

SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

**DIVISION OF LABOR AND MANAGEMENT**

123 W. Missouri Ave. Pierre, South Dakota 57501

Tel: 605.773.3681 Fax: 605.773.4211 dlr.sd.gov

**APPLICATION FOR CERTIFICATION OF CASE MANAGEMENT PLAN**

Use this form to certify your case management plan as required by SDCL 58-20-24, 62-5-21, and ARSD chapter 47:03:04. Answer completely the following questions about your case management plan. If more space is needed, use additional pages (identify your response with the question number). Any supporting documents should be attached to this application. Please return the application by September 30, of plan year. If you have any questions about the information requested, please call to 605.773.3681.

1. What is your company's name and the address of the place of business where the plan will be administered and records kept? No plan will be certified without a South Dakota place of business.

Company Name:

Address of Place of Business:

City :

State:

Zip:

EIN:

2. Incorporation information:

State of Incorporation:

Date of Incorporation:

3. Contact Person for Case Management Plan Information:

Name:

Street or Box #:

City:

State:

Zip:

Phone:

4. Day-to-day Administrator of Plan Information:

Name:

Street or Box #:

City:

State:

Zip:

Title:

Credentials:

5. What are the names and addresses of the officers or directors of the plan or the company that owns the plan?

Name

Address

City

State

Zip

6. Does your company operate a managed care, utilization review, or case management business outside South Dakota?

If yes, list the states in which you operate such a business and indicate whether the business is certified by any organization or government agency.

**State of Operation**

**Check if Certified**

**State of Operation**

**Check if Certified**

7. What are the names and credentials of the individuals who will be making final utilization review or medical case management decisions for the plan? The individuals must be licensed, registered, or certified health care providers under SDCL title 36.

Name	Credentials
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8. Will you use a network of participating medical practitioners?

**If you answered question 8 "Yes," answer questions 9, 10, and 11.**

**If you answered question 8 "No," answer question 12.**

9. What are the names, addresses, and specialties of all participating medical practitioners who will provide services under the care management plan? Attach a statement declaring that the practitioners have complied with any licensing or certification requirements to practice in South Dakota.(Submit attachment if more space is needed)

Name	Address	City	State	Zip	Specialty
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10. What are your procedures to ensure each participating medical practitioner meets the licensing and certification requirements to practice in South Dakota and to exclude a practitioner whose license is under suspension or has been revoked by the licensing board.

11. Attach a copy of the standard agreement that participating medical practitioner's sign. What other arrangements will you have with medical practitioners to deliver services to employees?

12. What arrangements will you have with medical practitioners to deliver services to employees under your plan since you do not have a provide network?

13. How will you provide employees prompt and convenient access to health care services as required by ARSD 47:03:04:04? Specifically, how will you make sure employers promptly notify the plan about injuries and employees receive prompt treatment when they request treatment from the plan? What are your procedures for referring an employee to an outside medical practitioner when services are unavailable or are not reasonably accessible within the plan?

14. How will your plan authorize necessary medical services provided by an outside medical practitioner as required by ARSD 47:03:04:05 and 47:03:04:06? Specifically, how will you work with a medical practitioner initially selected by an employee and make sure the medical practitioner complies with the provisions of the rules and the plan? How will you handle emergency treatment? What are your procedures for approving referrals for other treatment or before diagnostic testing.

15. How will you comply with ARSD 47:03:04:07, which prohibits discrimination against or exclusion from participation in the plan of any category of medical practitioner?

16. Attach the treatment standards your plan has developed to use in reviewing medical services. No plan will be certified without comprehensive treatment standards developed for worker's compensation injuries that have been reviewed and approved by the department. What is the source of your treatment standards? How will the treatment standards be used to review medical services to ensure services are necessary and appropriate?

17. What are your methods of utilization review to prevent inappropriate, excessive, or medically unnecessary medical services? Explain any pre-authorization requirements, concurrent review, or retrospective review that is part of your utilization review program.

18. What are your procedures for excluding medical practitioners who violate your treatment standards from participating in the plan?



19. How will you develop a treatment plan, monitor the treatment and medical progress of the employee, and make sure that the employee is following the treatment plan?

20. How will you develop a plan for promptly returning an employee to work?

21. How will you provide for cooperative efforts by employees, employers, and the case management plan to promote workplace health and safety?

22. How will individuals receive prompt information and advice on the medical services available from your plan and how to access those services on a 24-hour basis using your toll-free telephone service?

23. What are your procedures for reporting to the employer at least once a month on the medical status and return-to-work status of an employee?

24. What are your procedures for informing medical practitioners of the applicable treatment standards of the plan?

25. What other methods will you use to communicate to employees, employers, and medical practitioners the services and requirements of your plan? Attach or describe any written material that will be used as part of our communication program.

26. What are your plan's internal dispute resolution procedures, including methods to promptly resolve complaints by employees, medical practitioners, employers, and insurers? How will you notify individuals of decisions made by your plan and the procedures for disputing those decisions?

27. How will you record and report to the department information regarding medical service costs and utilization and regarding other necessary information as required by ARSD 47:03:04:03(11)? Please explain how you will maintain the required records and describe any additional information you will supply in your annual report that will assist the department in determining the effectiveness of your plan.

28. How will you ensure continuity of care when an insurer's contract with a case management plan terminates or a contract between the case management care plan and a participating medical practitioner terminates?

29. What are your methods for ensuring quality control in the delivery of managed care services?

Please send the original of this application to:

South Dakota Department of Labor and Regulation  
Divison of Labor and Management  
123 W. Missouri Ave.  
Pierre, SD 57501

Please attach to the application a copy of the following:

- The standard agreement that participating medical practitioners sign (if applicable);
- A statement declaring the medical practitioners have complied with any licensing or certification requirements to practice in South Dakota (if applicable);
- The treatment standards the plan has developed to use in reviewing medical services; and
- Any written materials the plan will use as part of its communication program.

The applicant, by its authorized corporate officer:

- Authorizes the department to audit or investigate the accuracy of any statement made in this application and related documents;
- Agrees to assist the department in conducting the audit or investigation;  
and
- Agrees to allow the department access to its place of business and to information and record requested by the department.

**The applicant understands and agrees that if a material fact in this application or related documents has been misrepresented or if the case management plan no longer meets the requirements of the law and administrative rules, the department may deny or may suspend or revoke the certification of the case management plan under ARSD 47:03:04:**

**APPLICANT NAME**

**APPLICANT SIGNATURE**

**DATE SIGNED**