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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
MICHAEL N. MANGOLD, M.D., RESPONDENT.	:	FINAL DECISION AND ORDER ORDER 0000587

Division of Enforcement Case No. 10MED320

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

Michael N. Mangold, M.D.
Respondent
Mangold Ctr for Family Hlth
120 N. Main St. Ste 120
West Bend, WI 53095

Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Medical Examining Board
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

On December 15, 2010, the Board issued an Order summarily suspending Respondent's license. A formal complaint was filed on December 16, 2010. Prior to the hearing on the formal complaint, the parties in this matter agreed 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 adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Michael N. Mangold, M.D., Respondent, date of birth January 30, 1957, is licensed and currently registered by the Medical Examining Board (Board) to practice medicine and surgery in the State of Wisconsin, pursuant to license number 32859-20, which was first granted December 19, 1991. Respondent specializes in family practice.

2. Respondent's address of record with the Department of Regulation and Licensing (Department) is Mangold Center for Family Health, 120 N. Main Street Suite 120, West Bend, WI 53095.

3. On January 24, 2007, in Case No. 03MED029, the Wisconsin Medical Examining Board (the Board) concluded that Respondent had violated Wis. Stat. § 448.02(3) and Wis. Admin. Code § MED 10.02(2)(h). In 2002, Respondent failed to properly evaluate an emergency room patient. Respondent's misconduct resulted in a 3-day delay of treatment of a large right hemothorax, and a fractured rib, in a patient who was also diagnosed with anemia, severe scoliosis, and neurofibromatosis. The Board ordered Respondent to complete 15 hours of continuing education in the evaluation and treatment of cardiothoracic injuries. Respondent completed the education as ordered.

4. On June 16, 2010, in Case No. 07MED112, the Board concluded that in 2006 and 2007, Respondent had repeatedly failed to keep and maintain patient health care records, in violation of Wis. Admin. Code § MED 10.02(2)(a) and (za), as well as Wis. Admin. Code § HFS 124.14(3)(c). The Board issued a reprimand and ordered Respondent to satisfactorily complete the Intensive Course in Medical Record Keeping offered by Case Western Reserve University School of Medicine. The Board further ordered Respondent to pay costs of the investigation, in the amount of $650.00, within 90 days of June 16, 2010.

5. On September 24, 2010, the Department of Regulation and Licensing received a new complaint alleging that between March 2010 and the present, Respondent failed to keep and maintain patient health care records as required by law and applicable practice standards. The complaint alleged that Respondent's failures continued despite repeated agreements to complete the records, and in spite of notice that Respondent would not be paid until records were completed. The complaint alleged that Respondent's persistent failure to maintain current and complete patient health care records created unacceptable risk of harm to patients' health and safety.

6. The complainant had made Respondent aware that his failure to complete and sign patient health care records kept other physicians from seeing the incomplete notes, including medications prescribed, and objective results of examinations. Respondent therefore knew that patient health would be unacceptably compromised when he did not complete his notes sufficiently or timely.

7. In context, it was on May 24, 2010, that Respondent stipulated to violations based on failure to keep patient health care records in Case No. 07MED112. Respondent took the required record-keeping course on June 3-4, 2010, and the Board entered its Order on June 16, 2010. Respondent subsequently again failed to maintain timely patient health care records and by July 1, 2010, Respondent's incomplete charts caused serious issues with patients' continuity of care. Respondent had a backlog of incomplete charts, several of which were over 30-days old. The corporation with whom Respondent worked as an independent contractor took the following measures, attempting to bring Respondent into compliance:

a. On July 1, 2010, the corporation sent Respondent an email indicating that for the last time Respondent would be paid in good faith based on the expectation that he would complete the charts. The corporation warned Respondent that in the future, he would be paid only for services that were properly documented in the medical record with completed charts.

b. During the week of July 11, 2010, an office manager reminded Respondent several times that he needed to complete his charts by July 15, 2010. The office manager offered to help Respondent if needed. Respondent failed to have charting completed by July 15, 2010.

c. On July 15, 2010, the contractor spoke to Respondent and his wife about the incomplete charts and disbursed a check on good faith that Respondent would complete the charts as soon as possible.

d. On July 29, 2010, Respondent had approximately one and one-half weeks of incomplete charts. Respondent's employee called the corporation demanding payment for patients seen. The employee indicated that unless Respondent received payment, Respondent would refuse to see patients scheduled for that day.

e. On July 29, 2010, Respondent called Dr. VL at the corporation and said that his charts were incomplete because he was unable to log into the system over the last four days and he was unable to reach IT support. However, the corporation receives notification whenever a physician has three unsuccessful long-in attempts, and the physician is then locked out of the system. The corporation never received notification that Respondent had been unable to log in. Respondent promised to complete the charts by August 1, 2010. Dr. VL therefore authorized one final good faith payment.

8. On August 26, 2010, the corporation sent Respondent an email alerting Respondent that he would not be paid because his patient charts were incomplete. Respondent notified the corporation that he completed charts for one day of service. The corporation issued a check for work only in cases in which the medical record was complete. The same day, Respondent was scheduled to work starting at 1:00 p.m. At 2:30 p.m., a staff member of Mangold Center called the corporation and said Respondent would not be in because his motorcycle broke down. Other staff attended to Respondents' patients, who had been prepared in examination rooms and had been waiting for Respondent for more than an hour.

9. On Saturday, August 28, 2010, Respondent was the only provider scheduled to work, but he called that morning and said he would not be in because he had a sick child.

10. On August 30, 2010, Respondent emailed the corporation's office manager and informed her he was on vacation for two weeks effective immediately.

11. As of September 9, 2010, Respondent had left the corporation with 39 incomplete patient health records. The corporation emailed Respondent asking that he finish documenting the charts. Respondent has not yet given any indication that he will complete the patient health care records or when.

12. On September 15, 2010 after not hearing from Respondent, Dr. VL sent Respondent a termination letter. As of September 24, 2010, the 39 incomplete charts were over 30 days old. Dr. VL and staff attempted to contact the 39 patients to obtain the missing information and to recommend follow-up with another provider.

13. Respondent's notes, when submitted, often appeared to be done in haste and lacked required information. Some of the patient health care records Respondent was to have kept since June 10, 2010, lacked identification of the chief complaint, information concerning prescriptions, and Respondent's review of patient systems. During one pay-period, one-third of the records Respondent said were completed were found to be inadequately documented and required follow-up.

14. The Board's Order in Case No. 07MED112, at ¶ 5, provided:

> Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs ordered...the Respondent's license may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs.

15. Wisconsin Admin. Code § Med 21.03(1) requires physicians to create patient health care records for every patient for whom services are provided, and to maintain those records for a period of not less than five years from the date of the last entry.

16. Wisconsin Admin. Code § MED 21.03(2) specifies that patient health care records must be prepared by the physician, and must include patient history, objective findings, assessment or diagnosis, and treatment plan.

17. Wisconsin Admin. Code § MED 21.03(3) requires all health care records to be dated, identify the practitioner and be sufficiently legible to allow interpretation by other practitioners for the benefit of the patient.

18. Violations of Wis. Admin. Code § 21.03 constitute violations of the Board's rules and of laws substantially related to the practice of medicine.

19. Minimal standards of the medical profession require that patient health care records maintained in an electronic system must be completed within thirty days and sooner if patient care is otherwise compromised. Failure to maintain the standard of the profession places patients at unacceptable risk of harm due to medication errors, missed diagnoses and delayed treatment.

20. The facts set forth above establish that, between June 10, 2010, and September 24, 2010, Respondent failed to maintain timely and adequate patient health care records as required by Wis. Admin. Code § MED 21.03.

21. The facts and circumstances set forth above establish that Respondent is unable or unwilling to maintain timely and adequate patient health care records despite: the Board's scrutiny in the previous disciplinary investigation; subsequent discipline; intensive remedial education; and financial pressures to maintain adequate and timely records. The circumstances set forth above establish by reasonable inference that Respondent is unable or unwilling to create and maintain patient health care records as required by law.

22. Respondent's unwillingness or inability to maintain timely and adequate patient health care records under the circumstances set forth above creates an immediate and unacceptable risk of harm to patient health, safety and welfare, including but not limited to unacceptable gaps in patients' continuity of care, gaps in continuity of pain management, delays in diagnosis, delays in treatment and delays in provider referrals.

23. Effective January 1, 2011, "ebix inc.," a medical billing services company, is responsible for all billing associated with the Mangold Center for Family Health.

CONCLUSIONS OF LAW

1. The Wisconsin Medical Examining Board has jurisdiction over this matter pursuant to Wis. Stat. § 448.02(3), and has authority to enter into this stipulated resolution of this matter pursuant to Wis. Stat. §§ 227.44(5) and 448.02(5).

2. Respondent, by failing to maintain patient health care records consistent with the requirements of ch. Med 21, has engaged in unprofessional conduct as defined by Wis. Admin. Code § MED 10.02(2)(za) and is subject to discipline pursuant to Wis. Stat. § 448.02(3).

3. Respondent, by failing to maintain patient health care records consistent with the requirements of ch. Med 21, under the circumstances set forth above, placed patients at unacceptable risk of harm, which is unprofessional misconduct, as defined by Wis. Admin. Code § MED 10.02(2)(h), and he is therefore subject to discipline pursuant to Wis. Stat. § 448.02(3).

ORDER

IT IS HEREBY ORDERED that Michael N. Mangold, M.D., Respondent, is hereby REPRIMANDED for the above conduct.

IT IS FURTHER ORDERED that:

1. The license of Michael N. Mangold, M.D. to practice medicine and surgery in the State of Wisconsin is LIMITED, as follows:

a. Within thirty days of the date of this Order, Respondent shall retain a professional mentor for patient health care records, who shall be pre-approved by the Board or its designee. The professional mentor shall randomly select patient health care records from among patients seen during an evaluation period, and shall review the records to determine whether or not the records are timely, and whether or not the records otherwise comply with the requirements of ch. Med 21.

b. For purposes of this Order, "timely" means records are completed within 72 hours of patient contact.

c. For one year from the date of this Order, the professional mentor shall review 5 randomly selected patient health care files per week.

d. For a period of one year immediately consecutive to the period provided for in paragraph (c), the professional mentor shall review 5 randomly selected patient health care files per month.

e. Respondent shall arrange for the professional mentor to submit formal written reports to the Department Monitor, Department of Regulation and Licensing, Division of Enforcement, P.O. Box 8935, Madison, Wisconsin 53708-8935, on a quarterly basis, or as otherwise directed by the Department Monitor. The professional mentor's reports shall verify that Respondent keeps and maintains patient health care records as described in paragraph (a) above.

f. A professional mentor shall have no prior or current business or personal relationship with Respondent, and shall have no other relationship that could reasonably be expected to compromise the ability of the professional mentor to render fair and unbiased reports to the Department (including but not limited to any bartering relationship, mutual referral of patients outside of the approved facility, etc.). For purposes of this Order, a professional mentor shall be a physician, nurse practitioner, or other health care professional determined by the Board's designee to be appropriate. The professional mentor shall hold a valid Wisconsin credential in a relevant health care field, shall have read this Final Decision & Order, and shall agree to be Respondent's professional mentor.

g. Respondent's professional mentor shall immediately report to the Department Monitor any conduct or condition of the Respondent which may constitute unprofessional conduct—including any deficiency in record keeping, any violation of this Order, or any other danger to the public or patient.

h. It is the responsibility of Respondent to promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order,

including any failures of the professional mentor to conform to the terms and conditions of this Order.

i. Respondent may petition the Board for modification of the limitation requiring monitoring of his patient health care records following receipt by the Board of two quarterly reports from the professional mentor. The determination of whether or not to modify the requirement is entirely within the discretion of the Board, and a decision by the Board not to remove or otherwise modify the requirement for a professional mentor shall not constitute a denial of licensure, and shall not entitle Respondent to a hearing on the Board's refusal to grant any such petition.

2. Respondent shall maintain the services of a third-party health care billing service who shall be responsible for maintaining all billing associated with the Mangold Center for Family Health, until otherwise ordered by the Board.

3. Respondent shall, within 180 days of the date of this Order, pay to the Department of Regulation and Licensing the costs of this proceeding in the amount of $900.00 pursuant to Wis. Stat. § 440.22(2).

4. All payments, requests and evidence of completion of the education required by this Order shall be mailed, faxed or delivered to:

Department Monitor
Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935
Fax (608) 266-2264
Telephone (608) 267-3817

5. Violation of any of the terms of this Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Respondent's license. The Board in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Order. In the event Respondent fails to timely submit payment of the costs as ordered, the Respondent's license (No. 32859-20) may, in the discretion of the Board or its designee, be SUSPENDED, without further notice or hearing, until Respondent has complied with payment of the costs or completion of the continuing education.

6. This Order is effective on the date of its signing.

Wisconsin Medical Examining Board

By: _____ MD MBA _____ 19 Jan 2011
A Member ~~of the Board~~ Date

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