



Every person has an exceptional experience... every time.



Customer Service Training FY 2027

What is Customer Service?

Customer Service responsibilities are to:

- Welcoming, have knowledge of services and ways to access the services.
- Provide help with questions and problems about community resources or benefits using collaboration with other community resources.
- Provide information about how to access all available mental health services.
- Provide information about when it may be appropriate and how to file a rights complaint.
- Document all customer service inquiries, complaints, grievance and appeals that are received. Gather facts and determine if it can be resolved with Customer Services as an inquiry or should be escalated as a Grievance.
- Assist people in filing grievances or appeals.
- Clear and complete follow through of all Grievances and Appeals.
- 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 OUR DOOR**



Intake Process

- Community members are screened for eligibility by a licensed clinician.
- An Assessment is completed to determine our community members mental health service needs
- Recommendations for services are collaborated upon through a Person-Centered Planning Process also known as an Individual Plan of Service (PCP/IPOS)
- If our community member is denied services or eligibility, individuals will receive a letter or notice known best as an adverse benefit determination which is a notification including appeal rights and 2nd opinion rights processes and this paper tells them to contact Customer Services at 1-866-729-8716 or 269-934-3478
- Emergency services are available 24/7 **without** prior approval based on medical necessity and circumstances
- Not every person is eligible for every service; it is based on need.



Does the patient qualify for CCBHC Services?

- CCBHC Services Include:
 - Crisis Services
 - Screening Assessment, and Diagnosis including Risk Assessment
 - Outpatient Mental Health and Substance Use Services
 - Psychotherapy, Medication Administration, Office or Outpatient visits, Home Visits, Behavioral Health Counseling, Alcohol and/or Drug Services and Interventions, Behavioral Health Prevention Educational services, Medication Training and support, Assertive Community Treatment (ACT), Family training and counseling for child development,
 - Outpatient Clinic Primary Care Screening and Monitoring
 - Nursing Assessments and RN services
 - Targeted Case Management
 - Psychiatric Rehabilitation

Behavioral Health Urgent Care Clinic

- **Behavioral Health Urgent Care Clinic**
- At Riverwood Center, we offer a Behavioral Health Urgent Care Clinic (BHUC). The BHUC is here to provide immediate help and compassionate support for those facing a behavioral health crisis—without the need for a hospital visit or referral. The BHUC offers a welcoming space where you can receive timely triage, brief assessments, stabilization, and intervention, along with psychiatric care, peer support services, and help with transitioning to ongoing support.
- **Behavioral Health Urgent Care Clinic**
1485 M139
Benton Harbor, MI 49022
- **Hours:** Monday-Friday from 8:30am to 4pm

GRIEVANCES & COMPLAINTS



- ➡ **Grievance** - complaint filed by a customer regarding the quality of their services. These issues are not considered Rights or Actions.
- ➡ Grievances are directed to Customer Services.

The Grievance Process

- A Grievance may be filed at any time by the patient, a guardian, or a legal representative. The patient may also ask that a representative help them with their grievance. In this case an **Authorized Representative Form** must be completed and signed by both the patient and their representative. The form must be returned to Customer Services to proceed with the grievance.
- A grievance may be filed by phone, in person, or in writing.
- The patient should be prepared to describe their situation and have a recommendation for a solution or 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.

The image shows a sample 'COMPLAINT' form. The form is titled 'COMPLAINT' in large, bold, orange letters. Below the title, there are several sections for information: 'TO:' followed by a blank line; 'WHOSE FAULT:' followed by a grid of checkboxes for 'NONE', 'POSSIBLE', 'OTHER', 'LITIGATION', 'PROMOTION', 'RESOLUTION', and 'CHANGE'; 'DESIRED OUTCOME:' followed by a grid of checkboxes for 'APOLOGY', 'EXPLANATION', 'LITIGATION', 'PROMOTION', 'RESOLUTION', and 'CHANGE'; and 'COMPLAINANT:' followed by a blank line. At the bottom right, there is a checkbox for 'ANONYMOUS'.

Grievance: An expression of dissatisfaction about any matter related to services except: Service Array issues.

- Customer Services will assist customers with filing grievances
- Gives prompt resolution/response
- Ensure staff assisting with grievance were not involved in the situation the grievance is regarding
- Provide written receipt of and 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.

*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*

**PROBLEM
SOLVED!**

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

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 from the request for Hospitalization)

Mental Health Code

IP Psych Hospital 2nd Opinions

- If denied IP Psych Hospital Admission
- The second opinion request must be performed within 3 days of the request for second opinion (excluding Sundays and legal holidays)
- The second Opinion must be Completed by psychiatrist, other physician, or licensed psychologist.
- If second opinion differs from original denial:
 - The 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.
- If second opinion agrees with original denial, CMH agency will provide information to customer regarding alternative services and referrals.

Mental Health Code

Access Second Opinions

- If denied mental health services a customer has the right to ask for a 2nd opinion.
- Second Opinion requests are filed by customer, guardian, or parent of a minor child.
- 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.

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. The patient is currently residing in an institution in which Riverwood Center cannot authorize services. (e.g. jail, prison, state hospital or an extended care facility)

Adverse Benefit Determination “ABD”



We must give Adequate Notice

- When denying payment for a service NOT previously authorized
 - This notice is provided at the time of action to deny payment for service.
- When denying or limiting an authorization for mental health or substance use services we must provide
 - **14** calendar days notice for standard decision to deny or limit service
 - **72 hours** for an expedited decision to deny or limit services (hospitalizations must be expedited)
- Adequate Notice must be sent for an initial service authorization or request for new service.

We must give Advanced Notice

- Actions taken against currently authorized services for a **CCBHC patient**
- Must be provided **30 calendar days** before intended action.
 - Termination
 - Reduction
 - Suspension
- Actions taken against currently authorized services for **Medicaid Non-CCBHC** patient
 - Termination
 - Reduction
 - Suspension
- Must provide 10 calendar days before any intended action.
- ****In both cases if you get it in writing and in the chart you can for-go the wait-periods (exceptions)**

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. Clinicians 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. Case holder documents it to the chart
- Customer has moved out of the service coverage area (they must provide a written statement to forgo the Advance Notice) 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)

Important
Information

Negative Action Determination “NAD”

- A Negative Action Determination is the CCBHC's version of the Medicaid's ABD (Adverse Benefit Determination)
- The Patient has the right to a notice under CCBHC Services Rules to receive notification anytime a denial or action is taken (termination, suspension or reduction of their services) by Riverwood Center.
- Denials or actions taken as a result of the person centered planning process or those ordered by a physician are not considered an adverse action, unless the treatment plan was signed in dispute.

Provide Notice of Negative Adverse Benefit Determination NABD

- All Negative Adverse Benefit Determinations (NABD's) for MDHHS Specialty or PIHP Services should be addressed/written to:
- All Negative Action Determination (NAD) for CCBHC Services should also be addressed /written to:
 - The Patient
 - Patient's Legal Guardian if applicable
 - Patient's parent if a minor child.
- Whenever mailed, any notice should be sent to the last known address on file for the Patient, Legal Guardian or Parent.

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
 - A Provider can also 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

APPEAL

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

- ▶ 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

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 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

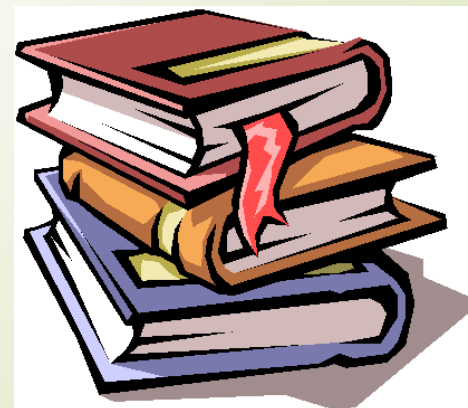


Need Communication Assistance?

- We offer free communication resources in alternative languages and formats, including Braille, Spanish, audio, sign language, and more. Contact Customer Service at [1-866-729-8716](tel:1-866-729-8716) to access these services.
- **Spanish** | ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al [866-729-8716](tel:866-729-8716) (TTY: 711).
- **Arabic** | ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانًا. اتصل برقم هاتف الصم: 866-8716-729 (TTY: 711).

Reference Materials

- www.disabilityisnatural.com
- Berrien Mental Health Authority
 - Customer Service Policies (6.1-6.10)
- PIHP Customer Service Standards *October 17th 2025*
- Michigan Certified Community Behavioral Health Clinic (CCBHC) Handbook Version 3 *October 2025*
- Michigan Mental Health Code
- Code of Federal Regulations
- Webster's Dictionary



SCAN QR CODE



Thank You!

Scan the QR code to download
and print your completed course
Certificate.

Customer Services



Every person has an exceptional experience... every time.

1485 M139 Benton Harbor, MI 49022

Local: 269-934-3478 | Toll-Free: 1-866-729-8716

08/2026