INDIANA DENTAL association

550 West North Street, Suite 300
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Peer Review Patient Mediation Overview

What is Peer Review?

Peer Review is a dispute resolution program offered by the Indiana Dental Association (IDA) to all parties involved in dental care: Patients, dentists and third parties. The program is staffed by specially trained dentists who value dentistry as a profession and as an important aspect of our society. Peer Review attempts to resolve care issues to the satisfaction of both the patient and the dentist, while also helping both parties avoid costly, time-consuming legal proceedings.

How Does Peer Review Work?

The program has two stages: Mediation and a panel review. Mediation is not judgmental in nature but is simply a dentist trained in mediation who works with both parties in an attempt to open communication and to facilitate a mutual agreement. Upon successful completion of mediation, a Mutual Release may be signed by all parties documenting the agreement.

If mediation is not successful, a panel review performs a detailed review of the disputed treatment. At this stage, the panel review makes an expert judgment regarding the standard of care of the treatment in question.

Do I Have to Pay for an IDA Peer Review?

Peer Review is normally provided without charge. It is a program that IDA provides as a service to both the public and to dentists.

Is a Panel Review Decision Binding?

No. The Panel Review has no disciplinary or legal authority. It can only inform and make recommendations, and neither the patient nor the dentist is legally bound to agree with or adhere to its findings. In addition, Peer Review does not cause the patient to lose any legal rights, and the patient can withdraw from the process at any point. If there is an agreed upon settlement either via Mediation or Panel Review, a Mutual Release will be signed by both parties documenting this agreement before the considerations are released.

What Is a Typical Panel Recommendation?

In most cases, the Panel Review's monetary recommendations are limited to retreatment or reimbursement of fees paid. The Panel Review can make no award based upon pain and suffering or loss of time.

Can a Dentist Lose His or Her License Because of a Peer Review Claim?

The IDA is a professional association of dentists in Indiana. It is not a government or regulatory agency and therefore has no authority to issue, suspend or revoke dental licenses.

Instructions for Returning Forms

Please complete the attached/enclosed forms and return them to the IDA at the address above. It may also be helpful to your case to include supporting materials such as photos or copies of correspondence between you and the dentist. If you have further questions concerning Peer Review, please contact Ed Rosenbaum at the IDA at **317-634-2610** or **edr@indental.org**.

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Peer Review–Patient Mediation Request

Upon receiving this fully completed form, a member of a Peer Review Committee will contact you to discuss your concerns and help resolve the issue. While a refund of the charges you have paid is one of the committee's resolution options, a refund request should not be made on this form.

Please type or clearly print in ink

OFFICE USE ONLY
Case Type: _____
IDA Case #:

Patient Information

Today's date: _____

Patient's name: _____ Phone: (___) _____

Address: _____

City: _____ State: _____ Zip: _____

Parent/Guardian Information (if patient is younger than 18 years old)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Dentist's Name

Name: _____ Phone: (___) _____

Name of practice, if any: _____

Practice address: _____

City: _____ State: _____ Zip: _____

Date of most recent appointment: _____ Date of original service: _____

Contact Information
Please provide numbers and the best time for a member of the Peer Review Committee to contact you.

Day Phone: (___) _____ Time: _____

Evening Phone: (___) _____ Time: _____

Disclosures

In order for a complete review be performed, I authorize the release/disclosure of any dental records or protected health information or other related information to this committee(s) and/or staff from anyone who has previously examined or treated me. I give my permission and authorize committee members to perform a clinical examination if necessary. I further agree that Indiana law shall govern all matters relating to the handling of this case by the local district (component) dental society and the state Peer Review Committees.

Patient or Parent/Guardian Signature _____ Date _____

☐ *Accept the typed signature above as my digital signature*

Personal Attempt(s) to Resolve Issue or Problem

You must have attempted to resolve the issue/problem yourself before the Peer Review process may begin. Briefly explain any/all efforts made to resolve your dispute to date.

Describe the issue

Briefly and specifically describe the problem(s) with the rendered dental treatment/services that you or your dependent received. Use an additional page if needed.

REQUEST FOR AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A – REQUESTING PARTIES

This request for authorization is made by the Indiana Dental Association State and Component (Local) Peer Review Committees (the Committees) on behalf of the Committees and Dr. _____ *Subject Dentist and all Related Dentist(s)*

SECTION B – INDIVIDUAL AUTHORIZING THIS REQUEST (patient)

Patient's name: _____

Address: _____

Telephone: _____ Email: _____

SECTION C: AUTHORIZATION

No Condition: This authorization is voluntary and unconditional.

Purpose of this Authorization and Protected Health Information to be Disclosed: By signing this form, you authorize:

(1) All Dentists to disclose to the Committees all information related to the matters described in the attached Patient Mediation Request concerning the Subject Dentist, including but not limited to, diagnostic materials, laboratory test results and all other relevant medical and dental records (the Protected Health Information).

(2) The Committees to review and use the Protected Health Information in connection with the investigation, evaluation, and resolution of the attached Patient Mediation Request and, in the Committee's discretion, to disclose the Protected Health Information to appropriate government agencies.

Effect of Granting this Authorization: The Protected Health Information may be disclosed and/or received by persons or organizations that are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, including appropriate government agencies. They may further disclose the Protected Health Information, and it may no longer be protected by federal health information privacy laws.

Inspection and Copy of Protected Health Information: You have right to inspect and/or copy Protected Health Information.

SECTION D: EXPIRATION AND REVOCATION

Expiration: This Authorization will expire upon final disposition of the Patient's Mediation Request by all relevant Committees.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action the Subject Dentist or the Committees took in reliance on this authorization before you received my written notice of revocation. I further understand that such revocation may make it impractical for the Committees to continue their review of my Patient Mediation Request.

Contact Office: IDA Peer Review Committee | 550 West North Street, Suite 300, Indianapolis, IN 46202 | Fax: 317-634-2612

I, _____, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that the Subject Dentist and the Committees may use and/or disclose to the persons and/or organizations named in this form the Protected Health Information for the purposes stated in this form.

I understand that, if the persons or organizations I authorize to receive and/or use the Protected Health Information are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

Patient's signature: _____ Date: _____

☐ *Accept the typed signature above as my digital signature*

If this authorization is signed by an individual's personal representative on behalf of the individual:

Personal representative's name: _____ Relationship to individual: _____

Return this completed form and any supporting materials to the address listed above. Be sure to make a copy for your records. You are entitled to a copy of this authorization after you sign it.