

SYNOPSIS

HEALTH CARE PROVIDER TAXES -- CONFORMITY WITH FEDERAL LAW
– The West Virginia broad-based health care provider tax must conform to federal regulations in that it must be both broad-based and uniform. 42 C.F.R. § 433.68 (1992).

HEALTH CARE PROVIDER TAXES -- CONFORMITY WITH FEDERAL LAW
– The West Virginia broad-based health care provider tax levies taxes on gross receipts of health care providers in conformity with the classifications permitted by federal regulations. 42 C.F.R. § 433.56 (1992).

HEALTH CARE PROVIDER TAXES -- PERMISSIBLE TAXABLE CLASSIFICATIONS -- The relevant West Virginia broad-based health care provider tax statutes, W. Va. Code §§ 11-27-9, 11-27-15 & 11-27-16, defines the services to be taxed by reference to a federal statute, 42 U.S.C. § 1396b.

HEALTH CARE PROVIDER TAXES -- STATUTORY TERMS NOT DEFINED – 42 U.S.C. § 1396b does not provide definitions for the relevant terms set out in the West Virginia broad-based health care provider tax statutes and, as a consequence, for purposes of construing the statutes said terms must be treated as undefined.

HEALTH CARE PROVIDER TAXES -- STATUTORY CONSTRUCTION WHERE TERMS NOT DEFINED -- “In the absence of any definition of the intended meaning of words or terms used in a legislative enactment, they will, in the interpretation of the act, be given their common, ordinary and accepted meaning in the connection in which they are used.” *CNG Transmission Corp. v. Craig*, 211 W. Va. 170, 564 S.E.2d 167 (2002).

HEALTH CARE PROVIDER TAXES – NON-CONTROLLING FEDERAL STATUTORY DEFINITIONS AS GUIDANCE – Other federal statutes and regulations define the terms used in the West Virginia broad-based health care provider tax statutes, which definitions, while not binding, may be used as guidance in construing the West Virginia states..

HEALTH CARE PROVIDER TAXES – NON-CONTROLLING FEDERAL STATUTORY DEFINITIONS AS GUIDANCE – The terms defined in the federal statutes and regulations are consistent with the common, ordinary and accepted meaning of the same terms used in the West Virginia broad-based health care statutes.

HEALTH CARE PROVIDER TAXES – COMMON, ORDINARY AND ACCEPTED MEANING OF TERMS USED IN THE STATUTE -- The common, ordinary

and accepted meaning of the terms used in the West Virginia broad-based health care statutes, consistent with the federal statutory and regulatory definitions, require that the Petitioner's gross receipts from reimbursements for the costs of providing bed and board, nursing services and other related services, use of hospital facilities and medical social services ordinarily furnished by the hospital, and drugs, biologicals, supplies, appliances and equipment for use in the hospital, as are ordinarily furnished by the hospital for the care and treatment of inpatients, and other diagnostic or therapeutic items normally furnished by the hospital or pursuant to arrangements made by the hospital constitute gross receipts to be taxed in the appropriate "hospital services" classification. W. Va. Code §§ 11-27-9 & 15.

HEALTH CARE PROVIDER TAXES – OPINION LETTERS NOT BINDING WHERE INCONSISTENT WITH CONTROLLING STATUTE – Opinion letters authored by a former state tax commissioner and a lawyer employed by the state tax commissioner are not binding on the Respondent except insofar as they are limited to the facts and circumstances articulated therein and insofar as they articulate legal principles that are inconsistent with the applicable statutes.

FINAL DECISION

On October 27, 2006, the Petitioner, filed a claim for refund of broad-based health care provider tax for fiscal year 2003, in the amount of \$____. Subsequently, personnel from the West Virginia State Tax Commissioner's Office (the "Respondent") conducted an audit of the Petitioner's books and records. During the field audit, the Petitioner reduced its refund claim to \$____. Pursuant to the field audit, the Respondent refunded the Petitioner \$____. Thereafter, by hand delivery on March 4, 2008, the Petitioner timely filed with this tribunal, the West Virginia Office of Tax Appeals, a petition for refund in the amount of \$____ for fiscal year 2003. W. Va. Code §§ 11-10A-8(1) [2007] and 11-10A-9 [2005].

On December 14, 2006, the Petitioner filed a claim for refund of broad-based health care provider tax for fiscal year 2004, in the amount of \$____. During the aforementioned audit, the Petitioner reduced its refund claim to \$____. Pursuant to the field audit, the Respondent refunded the Petitioner \$____. Thereafter, by hand delivery on March 4, 2008, the Petitioner timely filed with this tribunal, the West Virginia Office of Tax Appeals, a petition for refund in

the amount of \$_____ for fiscal year 2004. W. Va. Code §§ 11-10A-8(1) [2007] and 11-10A-9 [2005].

Also on December 14, 2006, the Petitioner filed a claim for refund of broad-based health care provider tax for fiscal year 2005, in the amount of \$_____. During the aforementioned audit, the Petitioner reduced its refund claim to \$_____. Pursuant to the field audit, the Respondent refunded the Petitioner \$_____. Thereafter, by hand delivery on March 4, 2008, the Petitioner timely filed with this tribunal, the West Virginia Office of Tax Appeals, a petition for refund in the amount of \$_____ for fiscal year 2005. W. Va. Code §§ 11-10A-8(1) [2007] and 11-10A-9 [2005].

On March 15, 2007, the Petitioner filed a claim for refund of broad-based health care provider tax for fiscal year 2006, in the amount of \$_____. Pursuant to the field audit, the Respondent refunded the Petitioner \$_____. Thereafter, by hand delivery on March 4, 2008, the Petitioner timely filed with this tribunal, the West Virginia Office of Tax Appeals, a petition for refund in the amount of \$_____ for fiscal year 2006. W. Va. Code §§ 11-10A-8(1) [2007] and 11-10A-9 [2005].

Subsequently, notice of a hearing on the petition was sent to the Petitioner and a hearing was held in accordance with the provisions of W. Va. Code § 11-10A-10 [2002].

FINDINGS OF FACT

The parties have stipulated relevant facts in this matter (Stipulations numbered 1 through 299) and have presented numerous exhibits (Exhibits “A” through “ZZ”) that are incorporated into the stipulations of fact. The stipulations and exhibits are incorporated herein by reference.

Also, the Petitioner has proposed unstipulated findings of fact, based on testimony of the witness at the evidentiary hearing in this matter. Although this Office finds the unstipulated findings of fact not necessary to this decision, they are incorporated herein by reference.

In the supplemental briefs filed in this matter, each of the parties presented matters which the other party considered to be additional evidence, and each party objected to the “evidence” presented by the other party. Pursuant to a telephone conference conducted on October 24, 2009, the parties requested that they be allowed to withdraw the “evidence” in their supplemental briefs and requested that this Office not consider such “evidence.” Such “evidence has not been considered.

DISCUSSION

The issue presented by this matter is the rate at which the Petitioner is required to pay broad-based health care provider tax on the gross receipts derived from certain of the services it provides to patients. With respect to the services at issue, the Petitioner paid tax as a provider of “outpatient hospital services” and “inpatient hospital services,” at the rate of two and one-half percent (2.5%). The Petitioner now contends that it should have paid tax as a provider of physicians’ services, at the rate of two percent (2%). It maintains that it is entitled to a refund of the difference in the tax rate on the services provided, which is equal to one-half of one percent of the charges for those services.

The State has imposed health care provider taxes on the providers of health care services in this State for the purpose raising revenue to fund the State’s portion of the Medicaid program, for the purpose of providing medical services to West Virginia’s uninsured and charity patients. The amounts the State pays for these services qualify for federal matching funds. In order to qualify for federal matching funds, the method by which the State raises funds must conform to

the provisions of 42 U.S.C. § 1396b. *See* W. Va. Code § 11-27-1. 42 U.S.C. § 1396b(w) prohibits the use of health care related taxes to qualify for federal matching funds unless the tax is broad-based. *See* 42 U.S.C. § 1396b(w)(3). 42 C.F.R. § 433.56 provides a list of the various classes of health care items and services that states may tax. These classes include: 1) Inpatient hospital services (42 C.F.R. § 433.56(1)), 2) Outpatient hospital services (42 C.F.R. § 433.56(2)), and 3) Physicians' services (42 C.F.R. § 433.56(5)).

42 C.F.R. § 433.68 (1992) provides, in relevant part:

(a) General rule. Beginning on the day after a State's transition period . . . ends, a State may receive health care-related taxes . . . only in accordance with the requirements of this section.

(b) Permissible health care-related taxes. [A] State may receive . . . health care-related taxes if all of the following are met:

(1) The taxes are broad based, as specified in paragraph (c) of this section; [and]

(2) The taxes are uniformly imposed throughout a jurisdiction, as specified in paragraph (d) of this section;

(c) Broad based health care-related taxes. (1) A health care-related tax will be considered to be broad based if the tax is imposed on at least all health care items or services in the class or providers of such items or services . . . , and is imposed uniformly, as specified in paragraph (d) of this section.

* * * *

(d) Uniformly imposed health care-related taxes. A health care-related tax will be considered to be imposed uniformly even if it excludes Medicaid or Medicare payments (in whole or in part), or both; or, in the case of a health care-related tax based on revenues or receipts with respect to a class of items or services (or providers of items or services), if it excludes either Medicaid or Medicare revenues with respect to a class of items or services, or both. The exclusion of Medicaid revenues must be applied uniformly to all providers being taxed.

(1) A health care-related tax will be considered to be imposed uniformly if it meets any one of the following criteria:

* * * *

(iii) If the tax is imposed on provider revenue or receipts with respect to a class of items or services (or providers of those health care items or services), the tax is imposed at a uniform rate for all services (or providers of those items or services) in the class on all the gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction. Net operating revenue means gross charges of facilities less any deducted amounts for bad debts, charity care, and payer discounts. . . .

The West Virginia Legislature enacted a broad-based health care provider tax, which provides a number of classifications. Three of those classifications are at issue in this matter. All three of the classifications are recognized by 42 C.F.R. § 433.56 as classification upon which states may levy a broad-based health care provider tax. The classifications that are at issue in this matter are those recognized by 42 C.F.R. § 433.56(1), (2) & (5).

W. Va. Code § 11-27-9, which pertains to “inpatient hospital services,” provides, in relevant part:

(a) Imposition of tax.—For the privilege of engaging or continuing within this state in the business of providing inpatient hospital services, there is hereby levied and shall be collected from every person rendering such service an annual broad-based health care related tax:

* * * *

(b) Rate and measure of tax.—The tax imposed in subsection (a) of this section shall be two and one-half percent of the gross receipts derived by the taxpayer from furnishing inpatient hospital services in this state.

(c) Definitions.

* * * *

(3) "Inpatient hospital services" means those services that are inpatient hospital services for purposes of Section 1903(w) of the Social Security Act.

(d) Effective date.—The tax imposed by this section shall apply to gross receipts received or receivable by providers after the thirty-first day of May, one thousand nine hundred ninety-three.

West Virginia Code § 11-27-15, which pertains to “outpatient hospital services,”

provides, in relevant part:

(a) Imposition of tax.—For the privilege of engaging or continuing within this state in the business of providing outpatient hospital services, there is hereby levied and shall be collected from every person rendering such service an annual broad-based health care related tax.

(b) Rate and measure of tax.—The tax imposed in subsection (a) of this section shall be two and one-half percent of the gross receipts derived by the taxpayer from furnishing outpatient hospital services in this state.

(c) Definitions.

* * * *

(3) "Outpatient hospital services" means those services that are outpatient hospital services for purposes of Section 1903(w) of the Social Security Act.

(d) Effective date.—The tax imposed by this section shall apply to gross receipts received or receivable by providers after the thirty-first day of May, one thousand nine hundred ninety-three.

The Petitioner has determined and contends herein that it should properly have paid the tax under the provisions of W. Va. Code § 11-27-16, which pertains to “physicians’ services” and provides, in relevant 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.

(b) Rate and measure of tax.—The tax imposed in subsection (a) of this section shall be two percent of the gross receipts derived by the taxpayer from furnishing physicians' services in this state.

(c) Definitions.

* * * *

(3) "Physicians' services" means those services that are physicians’ services for purpose of Section 1903(w) of the Social Security Act.¹

¹ Subsection (c)(3) was amended in 2009 to provide the following definition:

(d) Effective date.—The tax imposed by this section shall apply to gross receipts received or receivable by providers after May 31, 1993.

The Petitioner contends, rightfully, that in enacting the West Virginia health care provider taxes, the Legislature intended to comply with the Federal broad-based tax regulations. It contends that if a State enacts a statute taxing a class of services, all providers of those services must be taxed. It further contends that all services in a class must be taxed at the same rate, regardless of who provides those services. It contends that those on whom the tax is imposed are not taxable as entities, but are taxable based on the nature of the service that is provided. Thus, the mere fact that the Petitioner is a hospital does not mean that all of its receipts must be

(c) Definitions.

* * * *

(3) "Physicians' services" means and is limited to those services furnished by a physician within the scope of the practice of medicine or osteopathy, as defined by the laws of this state, whether furnished in the physician's office, the recipient's home, a hospital, a skilled nursing facility or any other location.

(A) The term "physicians' services" includes those professional services directly furnished by a physician in the scope of his or her employment by a hospital. Other services rendered in conjunction with employed physicians' services, such as the use of hospital facilities, staff, equipment, drugs and supplies ordinarily furnished by a hospital, are not considered physicians' services pursuant to this section: Provided, That hospitals that own and operate freestanding physician offices or primary care clinics in office buildings or other locations separate and apart from a hospital whereby employed physicians provide services ordinarily provided by physicians in a freestanding physician's office may class all revenue from such services as physicians' services. The status of a physician as a hospital employee shall be determined in accordance with criteria established under the United States Internal Revenue Code and United States Treasury regulations issued pursuant thereto.

(B) Any other service provided by a hospital may not be classified as physicians' services, notwithstanding the fact that such services are provided under the direct or indirect supervision of a physician who is not an employee of the hospital or provided or performed by a physician who holds privileges at the hospital or who works as an independent contractor for the hospital or for any other entity for the provision of health care services.

(C) The amendment to this definition enacted during the 2009 regular legislative session is intended to clarify the intent of the Legislature as to the activities that qualify as physicians' services.

reported in one of the “hospital services” classifications. The Petitioner contends that to the extent that it can identify certain of its services as physicians’ services, they are taxable as physicians’ services.

It does not appear that the Respondent disputes this contention. It appears that the Respondent concedes that to the extent the Petitioner provides services taxable in one of the other classification it may report those services in the other classification. In fact, the Respondent has refunded a portion of the taxes paid by the Petitioner on the grounds that the gross receipts were misclassified. Instead, it appears that the Respondent contends that most of the activities that are the subject of this dispute are by their very nature “hospital services,” not “physicians’ services” as contended by the Petitioner.

The parties have stipulated that for Medicare reimbursement purposes, there are three components for which a provider is reimbursed: 1) a work component, 2) a malpractice expense component, and 3) a practice expense component. The practice expense component could properly be called an overhead expense component, since it is designed to reimburse a provider for the costs of providing health care other than the charges for services, i.e. drugs, supplies, equipment, facilities and other similar items. It is the proper classification of the practice expense component that is the source of the dispute between the parties.

The Petitioner devotes substantial time and effort arguing that the codes used to bill certain of the services provided by the hospital are controlling. In essence, the Petitioner argues that where the services provided by the hospital are billed using billing codes that are the same or similar to those used by physicians in billing for their services, or by the Petitioner in billing for

There is nothing in the 2009 amendment which would make the new definition retroactive to the periods covered by this petition for refund. Thus, it is not controlling for purposes of this matter

the services of physicians employed by it, the service provided by the hospital should be classified as physicians' services.

A number of physicians own their own offices or practices. When the physician submits a bill to Medicare, he or she is reimbursed for all three components, and all three components are taxed in the "physicians' services" classification of the broad-based health care provider tax. However, when the Petitioner provides services through physicians employed by it, it has reported the work component and the malpractice component in the "physicians' services" classification, but has reported the practice expense component in the applicable "hospital services" classification. It argues that this violates 42 C.F.R. § 433.68(d)(1)(iii), because the tax is not uniformly imposed by reason of the fact that the Respondent requires it to report its practice expense component reimbursements as "hospital services," which is different than how physicians who own their own offices report their practice expense component reimbursements

In further support of this argument, the Petitioner points out that independent physicians who practice in the hospital are usually reimbursed for a practice expense component for the services they provide. When services are provided in this manner, the physician often, but not always, provides a certain amount of overhead and the Petitioner provides a certain amount of overhead (e.g. personnel, supplies, drugs, equipment). It argues that the physician receives a reduced reimbursement for this component, reflecting that the physician is not bearing the full cost of the overhead. The Petitioner receives a practice expense component reimbursement, reflecting the overhead that it provides. It argues that it bills for its overhead using the same or similar billing codes that are used by physicians to bill for their overhead costs. It maintains that the fact that it uses the same or similar billing codes to bill for the same or similar items renders the overhead it provides the same as the overhead that physicians provide. It contends that its

reimbursements for practice expense components should be classified as “physicians’ services,” in the same manner that physicians classify their reimbursements for practice expense components as “physicians’ services.” For the reasons set forth below, this Office disagrees.

The codes that the Petitioner uses in billing are not controlling for purposes of determining the proper classification under which gross receipts must be reported. It is the statutory classifications and the definitions prescribed by the statute that control.

Each of these provisions of the broad-based health care provider tax requires that we look to Section 1903(w) of the Social Security Act [42 U.S.C. § 1396b] for definitions of the specified terms, specifically “inpatient hospital services,” “outpatient hospital services,” and physicians’ services.” This is problematic, given that Section 1903(w) of the Social Security Act does not define any of these terms. Thus, it becomes necessary to use other means to determine the meaning of these terms.

This matter presents a circumstance which appears to be unusual. The state statutes, in attempting to define terms used in those statutes, do so by reference to a federal statute that has no such definitions. Given this circumstance, this Office is of the opinion that the terms in the West Virginia statutes must be treated as if they are undefined.

In the absence of any specific indication to the contrary, words used in a statute will be given their common, ordinary and accepted meaning.” Syl. Pt. 1, *Tug Valley Recovery Center, Inc. v. Mingo County Commission*, 164 W. Va. 94, 261 S.E.2d 165 (1979).’ Syl. Pt. 1, *Pennsylvania and West Virginia Supply Corp. v. Rose*, 179 W. Va. 317, 368 S.E.2d 101 (1988).” Syllabus Point 3, *Ohio Cellular RSA Limited Partnership v. Board of Public Works of the State of West Virginia*, 198 W. Va. 416, 481 S.E.2d 722 (1996).

Syl. Pt. 2, *Kings Daughters Housing, Inc. v. Paige*, 203 W. Va. 74, 506 S.E.2d 329 (1998).

“In the absence of any definition of the intended meaning of words or terms used in a legislative enactment, they will, in the interpretation of the act, be given their common, ordinary and accepted meaning in the connection in which they are used.” Syllabus Point 1, *Miners in General Group v. Hix*, 123 W. Va. 637, 17

S.E.2d 810 (1941), overruled on other grounds by *Lee-Norse Co. v. Rutledge*, 170 W. Va. 162, 291 S.E.2d 477 (1982).

CNG Transmission Corp. v. Craig, 211 W. Va. 170, 564 S.E.2d 167 (2002).

As set forth below, the parties have directed the attention of this Office to certain definitions of “inpatient hospital services,” “outpatient hospital services,” and “physicians’ services” in the United States Code and the Code of Federal Regulations. Because none of the definitions cited by the parties are set out in 42 U.S.C. § 1396b, they are not controlling for purposes of the West Virginia broad-based health care provider tax. However, they are, as the Petitioner characterizes the definition it puts forth, instructive. This Office agrees. While the definitions cited are not controlling, they provide guidance as to the meaning of the terms “inpatient hospital services,” “outpatient hospital services,” and “physicians’ services.”

With respect to the term “inpatient hospital services” the Respondent directs this Office’s attention to 42 U.S.C. § 1395x(b), which provides:

(b) Inpatient hospital services. The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, resident, or, services described by subsection (s)(2)(K), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist; and

(5) the services of a private-duty nurse or other private-duty attendant.

Paragraph (4) shall not apply to services provided in a hospital by—

(6) an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association, or in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of podiatry, approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(7) a physician where the hospital has a teaching program approved as specified in paragraph (6), if (A) the hospital elects to receive any payment due under this title for reasonable costs of such services, and (B) all physicians in such hospital agree not to bill charges for professional services rendered in such hospital to individuals covered under the insurance program established by this title.

The Respondent also directs this Office's attention to 42 C.F.R. § 411.351 (2004), which provides, in relevant part:

Inpatient hospital services means those services defined in section 1861(b) of the Act [42 U.S.C. § 1395x(b)] and § 409.10(a) and (b) of this chapter and include inpatient psychiatric hospital services listed in section 1861(c) of the Act and inpatient critical access hospital services, as defined in section 1861(mm)(2) of the Act. "Inpatient hospital services" do not include emergency inpatient services provided by a hospital located outside of the U.S. and covered under the authority in section 1814(f)(2) of the Act and part 424, subpart H of this chapter, or emergency inpatient services provided by a nonparticipating hospital within the U.S., as authorized by section 1814(d) of the Act and described in part 424, subpart G of this chapter. "Inpatient hospital services" also do not include dialysis furnished by a hospital that is not certified to provide end-stage renal dialysis (ESRD) services under subpart U of part 405 of this chapter. "Inpatient hospital services" include services that are furnished either by the hospital directly or under arrangements made by the hospital with others. "Inpatient hospital services" do not include professional services performed by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists and qualified psychologists if Medicare reimburses the services independently and not as part of the inpatient hospital service (even if they are billed by a hospital under an assignment or reassignment).

The Respondent further directs this Office's attention to 42 C.F.R. § 409.10 (1999), which provides, in relevant part:

(a) Subject to the conditions, limitations, and exceptions set forth in this subpart, the term "inpatient hospital or inpatient CAH services" means the following services furnished to an inpatient of a participating hospital or of a participating CAH or, in the case of emergency services or services in foreign hospitals, to an inpatient of a qualified hospital:

- (1) Bed and board.
- (2) Nursing services and other related services.
- (3) Use of hospital or CAH facilities.
- (4) Medical social services.
- (5) Drugs, biologicals, supplies, appliances, and equipment.
- (6) Certain other diagnostic or therapeutic services.
- (7) Medical or surgical services provided by certain interns or residents-in-training.
- (8) Transportation services, including transport by ambulance.

(b) Inpatient hospital services does not include the following types of services:

* * * *

(3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis. . . .

As with "inpatient hospital services," Section 1903(w) of the Social Security Act [42 U.S.C. § 1396b] does not expressly define "outpatient hospital services," either in the text of the statute, or in the regulations interpreting the statute. Thus, this Office must look elsewhere for a definition of the term. While 42 U.S.C. § 1395x(b) provides a definition of "inpatient hospital services," there is no corresponding definition "outpatient hospital services" in 42 U.S.C. § 1395x. However, the Respondent does point to the provisions of 42 U.S.C. § 1395x(s), which provide, in relevant part:

(s) Medical and other health services. The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)

(A) services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service, or kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills (or would have been so included but for the application of section 1847B [42 U.S.C. § 1395w-3b;

(B) hospital services (including drugs and biologicals which are not usually self-administered by the patient) incident to physicians' services rendered to outpatients and partial hospitalization services incident to such services;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

The Respondent also points to two provisions of the Code of Federal Regulations. One provision, 42 C.F.R. § 411.351 (2004) provides, in relevant part:

Outpatient hospital services means the therapeutic, diagnostic, and partial hospitalization services listed under sections 1861(s)(2)(B) and (s)(2)(C) of the Act [42 U.S.C. § 1395x(s)(2)(B) and (s)(2)(C)]; outpatient services furnished by a psychiatric hospital, as defined in section 1861(f) of the Act; and outpatient critical access hospital services, as defined in section 1861(mm)(3) of the Act [42 U.S.C. § 1395x(mm)(3)]. "Outpatient hospital services" do not include emergency services furnished by nonparticipating hospitals and covered under the conditions described in section 1835(b) of the Act and subpart G of part 424 of this chapter. "Outpatient hospital services" include services that are furnished either by the hospital directly or under arrangements made by the hospital with others. "Outpatient hospital services" do not include professional services performed by physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, certified registered nurse anesthetists, and qualified psychologists if Medicare reimburses the services independently and not as part of the outpatient hospital service (even if they are billed by a hospital under an assignment or reassignment).

The other provision, 42 C.F.R. § 440.20 (1995), provides, in relevant part:

§ 440.20 Outpatient hospital services and rural health clinic services.

(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.

The third item which is required to be defined by reference to Section 1903(w) of the Social Security Act [42 U.S.C. § 1396b] is “physicians’ services.” It, too, is not expressly defined by that section and, therefore, we must look elsewhere for definitions for that term.

The Petitioner contends that this Office should look to the Medicaid definition set out in 42 C.F.R. § 440.50 (1991). The Petitioner reasons that since the federal regulations are designed to prevent improper payments of federal matching funds under the states’ Medicaid programs, the Medicaid definition of “physicians’ services” is “instructive.” The Medicaid definition of “physicians’ services” provides, in relevant part:

(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.

The Respondent directs this Office’s attention to the definition contained in 42 U.S.C. § 1395x(q), which defines “physicians’ services” as:

(q) Physicians' services. The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6)).

The definitions of physicians' services proposed by the Petitioner, 42 C.F.R. § 440.50 (1991), includes services provided by a physician within the practice of medicine or osteopathy, by or under of the supervision of a person licensed to practice medicine or osteopathy, regardless of where the service is provided. The Respondent's definition is similar, meaning professional services performed by physicians, but it excludes services provided in a hospital by certain interns and residents-in-training. For the purposes for which the parties cite these definitions of "physicians' services," the differences are not significant.

42 U.S.C. § 1395x(b)(1)-(3) contains a definitions of "inpatient hospital services." It describes three broad categories included in "inpatient hospital services," specifically 1) bed and board; 2) nursing services and other related services, use of hospital facilities and medical social services ordinarily furnished by the hospital, and drugs, biologicals, supplies, appliances and equipment for use in the hospital, as are ordinarily furnished by the hospital for the care and treatment of inpatients; and 3) other diagnostic or therapeutic items normally furnished by the hospital or pursuant to arrangements made by the hospital. 42 U.S.C. § 1395x(b)(4) expressly provides that medical or surgical services provided by physicians are not "inpatient hospital services." 42 C.F.R. § 411.351 (2004) provides that "inpatient hospital services" means the services set out in 42 U.S.C. § 1395x(b), but does not include professional services performed by, *inter alia*, physicians, if Medicare reimburses the services independently. 42 C.F.R. § 409.10 (1999) provides that "inpatient hospital services" include bed and board; nursing and other related services; use of hospital facilities; medical social services; drugs, biologicals, supplies, appliances and equipment; other diagnostic or therapeutic services; medical or surgical services

provided by interns or residents; and transportation services. It further provides that “inpatient hospital services” do not include physician services that meet certain requirements for payment on a fee schedule basis.

With respect to “outpatient hospital services,” 42 U.S.C. § 1395x does not contain an express definition of “outpatient hospital services.” However, 42 U.S.C. § 1395x(s) defines “medical and other health services” to mean: 1) physicians’ services; 2) services and supplies furnished as an incident to a physicians’ professional services, or which are commonly furnished in physicians’ offices without charge or as part of the physicians’ bills; 3) hospital services incident to physicians’ services rendered to hospital outpatients and partial hospitalization services incidental to physicians’ services; and 4) diagnostic services furnished to an individual as a hospital outpatient or by others pursuant to arrangements made by a hospital, that are ordinarily furnished by a hospital to its outpatients. 42 C.F.R. § 411.351 (2004), which interprets 42 U.S.C. § 1395x(s), provides that outpatient hospital services mean the services listed in 42 U.S.C. § 1395x(s)(2)(B) & (C). It goes on to state that “outpatient hospital services” do not include professional services provided by, *inter alia*, physicians, if Medicare reimburses the services independently and not as part of the outpatient hospital service. 42 C.F.R. § 440.20 (1995) provides that “outpatient hospital services” means preventive, diagnostic, therapeutic, rehabilitative or palliative services furnished to outpatients by or under the direction of a physician and are furnished by an institution licensed or designated as a hospital by a state or meeting requirements for participation as a hospital by Medicare.

This Office is of the opinion that the definitions presented by the parties, primarily those cited by the Respondent, conform to the common, ordinary and accepted meaning of those terms. “Physicians’ services” expressly refers to the services provided by physicians, or by or under

their direct personal supervision. On the other hand, “hospital services” brings to mind the broad range of services provided by hospitals to their patients, with the distinction between the two different classifications of hospital services depending upon the status of the patient as either an inpatient or outpatient. The broad range of hospital services includes bed and board, the use of hospital facilities and treatment by hospital personnel, medical social services, medical services provided by hospital employees, surgical and other acute medical treatment, and a broad range of necessary diagnostic techniques, treatments and therapies, including the apparatus, equipment, drugs, biological treatments and other supplies necessary thereto. These services include both the work component and the practice expense component.

The delineation between “physicians’ services” and “hospital services” is consistent with the expectations of ordinary people, when considered in light of the common, ordinary and accepted meanings of those terms. A patient may go to a physician’s office with the expectation that the physician may require the patient to report to a hospital for diagnosis, care and treatment. However, a patient is not likely to go to a doctor’s office expecting to receive the variety of services that are offered by a hospital. One may receive a certain level of care that can be provided by a doctor, but when it comes to receipt of extensive, acute care requiring the high level of overhead required to provide such care, a patient will likely expect admission to a hospital, either on an inpatient or outpatient basis. The level of care that the ordinary person perceives that he or she will receive from a hospital, in terms of the equipment, facilities, treatment and the like, is clearly associated with the practice expense component.

These definitions also recognize that “inpatient hospital services” and “outpatient hospital services” are, of necessity, provided in conjunction with or ancillary to physicians’ services. That is, they are provided at the direction of physicians. However, this does not render them

physicians' services for purposes of federal law. There is a separation or delineation in the two types of services. So, too, the Legislature established the same delineation or separation in creating the different classes to be taxed for purposes of West Virginia broad-based health care provider taxes. This separation is provided for by statute. This Office must recognize the different classes established by the Legislature. It is not in the province of this Office to eradicate or otherwise cloud the line that separates physicians' services from hospital services.

The Respondent does not challenge taxation of the services provided by physicians employed by the Petitioner in the physicians' services classification, even when it is the hospital that receives payment for those services. At issue is the payment or reimbursement that the hospital receives for the expenses it incurs in providing and maintaining room and board, the facilities, paying the personnel necessary to provide the diagnostic tests and treatments, and purchasing, maintaining and providing all of the apparatus, equipment, drugs, biological treatments and other supplies necessary for treatment. While these items and services may be required by and performed at the direction of a physician, this does not eradicate the legal and functional difference between the two. These services fit within the common, ordinary and accepted meaning of "hospital services," not "physicians' services."

In considering the definitional guidelines proposed by the parties, this Office is of the opinion that those proposed by the Respondent more closely conform to the classifications set out in the West Virginia broad-based health care provider tax than those proposed by the Petitioner. The definition that the Petitioner proposes, as interpreted by it, would have the effect of classifying a substantial portion of services provided by hospitals as "physicians' services." Given the common, ordinary and accepted meaning of "hospital services," the services that would be so classified are services that are, in fact, traditionally provided by hospitals. They are

services that most lay persons and, in all likelihood, many healthcare professionals, would consider to be traditional hospital services. 42 U.S.C. § 1395x(b) & (q), and the regulations promulgated pursuant thereto, seem consistent with the traditional, common sense differentiation between “hospital services” and “physicians’ services.”

The parties devote substantial time and effort arguing about whether or not the Petitioner is attempting to classify “virtually all” of its revenue into the “physicians’ services” classification. If the Respondent is attempting to argue that the percentage of revenue classified as physicians’ services should be a relevant factor in determining the legal issues, then his argument is misplaced. Likewise, if he is attempting to argue that the volume of services that might be reclassified is a relevant factor, then his argument in this respect is also misplaced. This Office is not concerned with what percentage of the Petitioner’s services is classified as “physicians’ services,” as opposed to “inpatient hospital services” and “outpatient hospital services,” regardless of how they are measured. Their relative percentages are immaterial. The issue is, giving sole consideration to the nature of the services, whether the services have been properly classified.

The parties also argue respecting the legal effect that should be given to two letters written in response to solicitations of opinions by one of the Petitioner’s representatives. One letter was written by a former state tax commissioner. The other was written by an attorney for the State Tax Department. The Petitioner admits that the letters are not legally binding on the State Tax Commissioner.

The 2006 letter seems to state that gross receipts from a discrete service should be reported in a particular classification if the industry views that service as being within that classification and that the service is billed as such. Without going into great detail, the letter

states that certain services provided by hospitals, given the manner in which they are provided and billed, should be considered physicians' services. The Petitioner argues that this constitutes evidence supporting its contention that reimbursement for the practice expense component should be classified as "physicians' services."

As stated above, it is not the method of billing that controls the classification under which gross receipts are reported. It is the statutory scheme and the statutory definitions. As discussed above, the gross receipts from reimbursements for the practice expense component should be reported as "hospital services," whether inpatient or outpatient. To the extent that the letters can be read differently, the Respondent takes the position that the letters are incorrect and he is not required to act in accordance with the letters. This Office agrees that the letters are incorrect and are not binding on this Office in rendering this decision.

The Respondent has conceded that the gross receipts received or lithotripsy procedures should not be taxed. In this situation, the Petitioner has contracted with an independent entity to provide lithotripsy services. The independent entity provides the personnel who perform the services and the equipment necessary to perform the services. It appears that the Respondent concedes the refund not because the gross receipts are required to be reclassified from "hospital services" to "physicians' services," but because the gross receipts billed by the hospital are merely paid over to the entity that provides the services and equipment. As such, the Respondent concedes that they are not truly gross receipts of the Petitioner. Accordingly, they should not be subject to the tax.

CONCLUSIONS OF LAW

Based upon all of the above it is **DETERMINED** that:

1. In a hearing before the West Virginia Office of Tax Appeals on a petition for refund, the burden of proof is upon the taxpayer to show that it is entitled to the refund. *See* W. Va. Code § 11-10A-10(e) [2002].

2. The West Virginia broad-based health care provider tax must conform to federal regulations in that it must be both broad-based and uniform. 42 C.F.R. § 433.68 (1992).

3. The West Virginia broad-based health care provider tax levies taxes on gross receipts of health care providers in conformity with the classifications permitted by federal regulations. 42 C.F.R. § 433.56 (1992).

4. The relevant West Virginia broad-based health care provider tax statutes, W. Va. Code §§ 11-27-9, 11-27-15 & 11-27-16, defines the services to be taxed by reference to a federal statute, 42 U.S.C. § 1396b.

5. 42 U.S.C. § 1396b does not provide definitions for the relevant terms set out in the West Virginia broad-based health care provider tax statutes and, as a consequence, for purposes of construing the statutes said terms must be treated as undefined.

6. “In the absence of any definition of the intended meaning of words or terms used in a legislative enactment, they will, in the interpretation of the act, be given their common, ordinary and accepted meaning in the connection in which they are used.” *CNG Transmission Corp. v. Craig*, 211 W. Va. 170, 564 S.E.2d 167 (2002).

7. Other federal statutes and regulations define the terms used in the West Virginia broad-based health care provider tax statutes, which definitions, while not binding, may be used as guidance in construing the West Virginia states..

8. The terms defined in the federal statutes and regulations are consistent with the common, ordinary and accepted meaning of the same terms used in the West Virginia broad-based health care statutes.

9. The common, ordinary and accepted meaning of the terms used in the West Virginia broad-based health care statutes, consistent with the federal statutory and regulatory definitions, require that the Petitioner's gross receipts from reimbursements for the costs of providing bed and board, nursing services and other related services, use of hospital facilities and medical social services ordinarily furnished by the hospital, and drugs, biologicals, supplies, appliances and equipment for use in the hospital, as are ordinarily furnished by the hospital for the care and treatment of inpatients, and other diagnostic or therapeutic items normally furnished by the hospital or pursuant to arrangements made by the hospital constitute gross receipts to be taxed in the appropriate "hospital services" classification. W. Va. Code §§ 11-27-9 & 15.

10. Opinion letters authored by a former state tax commissioner and a lawyer employed by the state tax commissioner are not binding on the Respondent except insofar as they are limited to the facts and circumstances articulated therein and insofar as they articulate legal principles that are inconsistent with the applicable statutes.

DISPOSITION

WHEREFORE, it is the **FINAL DECISION** of the **WEST VIRGINIA OFFICE OF TAX APPEALS** that the Petitioner's petition for refund for tax in the amount of \$____, for fiscal years 2003 through 2006 is hereby **AUTHORIZED** in the amount of \$____, the amount conceded by the Respondent, and is hereby **DENIED** with respect to the remainder of the amount claimed.

As set forth in W. Va. Code § 11-10A-18 [2002], the West Virginia State Tax Commissioner's Office is to see that the payment of the refund is issued promptly.