Circuit Court for Montgomery County
Case No. 447732V

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 517

September Term, 2019

UNITED BEHAVIORAL HEALTH

v.

J.D.S. o.b.o C.N.M.

Fader, C.J.,
Shaw Geter,
Greene, Clayton, Jr.
(Senior Judge, Specially Assigned),

JJ.

Opinion by Fader, C.J.

Filed: June 17, 2020

The appellant, United Behavioral Health ("United"), asks this Court to reverse an order of the Circuit Court for Montgomery County that itself reversed a decision of the Maryland Insurance Administration ("MIA"). Although MIA determined that United had not violated Maryland insurance law in denying a claim for reimbursement of substance abuse treatment incurred by the appellee, C.M., the circuit court ordered United to provide full reimbursement for the cost of the treatment. United presents us with a single question: "Was the MIA's determination that [United] did not violate Maryland's insurance laws supported by substantial evidence?" We hold that it was, and will therefore reverse the circuit court's order and uphold MIA's determination.

BACKGROUND

Statutory Framework

This appeal arises from a complaint C.M. filed with MIA seeking review of United's decision to deny his claim for reimbursement of the cost of inpatient substance abuse treatment. The statutory authority for C.M.'s complaint is § 15-10A-04(c)(1) of the Insurance Article, pursuant to which "it is a violation of [Maryland law] for a carrier[1] to fail to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members."

Section 15-10A-04(c)(1) is enforced by MIA, "an independent unit of the State government" that is headed by the Maryland Insurance Commissioner. *Id.* § 2-101. Upon

[1] The statute defines a "carrier" as "a person that offers a health benefit plan and is," among other things, (1) "an authorized insurer that provides health insurance in the State," (2) "a nonprofit health service plan," or (3) "a health maintenance organization." Md. Code Ann., Ins. § 15-10A-01(c).

receiving an "adverse decision" from an insurance company,[2] and after exhausting the insurer's internal grievance process, an insured "may file a Complaint with the Commissioner" seeking review of that decision. *Id.* § 15-10A-03(a)(1). In such a review, the health insurance carrier has the burden of persuading the Commissioner that the carrier's decision to deny coverage was correct. *Id.* § 15-10A-03(e)(1). For complaints that challenge a determination of medical necessity, as C.M.'s complaint did, the Commissioner is required to "seek advice from an independent review organization or medical expert." *Id.* § 15-10A-03(d). A person aggrieved by the Commissioner's initial decision can demand a contested case hearing, as C.M. did here. *Id.* § 2-210(a)(2). The Commissioner's final decision following such a hearing is then subject to judicial review by a circuit court. *Id.* § 2-215(d). Any party may appeal from the circuit court's judgment to this Court. *Id.* § 2-215(j)(1).

The Insurance Policy

C.M. was a member of a UnitedHealthcare Choice Plus health insurance policy offered through his employer (the "Policy"). According to the Policy, United Healthcare (a related entity to the appellant, United) bears the responsibility to, among other things, "Determine Benefits" and "Pay for Our Portion of the Cost of Covered Health Services." The Policy provides coverage only for "Covered Health Services," which, among other

[2] An "adverse decision" is, in relevant part, "a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that: 1. a proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient; and 2. may result in noncoverage of the health care service." Ins. § 15-10A-01(b)(1)(i).

criteria, are limited to services that are "Medically Necessary."[3] The Policy defines "Medically Necessary" as:

> [H]ealth care services produced for the purpose of preventing, evaluating, diagnosing, or treating a Sickness, Injury, Mental Illness, substance-related or addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion.
>
> - In accordance with *Generally Accepted Standards of Medical Practice*.[4]
>
> - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
>
> - Not mainly for your convenience or that of your doctor or other health care provider.
>
> - Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

The Policy contains 35 different numbered categories of "Covered Health Services," which are covered if, among other criteria, they are Medically Necessary, received during

[3] In a belt-and-suspenders approach, the Policy both defines its grant of coverage as limited to services that are "Medically Necessary" and excludes from coverage any services that are "not Medically Necessary," "even if . . . recommended or prescribed by a Physician."

[4] According to the Policy,

> *Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

the policy period, and provided to a person covered by the Policy. Category 20 is "Mental Health Services and Substance Use Disorder Services . . . received on an inpatient basis in a Hospital, Related Institution, Residential Treatment Facility, or entity licensed by the *Department of Health and Mental Hygiene* to provide Residential Crisis Services." The Policy provides benefits under such coverage for services "provided on an inpatient basis" including, among others, "[d]iagnostic evaluations and assessment," "[t]reatment planning," "[r]eferral services," "[m]edication evaluation and management," and "[t]reatment and counseling."

Category 21 is "Mental Health Services and Substance Use Disorder Services . . . received on outpatient basis in a provider's office or an Alternate Facility." The Policy provides benefits under such coverage for many, but not all,[5] of the same types of services listed under Category 20, but only for services which are "provided on an outpatient basis." Category 21 also provides coverage for "Intensive Outpatient Treatment," which the Policy defines as "a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week."

Under the Policy, "[s]ome Covered Health Services require prior authorization." For any services that are to be provided by an out-of-network provider, the Policy states that the insured is "responsible for obtaining prior authorization before [he or she]

[5] For example, Category 21 does not provide coverage for "Services at a Residential Treatment Facility," "Inpatient professional fees," or "Inpatient Hospital and Inpatient Residential Treatment Facility services."

receive[s] the services." Prior authorization is required for all "Mental Health and Substance Use Disorder Services," including both inpatient and outpatient treatment programs, that are to be provided by an out-of-network provider.

In a section titled "How to File a Claim," the Policy states that an insured who receives services from an out-of-network provider is "responsible for requesting payment from us" by "fil[ing] the claim in a format that contains" specified information. One such requirement is "[a]n itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes[6] or a description of each charge."

C.M.'s Substance Abuse Treatment

C.M. developed an opioid addiction after taking medications that had been prescribed for him after undergoing surgery. On February 12, 2016, he sought treatment for the addiction at the Richard J. Caron Foundation residential treatment facility ("Caron"), an out-of-network provider. C.M. entered the Grand View Program at Caron, which is advertised as an "[a]ddiction rehab and behavioral health treatment [program] for executives needing discretion." According to program materials, the Grand View Program "differs from [Caron's] traditional adult treatment programs in several ways that offer

[6] *Current Procedural Terminology* is a publication of the American Medical Association that sets forth "the most widely accepted medical nomenclature used across the country to report medical, surgical, radiology, laboratory, anesthesiology, genomic sequencing, evaluation and management (E/M) services under public and private health insurance programs." AMA, *CPT® overview and code approval* (2020), https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval (last accessed June 10, 2020). CPT codes are "[d]esignated by the U.S. Department of Health and Human Services under the Health Insurance Portability and Accountability Act (HIPAA) as a national coding set for physician and other health care professional services and procedures." *Id.*

greater latitude and amenities as well as . . . [a] more similar patient community." The Grand View Program features include:

- "[S]eparate buildings for Grand View patients' living quarters and the majority of their treatment programming. Both buildings – a restored mansion and cottage-like residences – are situated in a secluded area of campus with pristine views."
- "Individual and group counseling seven days per week." (emphasis removed).
- "Technology-enabled care" in the form of "Passport[,] . . . a custom-developed, interactive mobile and web app adorned with Caron's nationally recognized therapeutic protocols." (emphasis removed).
- "[C]ell phone and computer privileges" for patients "as clinically indicated or appropriate, with Wifi access available during designated times and locations."

Although a representative from Caron had contacted United on February 11 to inquire "what the benefits were for certain levels of care," neither C.M. nor Caron sought prior authorization for C.M.'s treatment. On February 13, Caron requested authorization from United for five days of residential substance abuse services for C.M. A clinical assessor at United denied authorization at that time, offered an "ambulatory detox" level of care instead,[7] and referred C.M.'s case to peer review to assess the medical necessity of the requested residential services.

United's Associate Medical Director, Dr. Theodore Allchin, conducted the peer review. In a letter dated February 16, Dr. Allchin stated that "it is my determination that

[7] United's Regional Medical Director, Dr. Andrew Martorana, testified at the administrative hearing that ambulatory detox would entail "treatment . . . [in] a non-24 hour setting."

no authorization can be provided from 02/12/2016 forward" because C.M.'s case did not reach the residential rehabilitation level of care under the applicable Level of Care Guidelines.[8] Based on the status of C.M.'s condition, Dr. Allchin stated that "care could continue in the Substance Use Disorder Intensive Outpatient Program."

C.M. continued to receive residential treatment at Caron until March 5. During his stay, C.M. received a number of "passes" to leave the Caron facility, including twice to have dinner with his family and twice to attend religious functions. At the conclusion of C.M.'s stay, Caron issued an invoice for $36,520.00. The invoice, which identifies United as the payer, includes a single line item entry for each day of C.M.'s 22-day stay, with the description "RESIDENTIAL TREATMENT – CHEM DEP," and an associated charge of $1,660.00. The invoice did not identify charges for any individual services provided to C.M., although at some point Caron or C.M. provided United with treatment records from C.M.'s stay. Neither Caron nor C.M. ever submitted a claim to United for reimbursement of any individual services provided to C.M., nor did either identify the cost of any such services.

Procedural History

In a letter dated March 29, 2016, C.M. made "an official request to reverse UnitedHealthcare's decision to deny" coverage for the residential treatment that he

[8] The United Level of Care Guidelines "are derived from generally accepted standards of behavioral health practice" and are used by United to make determinations regarding questions of medical necessity. In the substance abuse context, the guidelines supply three levels of care—outpatient, residential, and inpatient—and provide criteria used to evaluate a request for authorization of each level of care.

received. In response, United's Regional Medical Director, Dr. Andrew Martorana, reviewed Dr. Allchin's determination. In a letter dated May 6, 2016, Dr. Martorana agreed with Dr. Allchin's assessment "that benefit coverage is not available." In reaching that conclusion, Dr. Martorana reviewed the United Level of Care Guidelines for substance use disorder residential rehabilitation and remarked:

> Your doctor wanted to treat your Substance Use Disorder (SUD) in [a] residential rehab setting. I reviewed your medical records. While you did need treatment, there is no clear documentation of the need for a 24 hour treatment setting. . . . All the treatment interventions could have occurred in a less restrictive setting. [United] will not cover admission to SUD Residential Rehab 2/12/2016 and forward. SUD Intensive Outpatient Program was an appropriate and available alternative.

In October 2016, C.M. invoked the MIA review process by sending MIA a written "request [for] an independent external review of a claim for inpatient drug treatment at Caron Foundation that was denied twice by United." Consistent with § 15-10A-03(d) of the Insurance Article, MIA sought independent review of the complaint from Health Quality Innovators, "an Independent Review Organization (IRO) certified by the [MIA] to review cases concerning adverse carrier decisions issued to managed care plan members." The review was conducted by Dr. Avtar Dhillon, a physician based in Williamsburg, Virginia who is board certified in Psychiatry, Addiction Psychiatry, Forensic Psychiatry, Pain Management, and Psychosomatic Medicine. Dr. Dhillon reviewed C.M.'s medical records as well as United's guidelines and its application of those guidelines. He ultimately concluded that C.M.'s "inpatient residential treatment was not medically necessary," that United had correctly applied its criteria in C.M.'s case, and that those criteria were

objective, clinically valid, "compatible with established principles of health care," and sufficiently flexible "to allow deviations from norms when justified on a case by case basis." After receiving that independent assessment, MIA determined that United had not violated the Maryland Insurance Article in denying C.M.'s coverage claim. MIA communicated its decision to C.M. in November.

C.M. requested a hearing. In that request, C.M. continued to assert that United should have approved his claim for coverage of the inpatient care he received at Caron. In the substantive final paragraph of his five-page request, C.M. also made, for the first time, an alternative argument that United had "no basis to deny *all* coverage." According to C.M., "United's main concern [was] the cost associated with inpatient services, not the actual treatment [C.M.] received," and, therefore, United should pay for "the equivalent of the outpatient services" that United agreed would have been appropriate.

On May 17, 2017, MIA's Associate Commissioner held a hearing in which she heard testimony and took other evidence. On June 7, the Commissioner issued a Memorandum and Final Order (the "2017 MIA Order") finding that United had met its "burden to show that its coverage decision and appeal decision were correct." The Commissioner thus affirmed "MIA's determination that [United] did not violate the Insurance Article." The majority of the Commissioner's 24-page decision addressed C.M.'s primary contention that MIA should have approved his claim for reimbursement of inpatient services. Near the conclusion of the decision, the Commissioner added, "As a final note, I am not authorized under the Insurance Article to fashion an equitable solution

to this matter or to order the Licensee to pay that portion of the $36,520.00 that it would have paid for a lower level of care." That statement appeared to be directed to C.M.'s alternative argument that United should be made to pay "the equivalent of the outpatient services" it agreed were medically necessary.

C.M. sought judicial review of MIA's decision in the Circuit Court for Montgomery County. For the first time, C.M. abandoned his claim that United was required to cover all of his inpatient treatment, and instead challenged the Commissioner's conclusion that MIA did not have authority to order United to make partial payment. After argument, the court issued an Opinion and Order on February 9, 2018, in which it concluded that "[w]hile the MIA may be correct that it lacks the authority to consider equitable solutions, the issue in this matter is legal, not equitable." Focusing on a clause in the Policy stating that United "make[s] administrative decisions regarding whether this Benefit plan will pay for any portion of the costs of a health care service you intend to receive or have received," the court held that United "retained the sole discretionary authority" to make partial payments, and so was required to exercise that discretionary authority in good faith. The court therefore concluded that whether United was required to make a partial payment was a legal, not equitable, issue that should have been reviewed by MIA. The court then stated:

> This is not to say [United] was not justified in their denial, nor is it clear that [C.M.] will ultimately be entitled to any reimbursement. . . . Rather, the opinion of this Court is that the MIA improperly considered this particular request for a partial payment as an equitable issue rather than a legal question. While the record below does not contain much evidence as to what treatments would have been covered, the medical records have been produced and some testimony elicited on this point. Therefore, "when an administrative agency renders a decision based on incorrect legal standards, but there exists some

> evidence, however minimal, that could be considered appropriately under the correct standard, the case should be remanded so the agency can consider the evidence using the correct standard." *Bd. of County Comm'rs for St. Mary's County v. S. Res. Mgmt., Inc.*, 154 Md. App. 10, 34 (2003) (citations omitted).

Accordingly, the court "ordered that this matter be remanded to the [MIA] for further proceedings not inconsistent with the opinion of this Court."

On remand, MIA requested additional briefing from the parties.[9] C.M. argued that because United had discretion to make payments under the policy and had recognized the need for treatment at the outpatient level, United could have determined the cost of the treatment that it deemed necessary and paid that amount. For its part, United did not dispute that some level of treatment—specifically, intensive outpatient services, as noted in the determination letters from Drs. Allchin and Martorana—was required to treat C.M.'s opioid addiction. United argued, however, that it should not be made to pay for such services because C.M. elected to stay at Caron, did not receive intensive outpatient services, and did not submit any claim for such services. According to United, it would be "impossible" to calculate the cost of such hypothetical services for reimbursement purposes.

The Commissioner issued an Amended Memorandum and Final Order on April 17, 2018 that restated all of its factual findings from the 2017 MIA Order, detailed the subsequent procedural history since C.M.'s first petition for judicial review, discussed each party's arguments made on remand and related evidence, and then applied the relevant law

[9] In accord with the court's direction to "consider the evidence using the correct standard," the agency did not reopen the evidentiary record.

to the facts. With respect to the issue of partial reimbursement for outpatient equivalent services, the Commissioner stated:

> [C.M.] did not seek pre-authorization for any other level of care [other than inpatient treatment], including outpatient care, never submitted either a claim or any evidence that he had received outpatient care, and did not offer any evidence regarding the cost of outpatient treatment. [United] further argues that it would be impossible to determine the cost of outpatient treatment due to variables such as the length of care, the actual cost of care, whether the outpatient treatment was provided by an in-network or out-of-network provider, and, as Martorana testified, inpatient care and outpatient care are not equivalent services. I find [United] did not fail to act in good faith under [C.M.]'s contract when it did not make payment for outpatient services [C.M.] had not received. It makes no sense to require [United] to speculate as to what services might have been provided to [C.M.] on an outpatient basis, and to compel [United] in this case to make payment for hypothetical outpatient services that were neither prescribed nor received. I therefore find, as a matter of law, [United] did not fail to fulfill the obligations set out in [C.M.]'s contract when in denied coverage for [C.M.]'s residential treatment claim.

(Internal record citations omitted).

C.M. again sought judicial review in the circuit court. After a hearing, the court reversed the MIA determination in an order entered on April 2, 2019. After quoting passages from the Policy stating that patients choose their health care professionals, that United makes payment decisions, and that "not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan," the court criticized United for "refus[ing] to even consider partial payment." Crediting statements from C.M.'s physicians at Caron about C.M.'s need for inpatient services, the court held that C.M.'s failure to "adhere[] to the letter of United's Plan . . . does not excuse United from considering the merit of partial reimbursement." The court concluded that United was

"capable of determining the costs" of outpatient services for which it would have paid and that its failure to do so constituted bad faith. As a result, the court ordered United to pay the full amount of C.M.'s medical care at Caron, $36,520.00, as well as "the total cost of this appeal."

United timely appealed.

DISCUSSION

On judicial review of a final decision by MIA, we "look through" the circuit court's decision, *People's Ins. Counsel Div. v. State Farm Fire & Cas. Ins.*, 214 Md. App. 438, 449 (2013) (quoting *People's Counsel v. Country Ridge Shopping Ctr.*, 144 Md. App. 580, 591 (2002)), and "directly evaluate the Commissioner's administrative determination," *Md. Ins. Comm'r v. Kaplan*, 434 Md. 280, 297 (2013).

In conducting our "look through," we are "limited to determining if there is substantial evidence in the record as a whole to support the agency's findings and conclusions, and to determin[ing] if the administrative decision is premised upon an erroneous conclusion of law." *People's Ins. Counsel Div.*, 214 Md. App. at 449 (quoting *UPS v. People's Counsel*, 336 Md. 569, 577 (1994)). Substantial evidence is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Owusu v. Motor Vehicle Admin.*, 461 Md. 687, 698 (2018) (quoting *Gigeous v. E. Corr. Inst.*, 363 Md. 481, 497 (2001)). "[W]e review the record in the light most favorable to the agency and 'defer to [its] fact-finding and drawing of inferences' if supported by any evidence in

the record." *People's Ins. Counsel Div.*, 214 Md. App. at 449 (quoting *Bd. of Physician Quality Assurance v. Banks*, 354 Md. 59, 68 (1999)).

C.M. contends that this well-trod standard of judicial review of agency action does not apply here, and that we should instead review the circuit court's decision for an abuse of discretion. According to C.M., this departure results from the broad dispositional options provided under § 2-215(h) of the Insurance Article, pursuant to which the circuit court is authorized to:

> (1) affirm the decision of the Commissioner;
>
> (2) remand the case for further proceedings; or
>
> (3) reverse or modify the decision of the Commissioner if substantial rights of the petitioners may have been prejudiced because administrative findings, inferences, conclusions, or decisions:
>
> (i) violate constitutional provisions;
>
> (ii) exceed the statutory authority or jurisdiction of the Commissioner;
>
> (iii) are made by unlawful procedure;
>
> (iv) are affected by other error of law;
>
> (v) are unsupported by competent, material, and substantial evidence in view of the entire record, as submitted; or
>
> (vi) are arbitrary or capricious.

To the extent C.M. implies that these dispositional options are unique to administrative proceedings under the Insurance Article, and so should be treated differently from judicial review of other administrative proceedings, he is incorrect. The dispositional options under § 2-215(h) are nearly identical to those provided in the Administrative Procedure Act, *see* Md. Code Ann., State Gov't § 10-222(h), pursuant to which appellate

courts "review an administrative agency's decision under the same statutory standards as the Circuit Court," and thus "reevaluate the decision of the agency, not the decision of the lower court,"[10] *Gigeous*, 363 Md. at 495-96 & n.12; *see also Motor Vehicle Admin. v. Smith*, 458 Md. 677, 685 (2018) ("When this Court reviews a decision of an administrative agency, we take the same posture as the circuit court or the intermediate appellate court, and limit our review to the agency's decision." (quoting *Anderson v. Gen. Cas. Ins.*, 402 Md. 236, 244 (2007))). Moreover, the Court of Appeals has stated expressly that where a "final administrative order is subject to judicial review pursuant to [Insurance] § 2-215, . . . we directly evaluate the Commissioner's administrative decision, not the decision of the Circuit Court." *Md. Ins. Comm'r v. Kaplan*, 434 Md. at 297. We will do the same.

I. THIS COURT IS NOT PRECLUDED FROM REVIEWING MIA'S DECISION.

C.M.'s first argument on appeal is that the law of the case doctrine and the mandate rule preclude this Court from reaching the merits of MIA's decision. According to C.M., MIA failed to adhere to the circuit court's mandate when the circuit court vacated and remanded MIA's initial decision, and MIA's failure to comply with that mandate insulates the circuit court's subsequent decision from review by this Court.

As we recently summarized:

> The law of the case doctrine provides that, "once an appellate court rules upon a question presented on appeal, litigants and lower courts become bound by the ruling, which is considered to be the law of the case." *Scott v.*

[10] In this sense, the law of judicial review in Maryland can be described as "hierarchically uniform" across all levels of review, with each successive reviewing court applying the same "look through" to the underlying agency decision. *Cf.* Aaron-Andrew P. Bruhl, *Hierarchically Variable Deference to Agency Interpretations*, 89 Notre Dame L. Rev. 727, 729-30 (2013) (describing the federal system in those terms).

> *State*, 379 Md. 170, 183 (2004). Furthermore, "[n]ot only are lower courts bound by the law of the case, but decisions rendered by a prior appellate panel will generally govern the second appeal at the same appellate level as well, unless the previous decision is incorrect because it is out of keeping with controlling principles announced by a higher court and following the decision would result in manifest injustice." *Id.* at 184.

Holloway v. State, 232 Md. App. 272, 279 (2017). The "mandate rule" is a "subset" of the law of the case doctrine that "prevents trial courts from dismissing appellate judgment and re-litigating matters already resolved by the appellate court." *Stokes v. Am. Airlines*, 142 Md. App. 440, 446 (2002); *see also Bd. of Public Works v. K. Hovnanian's Four Seasons at Kent Island, LLC*, 443 Md. 199, 222 n.10 (2015) (addressing the mandate rule in the context of an order of remand entered upon judicial review of an administrative agency decision). Put differently, "[w]hen a case is appealed and remanded, the decision of the appellate court establishes the law of the case, which must be followed by the trial court on remand." *Tu v. State*, 336 Md. 406, 416-17 (1994) (emphasis omitted); *see also* Md. Rule 8-604(d)(1) (stating, in pertinent part: "The order of remand and the opinion upon which the order is based are conclusive as to the points decided. Upon remand, the lower court shall conduct any further proceedings necessary to determine the action in accordance with the opinion and order of the appellate court.").

Setting aside, for purposes of analysis, whether this Court's review could possibly have been circumscribed by the circuit court's ruling, this case implicates neither the law of the case doctrine generally, nor the mandate rule specifically, because MIA complied fully with the circuit court's 2018 Opinion and Order (the "2018 Order"). In the 2018 Order, the circuit court ruled that MIA had erred as a matter of law in concluding that it

lacked authority to review United's "decision not to make partial payments in an amount equal to the services that would have been covered by level of care that was deemed necessary." The court therefore remanded the matter to MIA so that that decision could "be[] reviewed at the Agency level." In doing so, the court stated expressly that it had not decided either that (1) "[United] was not justified in [its] denial" or that (2) "[C.M.] will ultimately be entitled to any reimbursement." To the contrary, the court reiterated, its ruling was that "this particular request for a partial payment . . . [was] a legal question" that MIA should have decided. The court, therefore, vacated MIA's order and remanded the case for further proceedings.

In light of C.M.'s current arguments, we also note that the 2018 Order did not direct United to calculate a partial reimbursement of C.M.'s claim, nor even to reassess whether it should do so. The court also did not direct MIA to take additional evidence. To the contrary, the court referred to the evidence that was already in the record and stated that "the case should be remanded so the agency can reconsider the evidence using the correct standard." (quoting *Bd. of County Comm'rs v. S. Res. Mgmt.*, 154 Md. App. 10, 34 (2003)).

On remand, MIA complied with the circuit court's mandate by considering whether United had acted in good faith in declining to make any reimbursement, including partial reimbursement, of C.M.'s claim. MIA first entertained additional briefing on the issue by both parties. Based on that briefing and further consideration of the evidence, MIA issued a new decision that discussed and analyzed the arguments made by both parties as well as relevant evidence. MIA determined that United had carried its burden of demonstrating

that it acted in good faith in denying the claim in its entirety, including any partial reimbursement. MIA thus did not refuse to address the partial reimbursement claim, which was the flaw the 2018 Order had found with MIA's initial decision. To the contrary, MIA directly confronted and decided that issue.

C.M. relies heavily on this Court's decision in *Stokes*, 142 Md. App. 440. There, we overturned a damages award made by the Worker's Compensation Commission, and remanded for a "more limited reconsideration" that "might entitle [Stokes] to a lesser amount of compensation." *Id.* at 443-44. The Commission followed our mandate. *Id.* at 444-45. On a subsequent petition for judicial review, the circuit court summarily held that the plaintiff was entitled to no compensation, which was contrary to our initial mandate. *Id.* at 445-46. We reversed. Because we have concluded that MIA's revised decision did not contradict the circuit court's mandate, *Stokes* is inapposite.

C.M.'s contention that MIA failed to comply with the 2018 Order is based on an interpretation of that order that is in conflict with its plain language. C.M. interprets the 2018 Order as requiring MIA to determine whether United actually went through the exercise of (1) attempting to craft a claim for partial reimbursement for C.M.—"in an amount equal to the services" that United would have paid if C.M. had obtained care on an outpatient basis, and (2) deciding whether to exercise its discretion to reimburse that hypothetical claim. We do not read the order that way. As noted, the order first held that MIA had erred in deeming United's decision not to make partial payments to be an unreviewable equitable decision rather than a reviewable legal one, and then directed MIA

to review United's decision on remand. MIA did so. The law of the case, including the mandate rule, is not implicated.

II. SUBSTANTIAL EVIDENCE IN THE RECORD SUPPORTS MIA'S DETERMINATION THAT UNITED DID NOT FAIL TO ACT IN GOOD FAITH.

Turning to the merits, § 15-10A-04(c)(1) of the Insurance Article provides that "[i]t is a violation of this subtitle for a carrier to fail to fulfill the carrier's obligations to provide or reimburse for health care services specified in the carrier's policies or contracts with members." MIA determined that United did not violate the Insurance Article when it denied any reimbursement for C.M.'s substance abuse treatment at Caron. The issue for our review is whether MIA's decision is legally correct and supported by substantial evidence. *People's Ins. Counsel Div.*, 214 Md. App. at 449.

At the outset, it is important to identify clearly the question that was before MIA. That question is whether United violated its obligations to C.M. under the Policy—and, thereby, Maryland insurance law—when it denied coverage for the cost of the care C.M. received at Caron. As the circuit court concluded in the 2018 Order: (1) a component of an insurer's obligation to its policyholders is to make coverage determinations in good faith; and (2) a decision regarding coverage is not necessarily an all-or-nothing decision if the Policy permits partial payment of a claim. Thus, in reviewing C.M.'s claim, it was proper for MIA to address whether United satisfied its contractual obligation to C.M. when it denied any reimbursement—not just full reimbursement—of the cost of C.M.'s care at Caron. MIA did not address that issue fully in its initial decision, but did so in its amended decision.

In addressing whether United acted in good faith in assessing its coverage obligations, it was, of course, appropriate for MIA to consider the claim that had been submitted to United. Here, the only claim that was ever submitted to United was for reimbursement of the amount charged for the inpatient services rendered by Caron, which were billed on a lump sum basis at a daily rate. That is the only claim that United denied; that C.M. appealed within United; that C.M. appealed to MIA; and that MIA submitted for review to an independent assessor. C.M.'s current contention—that United should have authorized partial payment for the services Caron rendered, as though those services had been provided on an outpatient basis—was never actually presented to United. Instead, it is a twist that C.M. first added as an alternative argument during the course of MIA's review of United's decision. Even then, C.M.'s primary contention remained that United was obligated to pay his entire claim for inpatient services. It was only in his first petition for judicial review that C.M. abandoned what had been his primary claim and pivoted to focus on whether United should have authorized a partial reimbursement on a different basis.

On appeal, C.M. contends that MIA abused its discretion in concluding that United did not violate its duty of good faith by failing to take the claim C.M. submitted, engage in a number of theoretical exercises to convert it to a different claim, and then decide whether it could make partial payment based on the different claim. Specifically, C.M. argues that MIA should have concluded that United had an obligation under the Policy to (1) take his treatment records from Caron, (2) identify services he received that United would have

covered if the services had been provided on an outpatient basis, (3) assess the likely cost that a hypothetical outpatient provider would have charged for those services, (4) assess how much it would have reimbursed for those services if they had been provided by such an outpatient provider, and then (5) decide whether to make payment in that amount.

Most of MIA's decision is understandably focused on C.M.'s then-primary argument that United was obligated to cover the inpatient services he received. The Commissioner expressed sympathy for C.M. and for his view that the care he received at Caron was most appropriate for him. The Commissioner observed, however, that the issue for MIA's determination was whether United had "fail[ed] to fulfill its obligations to provide or reimburse for health care services specified in the policy with its member." After reviewing (1) detailed information regarding C.M.'s medical records and the other evidence regarding his addiction and treatment; (2) United's consideration of the claim and its application of appropriate guidelines for evaluating medical necessity; and (3) the consistent determinations of medical professionals and experts not affiliated with Caron that United's review had been thorough and appropriate, the Commissioner determined that United had not breached its obligations under the Policy in concluding that the care C.M. received at Caron was not medically necessary. C.M. no longer contests that determination.

The Commissioner went on to determine that United did not violate its duty of good faith to C.M. by failing to undertake a theoretical exercise to identify how much it might have paid had C.M. pursued outpatient treatment. In explaining that determination, the

Commissioner noted that C.M. did not submit a claim for outpatient care "and did not offer any evidence regarding the cost of outpatient treatment." The Commissioner also credited United's explanation that "it would be impossible to determine the cost of outpatient treatment due to variables such as the length of care, the actual cost of care, [and] whether the outpatient treatment was provided by an in-network or out-of-network provider." Further, the Commissioner credited Dr. Martorana's testimony that "inpatient care and outpatient care are not equivalent services." The Commissioner thus determined that it was not bad faith for United to refuse to "speculate as to what services might have been provided to [C.M.] on an outpatient basis," and declined "to compel [United] to make payment for hypothetical outpatient services that were neither prescribed nor received."

On this record, we agree with United that C.M. has not met the burden required to reverse MIA's decision. C.M. has not identified any legal error made by MIA, and substantial evidence supports MIA's ultimate determination. In the latter regard, United presented evidence, including through Dr. Martorana's testimony, that the exercise C.M. now claims was required was, in fact, not possible. Contrary to C.M.'s claims, Dr. Martorana testified that services provided on an inpatient and outpatient basis are not equivalent and that United could not identify what treatment C.M. would have received on an outpatient basis to make the calculation C.M. now requests. The Commissioner credited that testimony.

By contrast, the record does not contain any evidence that the calculation C.M. now requests was possible. C.M. argues that all of the substance use disorder services that are

listed in the Policy for both inpatient and outpatient treatment "could reasonably have been considered for partial payment[] by United," "to the extent actually received by C.M." But he did not present a single witness to contradict Dr. Martorana's testimony. Instead, the only two witnesses he presented (in addition to himself) both testified in support of his now-abandoned claim for reimbursement of the entire cost of his inpatient treatment. A member of his treatment team at Caron testified that his inpatient treatment was necessary and that outpatient treatment would not have provided the same benefit. And the founder and principal of a company that cared for C.M. after he left Caron testified that Caron's program was appropriate for C.M. and that "anything short of an inpatient treatment center, in my experience, would have given minimal likelihood he would have been able to establish a sustainable recovery." If anything, that testimony validates Dr. Martorana's testimony about the lack of equivalency in services. In any event, neither witness testified to what an outpatient treatment program would have entailed; whether some, any, or all of the specific services provided to C.M. would have been equivalent to services provided on an outpatient basis; or whether the calculation C.M. now seeks was reasonably possible.[11]

[11] We, of course, do not reach any conclusion regarding whether the exercise C.M. alleges United should have undertaken was reasonably possible or whether United would have been required to engage in that exercise under different circumstances. Although C.M.'s contention has intuitive appeal, he did not introduce any evidence to support it or to contradict United's evidence to the contrary. Presumably, he did not do so because he was still pursuing payment of the entirety of his claim, and evidence supporting partial reimbursement might have undermined his claim for full reimbursement. Regardless, on this record, MIA's decision was based on substantial evidence, and we have no basis to overturn it.

Moreover, because C.M.'s current contention is premised on United's alleged failure to consider in good faith the possibility of partial reimbursement, we view it as particularly relevant that C.M. never presented a claim for partial reimbursement to United. Nor did he send United an itemized bill for services or other information that might have facilitated the type of review he now says should have occurred. Although the Policy may have *permitted* United to consider making partial payment for uncovered services based on equivalent services that would have been covered, that is a far cry from saying that the Policy *required* United to do so when a claim for partial payment was not made.

The substantial evidence "test 'requires restrained and disciplined judicial judgment so as not to interfere with the agency's factual conclusions.'" *Motor Vehicle Admin. v. Smith*, 458 Md. 677, 686 (2018) (quoting *Supervisor of Assessments v. Asbury Methodist Home*, 313 Md. 614, 625 (1988)). A reviewing court "may not substitute its judgment . . . for that of the agency," *Smith*, 458 Md. at 685-86 (quoting *Liberty Nursing Ctr. v. Dep't of Health & Mental Hygiene*, 330 Md. 433, 442 (1993)), and owes deference to the agency's substantive expertise, *Motor Vehicle Admin. v. Carpenter*, 424 Md. 401, 412-13 (2012). Adhering to those precepts, we hold that MIA's decision was legally correct and supported by substantial evidence.

JUDGMENT OF THE CIRCUIT COURT FOR MONTGOMERY COUNTY REVERSED. CASE REMANDED WITH DIRECTIONS TO DENY THE PETITION FOR JUDICIAL REVIEW. COSTS TO BE PAID BY APPELLEE.