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STATE OF WISCONSIN

BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF

DISCIPLINARY PROCEEDINGS AGAINST:

PERRY G. COALMON, M.D.,	**FINAL DECISION AND ORDER**
RESPONDENT	LS0108223MED

The parties to this action for the purposes of § 227.53, Wis. Stats., are:

Perry G. Coalmon, MD

5515 Lincolnshire Blvd.

Milwaukee, WI 53223

Wisconsin Medical Examining Board

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation and Licensing

Division of Enforcement

P.O. Box 8935

Madison, WI 53708-8935

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Respondent Perry Gene Coalmon (dob 12/10/54) is and was at all times relevant to the facts set forth herein a physician and surgeon licensed in the State of Wisconsin pursuant to license #30001, first granted on 2/23/89. At the times set forth in the Findings of Fact, below, respondent was an internist in solo practice; he is now employed by an occupational medicine provider and functions in a group practice. He is not board certified in any specialty.

2. Respondent did, on or before June 8, 1999, fail to pay his Patient Compensation Fund assessment, but continued to practice medicine until he paid a partial past assessment on or about March 28, 2000. He also failed to have underlying malpractice insurance coverage between March 24, 2000 and September 30, 2000, but practiced medicine during this time. Additionally, he has never paid his PCF assessment for the period November 15, 1999 to January 1, 2000.

3. Respondent’s registration of his license to practice medicine and surgery expired without being renewed on November 1, 1999. Respondent continued to practice medicine without being currently registered until he renewed his registration on or about April 4, 2000.

4. On or about 7/2/98, respondent began treating patient M.R. Respondent’s chart note for the initial visit is, in its entirety: "43 years old female here for jaw pain. Patient has history of migraine headache. Past medical

history: migraine. Meds: Vicodin ES, Fiorinal, Valium 10. PE: HEENT negative. Heart: grade II/VI SEM. Lungs: clear. Abd: positive for old healed scars. A: migraines, adhesions. P: meds renewed Vicodin ES #20." Respondent then billed the third party payor for the following coded condition: "Brain Condition." Billing and pharmacy records show that the patient was prescribed a hydrocodone 10mg product, Fiorinal®, and diazepam 10mg.

5. On subsequent visits, the patient continued to complain about migraine headaches and other aches and pains; respondent continued to prescribe products containing hydrocodone, oxycodone, diazepam, other benzodiazepines, and butalbital. At no time did respondent refer the patient for any reason. At no time did he record any analysis of what might cause the patient's migraines, what kind of migraines they were, how frequently they occurred, or what other treatments had been tried in the past. No non-narcotic alternatives are recorded as being attempted for the patient. There is no drug use history recorded in the chart, and no recorded vital sign. There is no record made of whether respondent's prescribed drugs was improving the patient's condition in any way, by reducing the severity or frequency of headaches or improving her functioning. There is no record of establishing functional goals.

6. Respondent continued to treat the patient until at least 3/5/99 by prescribing narcotics and benzodiazepines for her migraines, for abdominal pain diagnosed as being from adhesions caused by incomplete healing of surgical scars, and knee sprain. There are multiple incidents of billing a third party payor for office visits and prescriptions issued, with no corresponding chart entries.

7. On or about 12/16/98, respondent began to care for N.H. The first chart note reads, in its entirety: "46 year old female history of anxiety. Hx of back pain since spinal tap and auto accident. Patient has treated back pains with Percocet and ibuprofen. PMH: Seizure, back pains, cholecystectomy. Family history: negative for cancer, heart disease, and DM. Meds: Dilantin 300qd. PE: BP 140/80, HEENT edentulous several, heart RRR, lungs clear, abdomen nontender, L-S positive pain with palp. A: Strain, P: E plus U to L-S with good results. Percocet #30, ibuprofen 600mg #90." The bill to the third party payor was coded to show that the diagnosis was back sprain. Pharmacy and billing records show that respondent prescribed oxycodone , ibuprofen, and Dilantin.

8. At the next visit, the patient complained of anxiety and stated that she had been helped with Valium in the past. Respondent then prescribed diazepam 5mg for the patient. Respondent continued to prescribe narcotics to the patient, who continued to complain of back pain, through at least 6/8/99. At no time did respondent refer the patient for any reason. At no time did he record any analysis of what might cause the patient's back pain, what kind of pain she experienced, how frequently it occurred, what exacerbated or relieved it, or what other treatments had been tried in the past. No non-narcotic alternatives are recorded as being attempted for the patient. There is no drug use history recorded in the chart, and no other recorded vital sign. There is no record made of whether respondent's prescribed drugs was improving the patient's condition in any way, by reducing the severity or frequency of pain, or improving her functioning. There is no record of establishing functional goals.

9. Respondent has many other patients who have similar complaints of pain, and respondent has treated them with narcotics as described above. In those cases, at no time did respondent refer the patients for any reason. At no time did he record any analysis of what might cause the patients' pain, what kind of pain the patients experienced, how frequently it occurred, what exacerbated or relieved it, or what other treatments had been tried in the past. No non-narcotic alternatives are recorded as being attempted for the patients. There is no drug use history recorded in the chart, and very few vital signs. There is no record made of whether respondent's prescribed drugs were improving the patients' conditions in any measurable way, by reducing the severity or frequency of pain, or improving functioning. There is no record of establishing functional goals.

10. Respondent's charts are largely handwritten and are frequently illegible. The investigation of this matter required respondent to decipher his own charts and dictate or type them for the Board.

11. On or about October 30, 2000, patients J.S. and A.S. attempted to contact respondent, who had been their primary care physician. At that time, they found that his telephone had been disconnected; further investigation showed that he had discontinued his private practice and that there was no forwarding telephone number and no information at his office premises concerning how to contact him. Respondent had not notified these patients of the discontinuation of his practice, and had made no arrangements for referring them, and his actions constitute abandonment of his patients. These patients made written requests for their charts on or about November 1, 2000, and mailed them to respondent through the US mail. Respondent did not provide either patient with a copy of the patient's health care record.

CONCLUSIONS OF LAW

A. The Wisconsin Medical Examining Board has jurisdiction to act in this matter pursuant to §448.02(3), Wis. Stats. and is authorized to enter into the attached Stipulation pursuant to §227.44(5), Wis. Stats.

B. The conduct described in ¶2, above, violated §655.23(7), Wis. Stats., and § Med 10.02(2)(z), Wis. Adm. Code. The conduct described in ¶3, above, violated §448.07(1), Wis. Stats., and § Med 10.02(2)(a), Wis. Adm. Code. The conduct described in ¶¶4-9, above, violated § Med 10.02(2)(h), Wis. Adm. Code. The conduct set forth in ¶10, above, violated § Med 10.02(2)(za), Wis. Adm. Code. The conduct described in ¶11, above, violated §146.83(1) and (4)(b), Wis. Stats., and § Med 10.02(2)(h) and (z), Wis. Adm. Code. Such conduct constitutes

unprofessional conduct within the meaning of the Code and statutes.

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED, that the attached Stipulation is accepted.

IT IS FURTHER ORDERED, that the license to practice medicine and surgery of Perry G. Coalmon, MD, is SUSPENDED for thirty days, effective 12:01 AM, September 8, 2001, to midnight, September 22, 2001, and then from 12:01 AM, December 1, 2001, to midnight, December 15, 2001, but this latter suspension to continue until he has obtained malpractice insurance coverage and paid his PCF assessment for the periods specified in ¶2, above.

IT IS FURTHER ORDERED, that the license to practice medicine and surgery of respondent is LIMITED as set forth in §448.02(3)(e), Wis. Stats., and as follows: Respondent shall take and pass the "Mini-Residency in the Proper Prescribing of Controlled Dangerous Substances," co-sponsored by Forensic and Educational Consultants and the Kennedy Memorial Hospital, of the University of Medicine and Dentistry of New Jersey, or an equivalent course approved by the Board or its monitoring liaison no later than September 30, 2001. Respondent shall arrange for the course sponsor to report directly to the Department Monitor on respondent’s performance, shall take all pre- and post-tests even if optional, and release all course performance records and permit department staff to discuss respondent’s performance with course sponsors and staff.

IT IS FURTHER ORDERED, that the license to practice medicine and surgery of respondent is LIMITED as set forth in §448.02(3)(e), Wis. Stats., and as follows: Respondent shall, at his own expense, participate in and successfully complete within 12 months of the date of this Order, an educational program established through the University of Wisconsin Continuing Medical Education program (which may conduct any program through the Medical College of Wisconsin or another CME provider) in recordkeeping, and approved by the Board or its designee.

Under the tutelage of a mentor selected by the program, respondent shall review a text selected by the mentor dealing with medical recordkeeping, and shall introduce the mentor's recommended improvements into his system over the period of the program in both his office and hospital records. All of respondent's records may be reviewed and discussed periodically with the mentor, as the mentor shall determine. The review may include not only the adequacy of documentation, but any other quality of care or related issue.

The mentor shall agree to report any matter which may constitute a danger to the health, safety or welfare of patient or public, or any violation of law, to the Board, whenever it comes to the mentor's attention.

Respondent's progress and the outcome of the program shall be reported directly to the department monitor, who may discuss respondent's progress with the mentor. The UW-CME shall certify to the Board the results of the program upon completion.

If respondent does not successfully complete the program or does not successfully achieve the objectives of the program, this matter shall be referred to the Board to determine any additional appropriate discipline for the conduct set out in the Findings of Fact. Respondent and the Division of Enforcement will have the opportunity to present argument to the Board on that issue. The Board will receive the results of respondent's performance in the program as evidence in determining appropriate discipline.

IT IS FURTHER ORDERED, that respondent shall pay the costs of investigating and prosecuting this matter in the amount of $2700, within 6 months of this order.

IT IS FURTHER ORDERED, that pursuant to §448.02(4), Wis. Stats., if the Board determines that there is probable cause to believe that respondent has violated any term of this Final Decision and Order, the Board may order that the license and registration of respondent be summarily suspended pending investigation of the alleged violation.

Dated this August 22, 2001.

WISCONSIN MEDICAL EXAMINING BOARD, by:

Sidney Johnson

A member of the Board