Riverwood Center

Customer Service Training 2025/2026

What is Customer Service?

Riverwood's Customer Services office is here to help you.

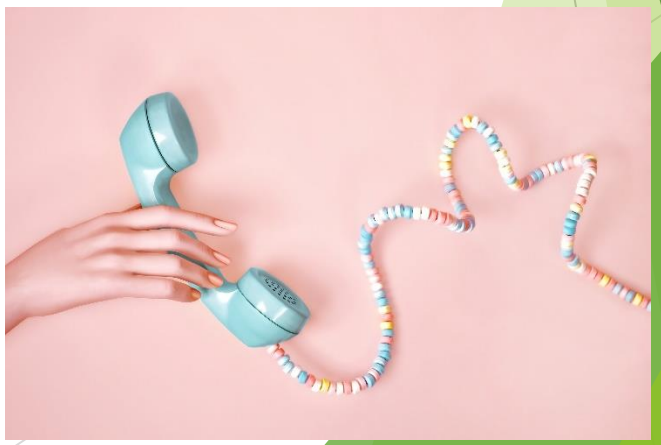
Our responsibilities are to:

•Welcome and orient people to services and benefits.
•Provide information about how to access caring and confidential mental health services such as services for children, families and adults with mental illnesses, intellectual/developmental disabilities and substance use disorders.
•Provide information about how to access rights processes.
•Assist people in filing grievances or appeals.
•Provide assistance with questions and problems about community benefits.
•Track and report problem areas for the organization.

Customer Services is here to insure every person has an exceptional experience……every time!

CONTACTING CUSTOMER SERVICES

- Customer Services hours are **Monday** through **Friday** from **8:30 a.m.** to **5:00 p.m.**
- You can call our Customer Services line at 269-934-3478 or Toll-Free at (866)729-8716. Calls are answered live during business hours. If you call outside of business hours, you can leave a message and your call will be returned.



Who Are Our Customers?

- Individuals receiving services
  - I/DD – Persons with Intellectual and Developmental Disabilities
  - MIA – Adults with Mental Illness
  - SED – Youth with Severe Emotional Disturbances
  - SUD – Persons with Co-Occurring Substance Use Disorder
- Parents/Family Members
- Staff Members
- Contracted Providers
- Community Members/Stakeholders
- Anyone who walks through the door

A Welcoming Environment

Webster's definition: wel·come

verb \ˈwel-kəm\

: to greet (someone) in a warm and friendly manner

- Provide empathy and acceptance
- Being mindful of body language, attitude, and words
  - Pay attention to how you are saying things
  - Make eye contact and smile
  - Actively listen
  - Be present. Give your full attention
- Being helpful
- Be kind

Intake Process

- Screen for eligibility
- Assessment is completed to determine service needs
- Recommendations for service through Person-Centered Planning/Individual Plan of Service (PCP/IPOS)
- If denied services or eligibility, individuals will receive notification including appeals/2nd opinion rights process and contact information for Customer Services
- Emergency services are available 24/7 **without** prior approval based on medical necessity and circumstances
- Not every person is eligible for every service

Person-First Language

INSTEAD of:	SAY:
She's mentally ill/disturbed.	She has a mental health diagnosis.
He's mentally retarded. He's slow.	He has an/a intellectual/cognitive disability.
She's brain damaged.	She has a brain injury.
They are non-verbal.	They communicate with their iPad.
He's autistic.	He has been diagnosed with autism.
Handicapped parking, hotel room, etc.	Accessible parking, hotel room, etc.
He's a schizophrenic.	He was diagnosed with schizophrenia.

Grievances, Appeals and 2nd Opinions

- **2nd Opinions**- Denial of all mental health services, intake or hospitalization at front door. (access denied) As well as diagnosis or treatment modalities. 2nd opinions are directed to Customer Service.
- **Appeal** – complaint regarding an "Action" taken regarding a requested or currently provided service: Actions are denials, suspensions, reductions, or terminations of services. Appeals are directed to Customer Service.
- **Grievance** - complaint filed by customer regarding the quality of their services. Issues here are not considered Rights or Actions. Grievances are directed to Customer Services.

What are Second Opinions?

- Second Opinions Definition: The process for having a second qualified person (clinician, doctor) assess a case to determine if they agree with the opinion or recommendation of the original staff.

- Where do Second Opinion Rights come from?
- Federal
  - Code of Federal Regulations
    - 42CFR 438.206 (b) (3)
- State
  - Michigan Mental Health Code
    - MCL 330.1705
    - MCL 330.1409
- Regional
  - SWMBH Policy 6.4 Customer Appeal System

Mental Health Code
Access Second Opinions

- If denied mental health services
- Second Opinion requests are filed by customer, guardian, or parent of a minor
- Second Opinion is completed by a “physician, licensed psychologist, registered professional nurse, or master’s level social work, or master’s level psychologist”
- If customer is found to have a serious mental illness, serious emotional disturbance, or a developmental disability, or is experiencing an emergency/urgent situation, the CMH agency will direct services to the customer.

Mental Health Code
IP Psych Hospital 2nd Opinions

- If denied IP Psych Hospital Admission
- Must be performed within 3 days of the request for second opinion (excluding Sundays and legal holidays)
- Completed by psychiatrist, other physician, or licensed psychologist.
- If second opinion differs from original denial:
  - Executive Director and Medical Director of the CMH agency will make a decision based on available clinical information.
  - Decision will be confirmed in writing to the customer.
    - Written decision must include signatures of executive director and medical director (or verified that medical director was consulted)
- If second opinion agrees with original denial, CMH agency will provide information to customer regarding alternative services and referrals.

Code of Federal Regulations

- Each PIHP/region must: Provide for a second opinion from a network provider or arrange for the customer to obtain one outside the network, at no cost to the customer.

- Regionally, these additional requests for a Second Opinion could include matters such as:
  - Diagnoses
  - Medications
  - Plan of care – such as type of therapy, treatment modalities, etc.

2nd Opinion Request Process

- When an applicant for CMHCM services is denied mental health services or hospitalization, as well as diagnosis or treatment modalities, the applicant, his/her guardian, designated patient advocate, or the applicant's parent in the case of a minor, shall be informed of their right to request a second opinion and are given a Notice of Second Opinion Rights. 2nd opinions are directed to Customer Service.
- If an individual disagrees with decision, they can contact Customer Service by phone or in writing to request a 2nd Opinion (request must be made within 45 days for intake denials and three business days for Hospitalization)

Riverwood Centers Process for 2nd Opinion Rights

Customers should contact

Leanne Adams - Customer Services

Riverwood Center

1485 M139 Benton Harbor, MI 49022
Local: (269) 934-3478 or Toll-Free: 1-866-729-8716

To request their 2nd opinion rights.

1. Customer Service will coordinate second opinion appointment with appropriate mental health professional within two business days.
2. The appropriate mental health professional will provide documentation of decision to Customer Service.
3. Notice of Second Opinion Decision letter will be provided in writing to the consumer by Customer Service.

What are some Grievances?

- Requesting a change in provider
- Problems with hours of operation
- Appointment availability concerns
- Telephone accessibility
- Conflict with an employee/staff
- Unhappy with choice of providers
- Wait time for scheduled appointment
- Not satisfied with Quality of Care

The Grievance Process

- A Grievance may be filed at any time by the enrollee, a guardian, or a legal representative
- May be filed by phone, in person, or in writing
- May be filed locally at CMHSP (community mental health services programs) or regionally through Southwest Michigan Behavioral Health (SWMBH) depending on service type and insurance
- Person should be prepared to describe their situation and a recommendation for solution/what they would like to happen

*Note: even when “resolved” there may be times a grievance cannot be fully resolved to 100% satisfaction of the customer.

Grievance Processing

Medicaid, Block Grant, Healthy Michigan Plan, etc.

- Assist customer with filing grievance
- Prompt resolution/response
- Ensure staff assisting with grievance were not involved in the situation the grievance is regarding
- Provide written resolution for each grievance
- Keep written records of grievances filed and resolved
- Resolve within 90 days or it can become an “action” which may be appealed.

If services were denied, it could be because……..

- The person do not meet the clinical eligibility criteria for specialty mental health or substance abuse services. They currently do not meet criteria for services for a person with a serious mental illness, a developmentally disability, a substance use disorder, or a child with a serious emotional disorder.
- Lack of Medical Necessity. It has been determined that the service(s) identified in this notice are not: clinically appropriate, or necessary to meet their needs; or consistent with their diagnosis, symptoms or impairments; or the most cost-effective option in the least restrictive environment; or consistent with current/clinical standards of care.
- They may have other resources available that will provide payment for service(s).
- Residency. They live outside of our service area.
- Residency. You are currently residing in an institution in which this agency cannot authorize your services. (e.g. jail, prison, state hospital, extended care facility)

Appeals

- An Appeal may be filed by the Customer, Legal guardian, Parent of a Minor or the Customers Authorized Representative
  - An Authorized Representative is an individual given written permission to act on behalf of the Customer
  - Provider can file if they have status of Authorized Representative
- An Appeal may be filed over the phone, in person, or in writing
- Customers may request an expedited appeal – 72 actual hours
- Contact Customer Service for State Fair Hearing Request Form

Reason for Appeals

- Denial of requested service(s) by a current customer
- Limited authorization of requested service(s)
  - Less (in amount/scope/duration) than requested
- Reduction in current service(s)
- Suspension of current service(s)
- Termination of current service(s)
- Delay in providing authorized/approved service(s)
  - If over 14 calendar days from agreed upon start date
- Grievance which takes over 90 calendar days to complete
- Previous appeal which takes over 30 calendar days to complete
- A denied payment for a service NOT previously authorized

Types of Appeals

- Local Appeal
  - Customers can file by contacting agency that made the determination.
  - File within 60 calendar days from the date of the Advance/Adequate Notice
- Administrative Fair Hearing
  - Impartial state level review of a Medicaid Beneficiary's appeal of a service determination presided over by an Administrative Law Judge. Medicaid beneficiaries can request a hearing after a local appeal resolution is reached.
  - File within 120 days of local appeal resolution notice
- MDHHS Alternative Dispute Resolution Process
  - Impartial State level review of an appeal presided over by MDHHS staff. This process is for Customers without Medicaid. It can be accessed only after a local appeal is exhausted and the Customer is not satisfied with the result
- 2nd Opinions
  - 2nd Opinions for **denial of access** to services should follow 2nd Opinion Request Process
  - 2nd Opinions for **denial of inpatient** should be completed within 3 days, excluding Sundays and legal holidays

Appeals Processing

Medicaid, Block Grant, Healthy Michigan Plan, etc.

- Assist Customer to file appeal
- Prompt resolution/response
- Assure that the reviewer for the appeal was not involved in initial decision to take the Action in question, nor a subordinate of such individual
- Assure that the clinical reviewer has the appropriate experience/ credentials to make a determination about the service(s) in question
- Complete appeal determination within 30 days for standard resolution
  - 72 hours for expedited
- Provide written resolution for each appeal filed
- Keep written records of appeals filed and resolved.
- Provide State Fair Hearing forms after local appeal

Adverse Benefit Determination

Adequate Notice

- To deny payment for a service NOT previously authorized
  - Provided at the time of action to deny payment for service
- To deny or limit authorization for mental health or substance use services
  - 14 calendar days for standard decision to deny or limit service
  - 72 hours for expedited decision to deny or limit services
- Can be for initial service authorization or request for new service

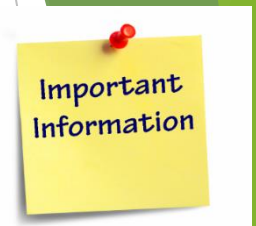
Advanced Notice

- Actions taken against currently authorized services
  - Termination
  - Reduction
  - Suspension
- Provided 10 calendar days before intended action

Exceptions to Advanced Notice

You still create & send the ABD, but the effective date can be shorter.

- Information is received confirming a customer's death (you create the ABD but do not mail it. They lost a loved one. Just upload it to the chart)
- Clear, written and signed statement that customer no longer wish to receive service(s) upload it to the chart
- Customer admitted to an institution such as jail/prison, State hospital or extended care facility where they become ineligible for services. document it to the chart in non-billable notes
- Customer's whereabouts are unknown, and the post office returns mail with no indication of a forwarding address. document it to the chart
- Customer has moved out of the service coverage area (written statement) upload it to the chart
- Change in level of medical care is prescribed by customer's physician.
- They didn't meet Pre-Screening requirements (Section 1919 (e)(7) of the Act. Inpatient Diversions must always be expedited and ABD sent within 72 hours.
- Date of Action will occur in less than 10 calendar days. Due to safety
- Facts (preferably verified by 2nd source) indicating possible fraud by the enrollee and indicate action should be taken (Advanced Notice may be 5 days)



Provide Notice of Adverse Benefit Determination

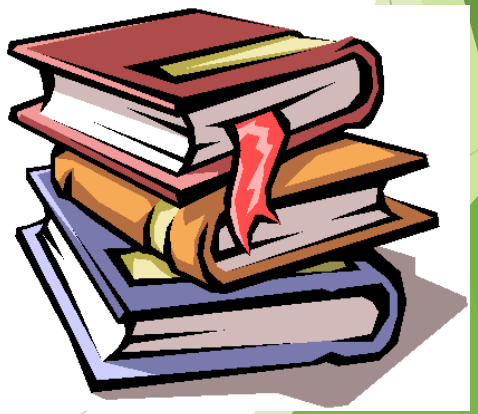
- All Adverse Benefit Determinations (ABD's) should be addressed/written to:
  - The Customer
  - Customer's Legal Guardian if applicable
  - Customer's parent if a minor child
- Whenever mailed, Notice should be sent to the last known address on file for the Customer, Legal Guardian or Parent

Limited English Proficiency (LEP)

- "I Speak" and Non-discrimination posters at agency sites
- Identify need for language assistance in client record
- language assistance is available at **No Cost** to the individual
- Please complete the **Interpreter form 8.18.21.** located on the S: drive and send all requests to Leanne Adams in Customer Service. Please remember that **ALL REQUESTS MUST BE SENT TO CUSTOMER SERVICE AT LEAST SEVEN (7) DAYS PRIOR TO REQUESTED SERVICE DATE.**
- Verbal or Written translation of vital documents as needed
- Tag-lines for requesting language assistance printed on educational materials
  - Top 15 languages – large documents
  - Top 3 languages – small documents

Reference Materials

- www.disabilityisnatural.com
- Berrien Mental Health Authority
  - Customer Handbook 2019
  - Customer Service Policies (6.1-6.10)
- MDHHS PIHP Contract Amendment 1, 2018
- Michigan Mental Health Code
- Code of Federal Regulations
- Webster's Dictionary
- https://www.swmbh.org



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