pay for services provided to *inpatients* based on the patient's diagnosis. App. R. vol. 2, 1314, ¶ 26 (emphasis added). The amount such insurers will pay for services in connection with that diagnosis is based on the usual amount and type of services required for treatment. *Id.* If services or other items are required beyond what is normal, those things are paid for separately, if covered. *Id.* Some insurers, including Medicare, pay for services provided to *outpatients* by categorizing procedures and services according to similarities in costs and clinical characteristics. App. R. vol. 2, 1314-15, ¶ 27 (emphasis added). The category

---

<sup>11</sup> The facts in this section are taken from the circuit court's findings of fact, App. R. vol. 2, 1311-22, which are not disputed by the Hospital, and the Joint Stipulations of Fact, App. R. vol. 1, 87-123.

or group determines the amount of reimbursement for a specific service. *Id.* The Hospital's bill, on form UB-92, lists CPT codes for use if the insurer requires them. App. R. vol. 2, 1316, ¶ 36.

There is no dispute that when a physician performs a *procedure*, in the Hospital or a facility owned by the Hospital, the health care provider tax imposed on the performance of this procedure is properly taxed as a physician service because the physician receives payment for the procedure. App. R. vol. 2, 1313, ¶ 21 (emphasis added). Thus, physicians receive payment and are taxed for reading and interpreting laboratory reports, performing outpatient breast biopsies and other procedures at Women's Health Center/Breast Center, performing outpatient cardiac catheterizations, performing inpatient dialysis at the Hospital, performing outpatient dialysis at freestanding renal dialysis facilities, and performing outpatient and inpatient surgical procedures. *Id.* Likewise, there is no dispute that physicians' provision of service for hospital or clinic *visits* to patients was properly taxed at the physician service rate because the physicians who made the visits received payment for them. App. R. vol. 2, 1314, ¶ 22 (emphasis added). Thus, physicians receive payment and are taxed for visits to Women's Health Center/Breast Center, Wound Care Center, and Sleep Lab and for treatment provided at Oncology Center/Nuclear Medicine. *Id.*

When the Hospital provides the overhead, *i.e.*, the facility, staff, incidental drugs and supplies, and medical equipment, as it has in the disputed services, and bills on the UB-92, the Hospital instead of the physician receives payment for this overhead.<sup>12</sup> App. R. vol. 2, 1316, ¶ 38; Stipulation 53, App. R. vol. 1, 94. The Hospital uses CPT codes on its bill to reflect the overhead

---

<sup>12</sup> The stipulations use the term "practice expense" to describe the overhead provided by the Hospital. App. R. vol. 2, 1316, ¶ 38. The circuit court found that use of the term "practice expense" did not transform the Hospital's provision of inpatient and outpatient services into a physician's service. *Id.*

that the Hospital provides in connection with a service or procedure provided by a physician. App. R. vol. 2, 1315, ¶ 35.<sup>13</sup>

**Women's Health Center/Breast Center:** The Women's Health Center/Breast Center (Women's Health Center) is located at a Medical Office Building that is owned by the Hospital. App. R. vol. 2, 1316, ¶ 39; Stipulation 126, App. R. vol. 1. When the physician provided a clinic visit 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. App. R. vol. 2, 1316, ¶ 40. However, he was not paid for all of the overhead associated with the visit and/or procedure because visit/procedure occurred at the Hospital's facility. *Id.* Because the Hospital provided the facility and other overhead (staff, incidental drugs and supplies, medical equipment) related to these visits/procedures at the Women's Health Center, the Hospital billed for its provision of these services on a UB-92 using the same CPT codes utilized by the physician and received payment for this overhead expense. App. R. vol. 2, 1316, ¶ 41.

Similarly, the Wound Care Center, Oncology Center, and Sleep Lab are all located in Hospital-owned facilities. App. R. vol. 2, 1316-17 ¶¶ 42, 45, 49; Stipulation 126, App. R. vol. 1, 103. These facilities all have physicians who bill for their work and malpractice components and are not reimbursed for all the overhead. App. R. vol. 2, 1316-17, ¶¶ 43, 46, 47, 50. The Hospital provides the overhead in all these facilities and bills for the provision of this expense on UB-92 using the same CPT codes used by physicians. App. R. vol. 2, 1317-18, ¶¶ 44, 48, 51.

---

<sup>13</sup> 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. App. R. vol. 2, 1320, ¶ 75. 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. *Id.*

**Outpatient Cardiac Catheterization:** 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. App. R. vol. 2, 1318, ¶ 52. However, the physician was not paid for all of the overhead associated with the visit because the treatment occurred at a Hospital facility. *Id.* Because the Hospital provided the facility and other overhead (staff, incidental drugs and supplies, medical equipment) 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 and received the payment for this overhead expense. App. R. vol. 2, 1318, ¶ 53.

**Hospital Pathology Services:** The Hospital has a pathology lab that analyzes tissue specimens for signs of disease. Stipulation 225, App. R. vol. 1, 115. For the tax years in question the Hospital employed pathologists. App. R. vol. 2, 1318, ¶ 54. The Hospital's billing for pathology services differs depending upon the payer. App. R. vol. 2, 1318, ¶ 55. 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. *Id.* Because the pathologists are employed by the Hospital, most non-Medicare payers require that all three components—physician work, malpractice expense, and practice expense/overhead—be billed on a UB-92. App. R. vol. 2, 1318, ¶ 56. Because the pathologists are Hospital employees, the Hospital received the entire payment for all three components of the Physician Fee Schedule charge. App. R. vol. 2, 1318, ¶ 57.

**Renal Dialysis Treatments:**<sup>14</sup> The Hospital has a joint venture with a group of physicians who provide renal dialysis treatments. App. R. vol. 2 , 1318, ¶ 58. The joint venture is a separate entity and provides the facility, equipment, staff, drugs and supplies necessary to provide renal dialysis treatments. App. R. vol. 2, 1319, ¶ 59. The joint venture currently owns and operates three free-standing renal dialysis facilities. Stipulation 239, App. R. vol. 2, 116. Before the creation of the joint venture, the Hospital owned a dialysis center as a division of the Hospital. Stipulation 237, App. R. vol. 1, 116. The physicians who provide the renal dialysis services are neither employed by the joint venture nor by the Hospital. App. R. vol. 2, 1319, ¶ 60.

When a person who has been admitted to the Hospital needs dialysis during the admission, the same physicians who provide treatments at the joint venture renal dialysis facilities provide the dialysis treatment in the Hospital. App. R. vol. 2, 1319, ¶ 61. When this happens, the joint venture bills the Hospital for the renal dialysis treatment provided, and the Hospital bills the patient. App. R. vol. 2, 1319, ¶ 62. The physician who provides dialysis bills Wheeling Hospital's inpatients for the work and malpractice components. App. R. vol. 2, 1319, ¶ 63. The Hospital, as part of the dialysis joint venture, provided the equipment, supplies, staff, and other overhead for the procedure. App. R. vol. 2, 1319, ¶ 64. Because the Hospital provided the facility and overhead related to the inpatient 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. App. R. vol. 2, 1319, ¶ 65. The Hospital received the payment for the remaining overhead expense. *Id.*

---

<sup>14</sup> Lithotripsy – The Tax Commissioner agreed to the refund requested by Wheeling Hospital at OTA, and thus it is no longer in dispute.

### **Emergency Room Services:**

**Hospital-Employed Physicians:** During some periods related to this case, emergency room services were provided by hospital-employed physicians. App. R. vol. 2, 1320, ¶ 76. Billing practices as to hospital-employed physicians differ depending on whether the payer is Medicare or non-Medicare. App. R. vol. 2, 1321, ¶ 77. Medicare requires two billings: part on form CMS-1500, the remainder on form UB-92. App. R. vol. 2, 1321, ¶ 78. Both billings include the CPT codes. *Id.* Most non-Medicare payers require that the entire billing occur on form UB-92. App. R. vol. 2, 1321, ¶ 79. The Hospital receives the payment for all three components of the Physician Fee Schedule, including related drugs and supplies, as to these hospital-employed physicians. App. R. vol. 2, 1321, ¶ 80.

**Independent Physicians:** At other times related to this case, emergency room services were provided by independent physicians, that is, physicians who were not employed by the Hospital. App. R. vol. 2, 1320, ¶ 76. When independent physicians provide emergency room services, the physician bills and is paid for the services by billing on form CMS-1500. App. R. vol. 2, 1321, ¶ 81. The Hospital bills with the same CPT codes used on the physician billing on form UB-92. App. R. vol. 2, 1321, ¶ 82. The Hospital receives payment for the support services and supplies provided to the patient being seen by the physician. *Id.*

**Anesthesia Services:** In order to bill anesthesia services, a number of variables need to be considered before a CPT code can be assigned. App. R. vol. 2, 1321, ¶ 83. The number of codes that can apply is too large to reasonably include in the chargemaster. *Id.* Accordingly, anesthesia services do not have CPT codes listed on the chargemaster. App. R. vol. 2, 1321, ¶ 84. For

anesthesia services, related drugs and supplies are billed by the Hospital on form UB-92 with drug and supply revenue codes. App. R. vol. 2, 1321, ¶ 85.

**Outpatient Surgery:** Many surgical procedures are performed at the Hospital on patients who are admitted to the Hospital but who are not inpatients. App. R. vol. 2, 1321, ¶ 86. 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. App. R. vol. 2, 1321-22, ¶ 87. 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. App. R. vol. 2, 1322, ¶ 88.

**Inpatient Surgery:** Some surgical procedures are so complex and risky they must be performed on an inpatient basis. App. R. vol. 2, 1322, ¶ 89. 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. App. R. vol. 2, 1322, ¶ 90. 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.* For inpatient surgery services, the physician bills for the work and malpractice component on form CMS-1500 using CPT codes. App. R. vol. 2, 1322, ¶ 91. The inpatient services provided by the Hospital in order for the physician to perform the surgery are billed by the Hospital on form UB-92. App. R. vol. 2, 1322, ¶ 92. Most payers do not require that a CPT code be included on the bill. *Id.* When it is required, the same CPT code used by the physician on form CMS-1500 is also used on the UB-92. *Id.*

## II. SUMMARY OF ARGUMENT

When a person is admitted to a hospital, whether as an inpatient or outpatient, he typically receives two bills – one from the physician for his services, one from the Hospital for its services. In this case, the Hospital seeks to change services it provided, billed, and was paid for into physician services, although the services were not provided by, billed by or paid to a physician.

The Tax Commissioner has faithfully ensured the proper collection of Health Care Provider Taxes in this case to obtain and preserve the substantial federal matching funds that are paid to all health care providers who furnish care to disadvantaged West Virginians. It is undisputed that the provider taxes collected must comply with the federal definition for each service taxed or federal funding may be lost. In this case, Wheeling Hospital seeks to reclassify services it originally billed and reported for tax purposes as inpatient and outpatient services as physician services. Thus, Wheeling Hospital's characterization of the Tax Commissioner's actions as arbitrarily shaking it down or robbing it is completely off-base. More to the point, the Hospital correctly reported its provision of the facilities, staff, drugs and equipment as either inpatient and outpatient services on its original tax returns.

Contrary to the Hospital's assertion, the Tax Commissioner and the Circuit Court did not rewrite or ignore federal law. Federal law requires that a physician provide physician services. Thus, the Hospital can only provide physician services through its employees, which is not the issue. With regard to the disputed services, the Hospital furnished the overhead (facility, staff, drugs and medical equipment) to an independent physician; therefore, the threshold requirement that a physician furnish the service has not been met. The numerous stipulations reflecting that independent physicians' practice of medicine in the Hospital or clinic was a physician service demonstrates that where the

9

service was provided is not controlling. However, the identity of the provider of the service is controlling: physician services must be provided by physicians.

In making its claim that the inpatient and outpatient hospital services provided by the Hospital are physician services, the Hospital ignores the fundamental fact that under West Virginia law a hospital cannot practice medicine. This is important because federal law applies state law to define the practice of medicine. Thus, the Circuit Court's application of state law defining the practice of medicine met the requirement of the controlling law: had the Circuit Court not applied the West Virginia definition for the practice of medicine, there would have been no definition to apply.

The Hospital next argues that the presence of CPT codes, an accepted billing device for physicians and hospitals on the Hospital's bills, is a definer of physician service to the exclusion of inpatient and outpatient services. This argument is wrong on its face and would abrogate the federal regulation defining physician services. If the controlling federal regulation meant to define a physician service by reference to a CPT code on an invoice, then it would have done so.

Finally because Wheeling Hospital's original classification of overhead as an inpatient or outpatient service was proper, federal matching funding is not at risk if its reclassification is denied. Rather, Wheeling Hospital's reclassification is contrary to federal law and could cause a reduction in federal funding with sweeping implications. Thus, the Tax Commissioner's denial of the reclassification and the Circuit Court of Ohio County's affirmance should not be disturbed by this Court. A reversal risks loss of federal funding and would severely limit the reach of the Health Care Provider Taxes on inpatient and outpatient services.

### III. STATEMENT REGARDING ORAL ARGUMENT

The Tax Commissioner seeks oral argument under Rev. R.A.P. 20 because the appeal raises an issue of fundamental public importance: a reversal by this Court could certainly result in substantial shortfalls to the State's Medicaid budget. If hospital services previously reported on Health Care Provider Tax (HCPT) returns as inpatient and outpatient hospital services may lawfully be reclassified on amended tax returns as physicians' services, this will reduce the tax rate on these services from 2.5% to 0.0%. (During the tax years at issue in the instant case, the rate on physicians' services declined from 1.8% to 0.8%, before being phased out completely in 2010.) Furthermore, the effect of a reversal in the instant case would not be limited to the refund sought by Wheeling Hospital, to the \$34.4 million total of protected claims pending, or even to future claims that could still be filed for the 2008 through 2011 tax years. As this Court has recognized, the Health Care Provider Tax revenues are paid into the Medicaid State Share Fund and used as the State's share that is required to receive matching funds from the federal government. Because of this, a reversal by this Court could create a substantial shortfall in the Medicaid budget, thereby depriving poor and medically needy West Virginia citizens of needed medical services, contrary to the law. Moreover, because West Virginia's Medicaid program generally consists of 75% federal monies, each West Virginia share dollar refunded may result in CMS's recoupment of a portion of the match received, thereby resulting in less revenue being available in the future. *See West Virginia Department of Health and Human Services Amicus Curiae Brief in Support of the Respondent, Craig A. Griffith, Tax Commissioner and Affirmance of the Order Below*, at 3.

## IV. ARGUMENT

### A. Standard of review

West Virginia Code § 11-10-9 establishes the hearing procedures applicable to petitions for reassessment and petitions for refunds. It provides, in pertinent part,

If the hearing is on a petition for reassessment the burden of proof shall be upon the taxpayer to show the assessment is incorrect and contrary to law, either in whole or in part. If the hearing is on a petition for refund or credit, the petitioner shall also have the burden of proof.

W. Va. Code § 11-10-9(a).<sup>15</sup> In the instant case, the Hospital petitioned for a refund based on its amended tax returns. Thus, it has the burden of proving that its original tax returns, which reported the disputed services as inpatient and outpatient services, were incorrect and that its amended/current reporting of the services as physicians' services is correct.

The Hospital's assignments of error raise two legal questions: (1) whether the circuit court used an incorrect legal standard by ignoring the federal definition of "physicians' services" and (2) whether the circuit court's use of that incorrect legal standard resulted in a violation of the federal requirement of uniformity in taxation. Questions of law decided by the circuit court are reviewed *de novo*. *Davis Memorial Hospital v. West Virginia State Tax Commissioner*, 222 W. Va. 677, 671 S.E.2d 682 (2008), citing *Chrystal R.M. v. Charlie A.L.*, 194 W. Va. 138, 459 S.E.2d 415 (1995). The Hospital does not dispute any of the circuit court's findings of fact. Nor could it – the findings

---

<sup>15</sup> "The provisions of [Chapter 11, Article 10] apply to . . . health care provider taxes . . ." W. Va. Code § 11-10-3(a).

are based almost exclusively on the joint stipulations of fact that were entered into evidence at the Office of Tax Appeals hearing below.<sup>16</sup>

**B. The circuit court applied, rather than ignored W. Va. Code § 11-27-16, and the federal definition of “physicians’ services” by considering whether the disputed services were (1) “furnished by a physician,” (2) “[w]ithin the scope of practice of medicine or osteopathy as defined by State law,” and (3) “[b]y or under the personal supervision of an individual licensed . . . to practice medicine or osteopathy,” 42 C.F.R. 440.50(a).**

**1. The disputed items and services cannot be physicians’ services because they were not *furnished* by physicians.**

This case involves the classification, for HCPT purposes, of three types of Medicaid-reimbursable health care services: (1) inpatient hospital services, (2) outpatient hospital services, and (3) physicians’ services. Section 1903(w) of the Social Security Act, codified at 42 U.S.C. § 1396b(w), establishes standards for state-enacted health care provider taxes. The statute provides nine classes of Medicaid-reimbursable health care items and services that may be covered by a health care provider tax.<sup>17</sup> 42 U.S.C. § 1396b(w)(7)(A)(i)-(ix). Inpatient hospital services, outpatient hospital services, and physicians’ services are included as separate classes. 42 U.S.C. § 1396b(w)(7)(A)(i),- (ii),-(v).

---

<sup>16</sup> This court reviews a circuit court’s findings of fact including mixed facts/law findings under the clearly erroneous standard. *Weaver v. Ritchie*, 197 W. Va 690, 478 S.E.2d 363 (1996). Under this standard, a finding is clearly erroneous when, “although there is evidence to support the finding, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed.” *Id.*, at 693 n.11, 478 S.E.2d at 366 n.11, quoting *In the Interest of Tiffany Marie S.*, 196 W. Va. 223, 231, 470 S.E.2d 177, 185 (1996).

<sup>17</sup> The last class is a catch-all, *viz*, “[s]uch other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.” 42 U.S.C. § 1396b(w)(7)(A)(ix). In accordance with this authorization, the Secretary has established additional classes of services. The implementing regulation lists 19 separate classes of health care items or services. 42 C.F.R. § 433.56(a)(1)-(19).

The definitions for these services are found in the Medicaid implementing regulation. The rule defines inpatient hospital services as follows:

(a) Inpatient hospital services means services that –

(1) Are ordinarily *furnished* in a hospital for the care and treatment of inpatients;

(2) Are *furnished* under the direction of a physician or dentist; and

(3) Are *furnished* in an institution that –

(i) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(ii) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting;

(iii) Meets the requirements for participation in Medicare as a hospital; and

(iv) Has in effect a utilization review plan, applicable to all Medicaid patients, that meets the requirements of § 482.30 of this chapter, unless a waiver has been granted by the Secretary.

42 C.F.R. § 440.10(a) (emphasis added).<sup>18</sup> The West Virginia Health Care Provider Act defines inpatient hospital services to be “those services that are inpatient hospital services for purposes of Section 1903(w) of the Social Security Act,” thereby incorporating the federal definition by reference. W. Va. Code § 11-27-9(c)(3).

---

<sup>18</sup> Obviously, the Hospital staff take direction from the physician, but the physician is not the hospital employees’ personal supervisor. *Ohio Dep’t of Hum. Serv.*, Docket No. 84-233 (Dec. No. 659) (Dep’t HHS, Dep’t App. Bd. June 18, 1985) (“We are not inclined to conclude lightly that ‘at the direction of’ means the same thing as ‘under the personal supervision of’”); [The Department of Health and Human Services Department Appeals Board is the highest administrative adjudicator in the Medicaid process. 42 C.F.R. § 498.80.].

The Medicaid rule defines outpatient hospital services as follows:

(a) Outpatient hospital services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that –

(1) Are *furnished* to outpatients;

(2) Are *furnished* by or under the direction of a physician or dentist;  
and

(3) Are *furnished* by an institution that –

(i) Is licensed or formally approved as a hospital by an officially designated authority for State standard-setting; and

(ii) Meets the requirements for participation in Medicare as a hospital; and

(4) May be limited by a Medicaid agency in the following manner: A Medicaid agency may exclude from the definition of “outpatient hospital services” those types of items and services that are not generally furnished by most hospitals in the State.

42 C.F.R. § 440.20(a) (emphasis added). The West Virginia HCPT Act defines outpatient hospital services to be “those services that are outpatient hospital services for purposes of Section 1903(w) of the Social Security Act,” thereby incorporating the federal definition by reference. W. Va. Code § 11-27-15(c)(3).

The Medicaid rule defines physicians’ services as follows:

(a) “Physicians’ services,” whether *furnished* in the office, the recipient’s home, a hospital, a skilled nursing facility, or elsewhere, means services *furnished* by a physician –

(1) Within the scope of practice of medicine or osteopathy as defined by State law; and

(2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

42 C.F.R. § 440.50(a) (emphasis added). For the years at issue in the instant case, the West Virginia HCPT Act defined physicians' services to be "those services that are physicians' services for purposes of Section 1903(w) of the Social Security Act," thereby incorporating the federal definition by reference. W. Va. Code § 11-27-16(c)(3).<sup>19</sup>

The federal definitions that the West Virginia Legislature incorporated into the HCPT Act all hinge on who, where, and how the medical items or services are "furnished." The term "furnish" means "to supply or provide . . . to provide for, to provide what is necessary for . . . to deliver, whether gratuitously or otherwise . . . ." Black's Law Dictionary (rev. 4<sup>th</sup> ed. 1999), p. 804.<sup>20</sup> In common usage, furnish means "to equip with what is needed . . . to supply, give." American Heritage College Dictionary (3d ed. 1997), p. 552.

In the instant case, the disputed services are overhead costs – that is, facility, staff, incidental drugs and supplies, and medical equipment. All of them were provided by the Hospital pursuant to an admission either as an inpatient or an outpatient. Stipulation 69, App. R. vol. 1, 96. Applying the above definitions to the disputed gross receipts of the Hospital, the proper analysis focuses on who provided the disputed items. For services that are ordinarily provided in a hospital – inpatient surgery, pathology, emergency room services, and the like – the disputed receipts are inpatient hospital services because the Hospital provided the facility, the staff, the incidental drugs and medical

---

<sup>19</sup> In 2009, the HCPT Act was amended to clarify the definition of physicians' services. Because the clarifying statute is consistent with federal law, the Tax Commissioner did not rely on it at the circuit court. Judge Gaughan found as a matter of law that the definition of physician services adopted in 2009 clarified the definition of physician services and as a result no change in the law occurred. Conclusion of Law 7, App. R. vol. 2, 1323. Therefore, the Court did not apply the clarifying statute. Conclusion of Law 8, App. R. vol. 2, 1323. Wheeling Hospital agrees that the clarifying statute does not apply. Petitioner's Brief, 13 n. 9; App. R. vol. 2, 1266.

<sup>20</sup> The current edition of Black's Law Dictionary contains no definition of the term.

supplies, and the medical equipment used for the treatment. Likewise, for services provided to outpatients by a hospital, by or under the direction of a physician, the gross receipts from overhead are outpatient services because the Hospital provided the facility, staff, etc.

For the disputed gross receipts from overhead to have been physicians' services, they would have to have been provided by physicians, and physicians rather than the Hospital would have been paid for them. Because they were not provided by the physicians, but rather by the Hospital or hospital-owned facilities, they were not physicians' services, and the circuit court correctly concluded that they had been properly identified as inpatient and outpatient hospital services in the original tax returns.

In *Children's Hospital v. State of Nebraska, Department of Health and Human Services*, 768 N.W.2d 442 (Neb. 2009), the Nebraska Supreme Court considered whether services provided to two of the hospital's patients in the hospital's hematology/oncology clinic were properly billed as outpatient hospital services or whether they should have been billed as physicians' services. *Id.* at 443-444. The hospital billed the services to Medicaid as outpatient hospital services, but Medicaid asserted that they were physician services.<sup>21</sup> The court below had affirmed Medicaid's position based on a conclusion that the facility where the treatment was provided was a "healthcare practitioner facility," which is excluded from the definition of "hospital." *Id.* at 445. Medicaid also argued that it could reduce payment for outpatient services to "the amount payable at the least expensive appropriate place of service." *Id.* at 445.

---

<sup>21</sup> The Court recognized that its decision as to the proper classification of services would affect the reimbursement the hospital received "because Medicaid reimburses expenses for hospital services on a cost-to-charge percentage, while expenses for practitioner services are reimbursed via a fixed fee schedule." *Id.* at 444.

The Supreme Court rejected the lower court’s analysis based on where the services were provided, *id.* at 447, and instead focused on whether the services at issue met the Medicaid definition of “outpatient hospital services.” *Id.* at 446.

“Hospital outpatient services” are defined by Medicaid regulations as “[p]reventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients under the direction of a physician or dentist in an institution that meets the standards for participation.

*Id.* The Supreme Court noted that there was evidence that the patients had been registered as outpatients, that the clinic met the standards for Medicaid participation, and that the patients were provided “preventive, diagnostic, therapeutic, rehabilitative, or palliative services” under the direction of a physician. *Id.* Importantly, the court also noted that “[n]o doctor was directly involved in the treatment of either [patient]” as to the disputed services – that is, no physician *provided* the services at issue. *Id.* at 444. The Court concluded,

[O]ur concern is not with *where* the services were provided, but, instead, our concern lies with the *nature* of the services actually provided. And we have concluded that those services met the definition of “hospital outpatient services.” Whether those services could have been delivered by a practitioner and thus properly billed on the practitioner form is a separate question.

*Id.* at 447.

In the instant case, the Hospital has not suggested that any of the services in dispute have occurred or should have occurred elsewhere, nor has it suggested that the services were not “[p]reventive, diagnostic, therapeutic, rehabilitative, or palliative” and provided to outpatients under the direction of a physician. Accordingly, the clinic services at issue meet the definition of outpatient hospital services, and the other services meet the definition of inpatient hospital services.

**2. Congress intended physicians' services, inpatient services and outpatient services to be separate and distinct and West Virginia Medicaid treats them as such.**

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.’”<sup>22</sup> “In terms of reimbursement by . . . Medicaid programs . . . physicians and hospitals are not treated alike. [S]eparate 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, hospital services and physician services are not equivalent.”<sup>23</sup> Indeed, the West Virginia Department of Health and Human Resources, Bureau of Medical Services (hereinafter Bureau of Medical Services), the State agency that oversees West Virginia’s Medicaid program, pays them differently: (1) physicians are reimbursed (*i.e.*, make gross revenues) based 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 within a Diagnostic Related Group; and, (3) hospitals are reimbursed (*i.e.*, make gross revenues) for *outpatient services* based on a fee for service.<sup>24</sup>

---

<sup>22</sup> 42 C.F.R. § 433.56 and *Virginia, Dept. of Medical Assistance Services v. Johnson*, 609 F. Supp.2d 1, 5 (D.D.C. 2009).

<sup>23</sup> Tammy Lundstrom, Note, *Under-reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services*, Wayne L. Rev. 1243, 1249-50 (2005) (footnotes omitted).

<sup>24</sup> W. Va. State Medicaid Plan, Attachment 4.19-A; 4.19-B.2.a; 4.19-B.5.a. App. R. vol. 2, 1096-1129.

As discussed herein, Wheeling Hospital’s effort to conflate the three services into one violates both state and federal law. Plainly stated, the Hospital is asking this Court to change – for tax purposes only – overhead appropriately billed and paid for as inpatient and outpatient services to physician services. The reclassification sought is improper under the W. Va. Code § 11-27-16 and 42 C.F.R. § 440.50.

West Virginia Code § 11-27-16 (which imposes the tax on providers of physician services) states, in pertinent part, “(a) *Imposition of tax.* – For the privilege of engaging or continuing within this state in the business of providing physicians’ services, there is hereby levied and shall be collected from *every person rendering such service an annual broad-based health care related tax.*” The word *render* when used as a verb means “to transmit or deliver.” Black’s Law Dictionary, (7th ed. 1999). “Physicians’ services<sup>25</sup>” are defined as “those services that are physicians’ services for purposes of Section 1903(w) of the Social Security Act.” W. Va. Code § 11-27-16(c) (pre-2010). Section 1903(w) is part of subchapter XIX of the Social Security Act, which covers Medicaid. The implementing regulation applicable to the Medicaid program provides the following definition for physicians’ services:

“Physicians’ services,” whether furnished in the office, the recipient’s home, a hospital, a skilled nursing facility, or elsewhere, means services *furnished by a physician*—(1) Within the scope of practice of medicine or osteopathy as defined by State law; *and* (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

42 C.F.R. 440.50 (emphasis added).

---

<sup>25</sup> Wheeling Hospital admits that 42 C.F.R. 440.50 contains the definitions of physician services applicable to this case. App. R. vol. 2, 974; *See also* Petitioner’s Brief, p. 7.

A physician service can be furnished by a physician or by someone under the physician's personal supervision. The phrase "by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy" encompasses the services of the physician's employee, *i.e.*, nurses or nurse practitioners who work at the physician's office. However, because the physician must furnish the service, the provision of the overhead at issue provided by the Hospital is not a physician service. The fact that the overhead provided by the Hospital is not a physician service is further demonstrated by what 42 C.F.R. § 440.50 does not say. A physician service is *not* defined to include anything provided by a hospital or clinic that is associated with the service provided by a physician.

There is no dispute that physicians' services can be provided in a hospital.<sup>26</sup> The parties agree that a physician's performance of a procedure or other work performed within the scope of the practice of medicine or osteopathy in Wheeling Hospital's outpatient clinic or in the Hospital is a physician service, as are physician visits to patients there. The physicians "billed" and received payment for such procedures, work, and visits that took place at the Hospital. Stated differently, there is no dispute that a physician practices medicine in the Hospital when, for example, the physician performs a procedure or makes clinical interpretations. Physicians with hospital privileges were paid for their provision of medical services as a result of their individual billing. App. R. vol. 1, 110-15, 117, 119-23. No one disputes that a physician's provision of medical services is a physician service.

---

<sup>26</sup> The services provided by Wheeling Hospital's employed physicians are admitted to be physician services.

However, the dispute in this case does not involve such procedures or visits; to the contrary, it involves the Hospital's provision of overhead. The stipulations refer to the overhead provided by Wheeling Hospital as the practice expense. Wheeling Hospital's witness, Ms. Anderson, testified that the practice expense is "the facility, the drugs, the equipment and the staff." App. R. vol. 2, 694. A few examples bring the dispute into focus. In the oncology center, a physician billed for his work and malpractice component of the visit, Stipulation 204a and 205a and b, App. R. vol. 1, 112-13, and the Hospital billed for its provision of overhead relating to the outpatient visit, Stipulation 204b and 205b, App. R. vol. 1, 113. Likewise, with regard to inpatient surgery services, the physician billed for his work and malpractice component, and the Hospital billed for all the items and services that it provided in order for the physician to perform the surgery. Stipulation 298a and b, App. R. vol. 1, 123. Thus, the Hospital provided and was paid for the provision of overhead for all the disputed services.

In an effort to re-frame the overhead as a physician service, the Hospital states the following with regard to chemotherapy services: "For example, in many cases *physicians choose to provide chemotherapy services* at Wheeling Hospital for Medicare and Medicaid patients because Medicare and Medicaid drastically cut reimbursement for chemotherapy drugs to independent physicians." Petitioner's Brief, pages 1-2. In spite of the way that Wheeling Hospital worded this sentence, the physicians do not choose to *provide* chemotherapy at the outpatient clinic. Rather, physicians choose to have Wheeling Hospital provide the chemotherapy and the Hospital provides it.

Again, the physician did not provide the facilities, staff, equipment or drugs which are in dispute. Rather, a physician executed a doctor's order to admit the patient as either an inpatient or outpatient. Stipulation 69, App. R. vol. 1, page 96. The Hospital's witness admitted that the

decision was based on concerns about reimbursement rates: the doctors would not have made enough money if they had provided the service at their own offices because the doctors' compensation under the physician's fee schedule would have been too low.<sup>27</sup> App. R. vol. 2, 694-95.

The language at 42 C.F.R. § 440.50 is clear a physician must "furnish" – that is provide – the service<sup>28</sup> for it to qualify as a physician service. The fact that a physician could have chosen to provide some of the disputed services is irrelevant because, like the provision of chemotherapy treatment, both the physician and the Hospital chose to have the overhead provided by the Hospital for each of the reclassified services. Therefore, the threshold requirement that a physician "furnishes" the disputed service has not been met for any of the reclassified services.

Additionally, Wheeling Hospital cannot meet the second separate requirement for a service to qualify as a physician service. Specifically, "West Virginia has a long-standing and broad prohibition against the corporate practice of medicine."<sup>29</sup> Only a natural person, not a juridical one, can practice medicine in West Virginia.<sup>30</sup> Consequently, anything done or furnished by a hospital

---

<sup>27</sup> It is undisputed that the Hospital – and not the physician – provided the chemotherapy services. No amount of wordsmithing can change that. Furthermore, in the body of the Petitioner's Brief, p. 2, the Hospital states that its provision of the chemotherapy service will cause it to sustain a loss. However, nothing in the record establishes that Wheeling Hospital sustained a loss when it provided the chemotherapy. Ms. Anderson's testimony was, "And so the hospital pays for the costs of providing that practice expense component and gets reimbursed *probably* below that cost." App. R. vol. 2, 694 (emphasis added).

<sup>28</sup> A physician can provide the service personally or through the service of his staff under his supervision. However, neither a physician nor his employee provided the overhead which is in dispute.

<sup>29</sup> D. Cameron Dobbins, *A Survey of State Laws Relating to the Corporate Practice of Medicine*, 9 NO. 5 Health Law.18, 23 (1997).

<sup>30</sup> *See, e.g.*, W. Va. Code § 30-3-10(b) (license to practice medicine limited to males and females). *Accord* 41 C.J.S. *Hospitals* § 38 ("A hospital, as an entity, cannot practice medicine, diagnose illness or establish a course of treatment").

is not the practice of medicine and cannot be a physician service. West Virginia's requirement that only a person can practice medicine is consistent with 42 C.F.R. 440.50(a), which defines physicians' services to be "services furnished by a physician [w]ithin the scope of practice of medicine or osteopathy as defined by State law." Therefore, under state and federal law, this is a second separate reason why the attempted reclassification must fail.

Wheeling Hospital additionally argues that the Health Care Provider Tax imposed on physician services at W. Va. Code § 11-27-16 encompasses the overhead in dispute because W. Va. Code § 11-27-3, which provides some definitions for the health care provider taxes, defines corporations as persons upon whom the taxes can be imposed.

The applicable statute imposing taxes on physician services for the time period in question stated in pertinent part:

For the privilege of engaging or continuing within this state in the business of providing *physicians' services*,<sup>31</sup> there is hereby levied and shall be collected from every person *rendering such service* an annual broad-based health care related tax.

W. Va. Code § 11-27-16(a) (emphasis added).

The definitions for some of the terms contained in the Health Care Provider taxes are found in W. Va. Code § 11-27-3 with W. Va. Code § 11-27-3(7) defining "person" as "any individual, partnership, association, company, *corporation or other entity engaging in a privilege taxed* under this article." Wheeling Hospital argues that because it is a "person" pursuant to W. Va. Code § 11-27-3(7), all the services it provides are physician services.

---

<sup>31</sup> As discussed herein this tax, like all the Health Care Provider taxes, must comply with Section 1903(w) of the Social Security Act.

The Commissioner admits that Wheeling Hospital provides some physician services; however, these services are limited to the practice of medicine performed by its employed physicians. Thus, the imposition of the tax on Wheeling Hospital when its employed physicians engage in the practice of medicine is undisputed. However, the fact that Wheeling Hospital is taxed at the physician rate when its employed physicians practice medicine does not convert any of the disputed services into physician services because employed physicians of Wheeling Hospital did not furnish the procedures or clinical interpretations associated with the disputed provision of overhead. Furthermore, the Hospital's provision of the overhead in dispute, as discussed herein, is not a physician service. Nothing contained in W. Va. Code § 11-27-16 or 11-27-3(7) changes the definition of physician services or the practice of medicine. Assuming, *arguendo*, that these statutes were to allow Wheeling Hospital to practice medicine, they would conflict with 42 C.F.R. 440.50. Such conflict is directly at odds with the Legislature's clear intent to comply with the Social Security Act, and conflicts with West Virginia's prohibition against the practice of medicine by hospitals.

Thus, Wheeling Hospital's argument that because it is defined as a person for purposes of the Health Care Provider Taxes, the overhead services it provides are physician services is wrong because: (1) the applicable federal regulation found at 42 C.F.R. 440.50 explicitly requires that a physician or his employee must furnish the service; (2) it ignores the fact that only a natural person can practice medicine under federal and state law; and (3) it assumes that the provision of overhead to a physician with hospital privileges is a physician service, which it is not.

**3. CPT codes are a short-hand billing tool and not an exclusive identifier of physician services.**

“CPT is the commonly used abbreviation for ‘Current Procedural Terminology,’ a ‘system of terminology [that] is the most widely accepted medical nomenclature used to report medical procedures and services under public and private health insurance programs.’”<sup>32</sup> “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.” Stipulation 26, App. R. vol. 1, 92. While CPT codes are used for physician reimbursement, that is not their only purpose.<sup>33</sup> “CPT codes describe medical, surgical, radiology, laboratory, anesthesiology, and evaluation or management services of physicians, hospitals, and other health care providers.”<sup>34</sup> In short, the CPT code is used to indicate the service performed and, therefore, 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.”<sup>35</sup> The CPT, on the Hospital’s bill, reflects, therefore, not only *what* was done, but the Hospital resources necessary to *do* it.<sup>36</sup>

---

<sup>32</sup> *Krauss v. Oxford Health Plans, Inc.*, 517 F.3d 614, 620 n.5 (2nd Cir. 2008)(citation omitted).

<sup>33</sup> John V. Jacobi, *Canaries in the Coal mine: the Chronically Ill in Managed Care*, 9 Health Matrix 79, 138 n.24 (1999)(observing that CPT’s have “many purposes.”)

<sup>34</sup> John Dewar Gleissner, *Proving Medical Expenses: Time for a Change*, 28 Am. J. Trial Advoc. 649, 651 (2005).

<sup>35</sup> *U.S. ex rel. Woodruff v. Hawaii Pacific Health*, 560 F. Supp.2d 988, 993 (D. Hawaii 2008).

<sup>36</sup> *Ohio Hosp. Ass’n v. Shalala*, 201 F.3d 418, 420 (6<sup>th</sup> Cir.1999) (“The hospitals’ applications for reimbursement are submitted to designated ‘fiscal intermediaries’-usually insurance companies-that handle the paperwork for the Secretary. To obtain reimbursement, the hospitals must assign ‘billing codes’ to the services they have provided. (The Rosetta Stone for the billing codes is found in an American Medical Association publication called ‘Physicians’ Current Procedural Terminology,’ or ‘CPT.’) In paying for  
(continued...)

Thus, the CPT is a coding tool. This is borne out in Stipulation 30, which states that “CPT codes exist only for professional health care services and *related items*.” (Emphasis added.) Additionally, a review of the stipulations in their totality reflects their use to describe physician services as well as Hospital overhead. Therefore, in addition to appearing on a physician’s bill for service, they were used by the Hospitals on its bills for the overhead which it seeks to reclassify as a physician service. ( Stipulations 190b, 191b, 197b, 198b, 204b, 205b, 210b, 216b, 223b, 243b, 262, 263, 266, 283b and 298b, which reflect CPT’s presence on Wheeling Hospital’s institutional billing on form UB-92). Thus, the CPT codes are not, as urged by Wheeling Hospital, an exclusive identifier of physician services. If they identified only physician services they would not have appeared on the Hospital’s UB-92, which is its institutional bill for services including the disputed overhead. Stipulation 18. Moreover, if CPT codes were the definer of physician services then 42 C.F.R. § 440.50 would have said, “Physician services are services furnished by a physician or services furnished by a hospital or clinic when the bill for service includes a CPT code.” Furthermore, the discussion of the Physician Fee Schedule is misplaced because physicians chose to admit their patient to the Hospital or its clinic instead of treating them at their office. Additionally, none of the services at issue were paid as physician services, because the Hospital initially reported its gross receipts for the disputed services as inpatient or outpatient services.

---

<sup>36</sup>(...continued)  
services rendered by the hospitals, the fiscal intermediaries use a reimbursement rate set by the Secretary for each CPT billing code.”).

**4. The 2000 and 2006 informal letters do not support the Hospital's position.**

The Hospital relies on two letters from the Tax Department to its consultant/witness Debra Anderson to imply that the Tax Department's position on what constitutes physicians' services under the HCPT has changed since the letters were written in 2000 and 2006 and that the letters support the Hospital's position. Petitioner's Br. at 9-10. The Department's position has not changed, and these letters do not support the Hospital's position. Both letters make it clear that various types of services may be taxed at the physicians' services rate "to the extent they are not billed as part of another taxable service" App. R. vol. 1, 127, 135-36 (emphasis added). The correlative to that, however, is that if they are billed at another rate such as inpatient or outpatient services, then they will be taxed at the same classification for which they were billed and paid. *Id.*

- Pathology services are taxable at the physicians' services rate *to the extent they are not billed as part of another taxable service*. For example, if an individual is admitted on an inpatient basis and testing is performed and billed as part of the inpatient charge, it would be subject to the West Virginia health care provider taxes under the inpatient hospital services classification. App. R. vol. 1, 127 (emphasis added).
- Physicians' services are taxable at the "physicians' services" rate *to the extent they are not billed as a part of another taxable service*. For example, if an individual is admitted on an inpatient basis and testing is performed by a physician and billed as part of the inpatient charge, that service would be subject to the West Virginia health care provider taxes under the inpatient hospital services classification. *Id.* (Emphasis added.)
- Services performed by an independent physician are taxable under the physicians' services classification *to the extent that they are billed separately as physicians' services*. *Id.* (Emphasis added.)
- 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*. *Id.* (Emphasis added.)

- 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*. For example, if an individual is admitted to a hospital on an inpatient basis and testing is performed by a physician and billed as part of the inpatient charge, that service (including any drugs or medical supplies provided in conjunction with the service) would be subject to the West Virginia Health Care Provider Tax under the inpatient hospital services classification. App. R. vol. 1, 135-36 (emphasis added).
- Services performed by an independent physician are taxable under the physicians' services classification *to the extent that they are billed separately as physicians' services*. App. R. vol. 1, 136 (emphasis added).
- 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*. *Id.* (Emphasis added.)

The Health Care Provider Tax is a gross receipts tax. Therefore, the service for which a health care provider is paid provides the appropriate measure of the tax to be imposed on that payment. If a physician provides services and is paid at the rate for physicians' services, then he is appropriately taxed on these gross receipts at the physicians' services rate. If the Hospital provides inpatient or outpatient hospital services and is paid at the rate for inpatient and outpatient hospital services, then it is appropriately taxed on these gross receipts at the inpatient and outpatient hospital rates. The consistent application of the tax at the rate applicable to the service that generated the gross receipts obviously prevents a taxpayer from gaming the system.

**C. The circuit court’s order does not violate federal uniformity requirements because the disputed services are not physician services and are properly classified as inpatient and outpatient hospital services.**

In 1991, Congress enacted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (MVCPST)<sup>37</sup> 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;<sup>38</sup> and (3) must not hold taxpayers harmless for the costs of the tax.<sup>39</sup> If a health care tax fails any of these three tests the amount of federal matching funds will be reduced.<sup>40</sup> “The general purpose of the MVCPST 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.”<sup>41</sup> A provider tax is broad based if imposed on “all items or services” in a class.<sup>42</sup> A provider tax is uniform if imposed at a uniform rate “for all items and services . . . in the class.”<sup>43</sup>

In enacting the Health Care Provider Tax, the Legislature found that participation in the Medicaid program was necessary to ensure (1) that West Virginia’s citizens who are not physically,

---

<sup>37</sup> Pub. L. No. 102-234, 105 Stat. 1793 (1991) (codified at 42 U.S.C. § 1396b(w)).

<sup>38</sup> From enactment of the HCPT, the physician tax rate has been less than the hospital tax rate. The Federal Centers for Medicare and Medicaid and its predecessor, the Health Care Finance Administration must approve state plans—that is a “comprehensive . . . statement . . . describing the nature and scope of [the State’s] Medicaid program.” 42 C.F.R. § 430.10 (1989). “The state plan is required to establish, among other things, a scheme for reimbursing health care providers for the medical services provided to needy individuals.” *Wilder v. Virginia Hosp. Ass’n*, 496 U.S. 498, 502 (1990).

<sup>39</sup> 42 U.S.C. §§ 1396b(w)(3)(B); 1396b(w)(3)(c); 1396b(w)(3)(D); 1396b(w)(4).

<sup>40</sup> 42 U.S.C. § 1396b(w)(1)(A).

<sup>41</sup> 2 Mark H. Gallant, *Health L. Prac. Guide* § 27:2 (2010).

<sup>42</sup> 42 U.S.C. § 1396b(w)(3)(B)(i).

<sup>43</sup> 42 U.S.C. § 1396b(w)(3)(C)(i)(III).

mentally or economically able to provide for their basic healthcare receive medical care;<sup>44</sup> and (2) that health care providers are adequately compensated to ensure the provision of these medical services.<sup>45</sup> There is no dispute that the Health Care Provider Taxes were enacted to draw down the federal match to provide compensation to health care providers who furnish medical services to the indigent population in West Virginia. The tax was initially imposed on providers of inpatient, outpatient and physician services. W. Va. Code §§ 11-27-9, 11-27-15 and 11-27-16.

Wheeling Hospital's attempt to suggest that the taxes at issue violate federal uniformity requirements is wrong. Under 42 C.F.R. § 433.56, inpatient, outpatient and physician services are separate classes of health care items or services. 42 C.F.R. § 433.56(a)(1) inpatient services; 42 C.F.R. § 433.56(a)(2) outpatient services; and 42 C.F.R. § 433.56(a)(5) physician services. To satisfy federal uniformity, a health care provider tax need only impose the same rate for all items and services in the class. Because the services at issue were, in fact, inpatient and outpatient hospital services, there is no uniformity problem in taxing them at that rate rather than at the physicians' service rate. Even if the Hospital were correct in asserting that West Virginia's tax is a service tax and not a provider tax, there would still be no uniformity problem because Wheeling Hospital's reclassified services are not physician services.

To suggest, as Wheeling Hospital has, that the Tax Commissioner and the Circuit Court of Ohio County ignored the law, when they actually applied it, can only be explained by the Hospital's self-interest. The federal definition plainly states that a physician must "furnish" a physician service, which undisputedly did not happen here. It is equally clear that the federal definition

---

<sup>44</sup> The federal government sets the eligibility requirements as well as mandating that certain services be provided. W. Va. Code § 11-27-1(e).

<sup>45</sup> W. Va. Code § 11-27-1.

incorporates the definition of the practice of medicine or osteopathy in the state where the service is rendered. Because the overhead provided by the Hospital is not a physician service, there is no uniformity issue with regard to the tax rate imposed on physician services. 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.

Conclusions of Law 37, App. R. vol. 2, 1328. As a result there is nothing improper for CMS to notice.

**D. The circuit court’s order was correct; therefore, its affirmance will not have disastrous consequences for the West Virginia Medicaid program.**

As discussed above, Wheeling Hospital is not entitled to a refund: it originally correctly classified and received payment for the disputed services as inpatient and outpatient services and paid Health Care Provider Tax on them at the inpatient and outpatient service rate. The Hospital’s provision of its facility, staff, equipment and supplies for inpatient and outpatient services was appropriate. All of the services were performed pursuant to a Hospital admission, and there is no evidence that any payer, including BMS, is seeking a return of the money paid for what were billed as inpatient or outpatient services. Furthermore, Wheeling Hospital accepted the admissions and is not *now* saying that the services done in the Hospital or its clinic should have or could have been

performed in a physician's private office. Obviously, the resources of the Hospital were needed and were used.

Notwithstanding the foregoing, Wheeling Hospital asks this Court to ignore or re-write 42 C.F.R. 440.50 for its benefit by allowing it to bill and be paid for services as inpatient and outpatient services but pay provider tax on them as physician services.<sup>46</sup> Allowing this would place West Virginia's Health Care Provider Tax in nonconformity with federal law and would thereby jeopardize the federal match. The federal match received as a result of the Hospital's original reporting might, in CMS's discretion, need to be returned. The fourteen (14) hospitals with claims pending at OTA and the Tax Department would have to be given refunds, also with the potential return of the federal match. Furthermore, any remaining hospitals in the State who do not have pending claims for refund would likely file for refunds retroactively for three years, within the applicable statute of limitations, if the Hospital prevails. Such a result would virtually write the inpatient and outpatient Health Care Provider Tax out of existence. This was surely not the Legislature's intent when it eliminated the tax on physician services.

---

<sup>46</sup> The Petitioner's repeated criticism of the Attorney General involves matters outside the record and has no relevance to the case *sub judice*. Furthermore, the Petitioner's reliance on this distraction is a reflection of the lack of substance to its position.

**VII. CONCLUSION**

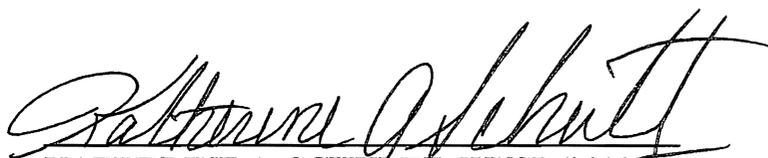
For the reasons set forth herein, this Court should affirm the Circuit Court's decision.

**Respectfully submitted,**

**CRAIG A. GRIFFITH, WEST VIRGINIA  
STATE TAX COMMISSIONER,**

**By Counsel**

**DARRELL V. MCGRAW, JR.  
ATTORNEY GENERAL**

A handwritten signature in cursive script, appearing to read "Katherine A. Schultz", is written over a horizontal line.

**KATHERINE A. SCHULTZ, WWSB # 3302  
SENIOR DEPUTY ATTORNEY GENERAL  
CHARLI FULTON, WWSB #1314  
SENIOR ASSISTANT ATTORNEY GENERAL  
OFFICE OF THE ATTORNEY GENERAL  
Building 1, Room W-435  
1900 Kanawha Boulevard, East  
Charleston, West Virginia 25305  
(304) 558-2522**

IN THE SUPREME COURT OF APPEALS OF WEST VIRGINIA

NO. 11-0252

WHEELING HOSPITAL, INC.

Petitioner,

v.

CRAIG A. GRIFFITH, WEST VIRGINIA  
TAX COMMISSIONER,

Respondent.

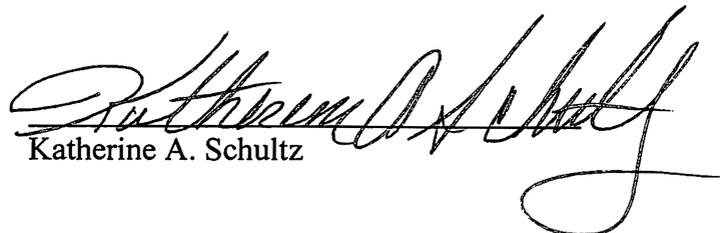
CERTIFICATE OF SERVICE

I, Katherine A. Schultz, Senior Deputy Attorney General and counsel for Respondent, hereby certify that on the 2<sup>nd</sup> day of February, 2012, I served the foregoing *Brief of the Respondent Craig A. Griffith, West Virginia State Tax Commissioner* upon the following via hand delivery to the Petitioner's Counsel and via United States mail to the remaining persons listed below:

Kimberly Stitzinger Jones (WV Bar#6583)  
Assistant Attorney General  
350 Capitol Street, Room 251  
Charleston, West Virginia 25301

Marianne Kapinos (WV Bar #1781)  
General Counsel  
West Virginia Health Care Authority  
100 Dee Drive  
Charleston, West Virginia 25311

Niall A. Paul (WV Bar #5622)  
Timothy D. Houston (WV Bar #10858)  
Spilman Thomas & Battle, PLLC  
300 Kanawha Boulevard, East  
Post Office Box 273  
Charleston, West Virginia 25321-0273  
*Counsel for Petitioner Wheeling Hospital, Inc.*

  
Katherine A. Schultz