

ABOUT PEER REVIEW

The Rhode Island Dental Association, and its local component societies conduct professional review services as part of their program for education and discipline of its members and affiliates. Peer Review is possible because RIDA member dentists volunteer their time and expertise. This is a free service to the public, and RIDA members and affiliates.

While peer review proceedings are not intended as purely dispute resolution services, professional review often can resolve some kinds of disputes between patients and dentists and/or third party payors, (i.e. dental insurance carriers). The process is confidential and is available provided the complaints fall within peer review guidelines.

The peer review system has been able to satisfactorily resolve the majority of complaints received. However, there are limitations to the types of complaints, which are within the scope of peer review.

The RIDA reserves the right to not accept or act on any request for review.

The Peer Review process is also not suitable or available in situations involving possible claims for other kinds of damages (i.e. pain, suffering, loss of work, punitive damages, etc.). The system strives to fairly evaluate treatment/care and when appropriate, has the option of:

- A. Directing re-treatment services without charge;
- B. Adjustment of fee;
- C. Refund of fee;

This review process is available only if the patient, dentists, and third party payor (if any), all consent in writing to submit to review, in accordance with the Peer Review Manual procedures.

All requests are screened before the process begins to be sure that they are appropriate for review. If the complaint is accepted for peer review, the first step is for an impartial dentist to attempt to informally mediate the matter. If mediation is not successful, a component Peer Review Panel of at least three member dentists will be appointed to review the case and determine the issues. The review will include examination of dental records, an interview with the patient and dentist, and where appropriate, other involved persons. If necessary, a clinical examination will be arranged, without charge to the person examined. Once the committee concludes its review, all participants will be informed, at a later date, of the committee's decision, in writing.

There is a process for appeal of the decision to the RIDA Peer Review Committee. Specific grounds for appeal and supporting details or documentation must be specified in a written request for appeal. Simply because a party does not like the decision is not sufficient grounds for appeal as it is not the function of the appellate review to re-try a matter or to hear evidence that was or could have been presented in the initial hearing.

To initiate review of your complaint, the peer review request and agreement forms must be completed, signed and returned with supporting evidence to the RIDA office. If the request is not within peer review guidelines or proper consent is unavailable, you will be notified promptly.

Please return the completed mediation form to the Rhode Island Dental Association, 200 Centerville Road, Suite 7, Warwick, RI 02886.

If you have any further questions regarding peer review, please contact the RIDA at 1-401-732-6833.

Form A
Revised 2/1/91

PATIENT REQUEST FOR MEDIATION

Upon receipt of this completed form, a mediator will be assigned and will contact you within 30 days to discuss your request and help resolve the issue. **Briefly**, describe the treatment/care you wish the committee to evaluate. Please do not indicate on this form what resolution/compensation you are seeking as this may limit the committee in their final recommendations. During the Peer Review process, you will be given ample opportunity to present detailed information regarding your complaint.

Patient Information: (please print)

Date ____/____/____ Case # _____

Name _____ Phone # (____)____ - _____

Address _____

City _____ State _____ Zip Code _____

Name of Dentist: (please print)

Name _____ Phone # (____)____ - _____

Address _____

City _____ State _____ Zip Code _____

Date of Last Appointment ____/____/____

Please describe the problem(s) specific to the dental treatment received: (please print)
