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BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of
DARRYL J. MOHR, M.D.,
Holder of License No. 11224
for the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-11A-11224-MDX
**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**
(Revocation)

On April 4, 2012, this matter came before the Arizona Medical Board ("Board") for consideration of the Administrative Law Judge (ALJ) Thomas Shedden's proposed Findings of Fact, Conclusions of Law and Recommended Order. Darryl J. Mohr, M.D., ("Respondent") appeared before the Board on his own behalf; Assistant Attorney General Anne Froedge, represented the State. Christopher Munns with the Solicitor General's Section of the Attorney General's Office, was available to provide independent legal advice to the Board.

The Board, having considered the ALJ's decision and the entire record in this matter, hereby issues the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. The Arizona Medical Board ("Board") is the duly constituted authority for licensing and regulating the practice of allopathic medicine in the State of Arizona.
2. Darryl J. Mohr, M.D. is the holder of License No. 11224 issued by the Board for the practice of allopathic medicine in Arizona.
3. On December 13, 2011, the Board issued a First Amended Complaint and Notice of Hearing setting this matter for hearing beginning at 1:00 p.m. January 17, 2012.
4. The First Amended Complaint alleges that Dr. Mohr committed acts of unprofessional conduct in five cases. The Board requested that Dr. Mohr's license be revoked given the nature of his conduct and the risk to patients and the public that his conduct presented.

1 5. The Board presented the testimony of Elle Steger, Richard Ruskin, M.D., Carol
2 Peairs, M.D., and Matthew D. Holland, M.D., and had 53 exhibits entered into evidence.
3 Dr. Mohr appeared and testified on his own behalf.

Case MD-10-0683A

4 6. The complaint in Case MD-10-683A, which involves patients MB and CD, was
5 initiated by MB's father. The complaint alleged that Dr. Mohr had prescribed high doses of
6 opioids to MB and to patient CD without providing adequate workups.

7 7. The Board referred this case to Dr. Holland for a review. Dr. Holland is board
8 certified in anesthesiology and pain management.

Patient MB

9 8. MB was initially seen by Dr. Mohr on November 6, 2009. MB's complaint was
10 multi-focal pain involving the knees and lower back, with radicular pain in the lower
11 extremities. MB was 20 years old at the time of the first visit.

12 9. At the initial visit, Dr. Mohr prescribed oxycodone 30 mg tablets, 2 tablets 4 times a
13 day, and Xanax. Dr. Mohr continued to prescribe these drugs throughout the course of
14 MB's treatment.

15 10. With respect to MB's initial visit, Dr. Holland expressed the following concerns:

- 16 a. The medical records Dr. Mohr reviewed were not appropriate to evaluate
17 MB's reported pain;
- 18 b. Dr. Mohr's records did not demonstrate that he had conducted an adequate
19 physical examination;
- 20 c. Dr. Mohr's records did not explain why MB was experiencing the type of pain
21 he reported;
- 22 d. The prescribed dosage of oxycodone was a concern because it was a large
23 dose for unexplained pain and there was no workup or history of prior drug
24 use;
- 25 e. OxyContin, not oxycodone, is generally appropriate for chronic pain because
it is time released.

11. MB's last visit with Dr. Mohr was in May 2010, at which time Dr. Mohr conducted a
urinalysis. The urinalysis was positive for Ativan, which was not being prescribed to MB,

1 and oxycodone, but not Xanax. Dr. Mohr's records do not show that he discussed the
2 urinalysis results with MB.

3 *Patient CD*

4 12. CD first saw Dr. Mohr on January 5, 2010, at which time CD was 20 years old. CD
5 was MB's girlfriend. CD reported that she was suffering from chronic pain in her neck.

6 13. Dr. Mohr reviewed CD's medical records from an accident five years prior to her
7 visit, but these records were not adequate to evaluate CD's reported pain.

8 14. Dr. Mohr prescribed oxycodone 30 mg, 2 tablets, 4 times per day. Dr. Mohr
9 continued to prescribe oxycodone to CD throughout the course of her treatment, but his
10 records do not show that he did any further workups (e.g., x-rays or MRIs).

11 15. Dr. Holland's opinion is that MB and CD were young, healthy individuals who were
12 prescribed pain medication without adequate workups, without clear medical information
13 for chronic outpatient opiate therapy, and without a showing that the risks and benefits of
14 these medications had been discussed.

- 15 16. The standard of care required Dr. Mohr to:
- 16 a. Obtain MB's and CD's prior medical records;
 - 17 b. Obtain MB's and CD's prior history of drug use;
 - 18 c. Conduct physical examinations, including looking for Waddell's signs, which
19 in lay terms means that the patients are faking their pain;
 - 20 d. Consider other modalities of treatment, including physical therapy or a
21 referral for surgery;
 - 22 e. Have the patients agree to undergo surveillance while using the prescribed
23 medications.

24 17. Dr. Mohr's records for MB and CD do not have any information to show that he
25 met any of the elements of the standard of care.

18 18. Dr. Holland found some of Dr. Mohr's records hard to read. Dr. Holland's opinion
19 is that Dr. Mohr's records for MB and CD were not adequate to allow another physician to
20 assume treatment of MB or CD.

21 19. Dr. Holland expressed concern that in his response to the Board, Dr. Mohr had
22 written that he prescribed the drugs because if he did not, another doctor would. Dr.

1 Holland likened Dr. Mohr's treatment to what one would expect at a bar, where the patient
2 comes in and "orders" the drugs they want.

3 20. Dr. Mohr's treatment of MB and CD was potentially harmful in that opioids have
4 potential negative side effects, and because there was a risk that the drugs would be
5 diverted (either deliberately by the patients or innocently through theft from the patients).

6 **Case MD-10-1075A**

7 21. The complaint in Case MD-10-1075A was initiated by patient JS's mother who
8 alleged that Dr. Mohr had prescribed high doses of opioids to JS.

9 22. The Board referred this case to Dr. Ruskin for a review. Dr. Ruskin is board
10 certified in anesthesiology and pain management.

11 23. JS's first visit to Dr. Mohr was on October 12, 2009. The purpose was treatment
12 for pain.

13 24. Dr. Mohr prescribed OxyContin 60 mg, 2 tablets 2 times per day, Roxycodone 30
14 mg 4 times a day, and Xanax.

15 25. With respect to JS's initial visit, Dr. Ruskin expressed the following concerns:

- 16 a. Dr. Mohr did not obtain JS's existing medical records;
- 17 b. Both the history and the physical examination were very brief;
- 18 c. Dr. Mohr's records were hard to read;
- 19 d. There was no assessment and no enunciation of concern related to the high
20 doses of opioids that were prescribed;
- 21 e. There was no clear treatment plan articulated.

22 26. Dr. Ruskin's opinion is that the standard of care required Dr. Mohr to do a
23 complete history and physical examination, to formulate an assessment as to why JS was
24 in pain, and to determine the appropriate treatment. Dr. Mohr did not try any treatment
25 other than pain medication, and he did not make any referrals for physical therapy or other
treatment. Dr. Ruskin also expressed concern that Dr. Mohr did not conduct a urine drug
screen, and he did not even discuss one with JS.

26 27. Dr. Ruskin's opinion is that Dr. Mohr's treatment of JS did not meet the standard of
care.

1 28. Dr. Ruskin's opinion is that Dr. Mohr's workup on JS did not justify the dosage of
2 opioids he had prescribed for JS. Prescribing opioids such as Dr. Mohr did for JS risks
3 enabling the patient to engage in a pattern of misuse through diversion or overdose.

Case MD-10-1390A

4 29. The complaint in Case MD-10-1390A was initiated by patient GW's sister who
5 alleged that Dr. Mohr had engaged in inappropriate prescribing that led to GW's death by
6 an overdose.

7 30. The Board referred this case to Dr. Peairs for a review. Dr. Peairs is board
8 certified in anesthesiology and pain management.

9 31. GW's first visit to Dr. Mohr was on August 18, 2009. GW's last visit was on
10 January 5, 2010 and he died on January 6, 2010.

11 32. The autopsy report shows that GW's death was an accident and that he died of
12 acute hypoxic/ischemic encephalopathy due to respiratory arrest caused by multidrug
13 intoxication including Oxycodone.

14 33. With respect to GW's initial visit, Dr. Peairs expressed the following concerns:

- 15 a. Dr. Mohr's records have no indication of GW's pain history or what
16 medications he was taking;
- 17 b. Dr. Mohr's records show only that GW was there for a refill;
- 18 c. There was no documentation to show that Dr. Mohr had reviewed GW's
19 medical records;
- 20 d. Dr. Mohr's records do not show what medications he prescribed to GW.

21 34. Dr. Peairs accessed pharmacy records to determine that Dr. Mohr had prescribed
22 Soma at the first visit and Soma and Oxycodone at subsequent visits. Dr. Peairs' opinion
23 is that Dr. Mohr's records show no justification for prescribing these medications to GW.

24 35. Dr. Peairs found no information to show that Dr. Mohr had ordered any diagnostic
25 workup for GW or that he had ordered any urine drug testing.

36. Dr. Peairs' opinion is that the standard of care required Dr. Mohr to do a targeted
physical examination and pain history, including a review of past medical records, to verify
any prescriptions, to identify any history showing that GW was at risk for opioid abuse,
and ongoing monitoring of GW's opioid use.

1 37. Dr. Peairs' opinion is that Dr. Mohr failed to meet the standard of care in every
2 regard and that there was a gross deviation from the standard of care. Dr. Peairs' opinion
3 is that Dr. Mohr's records do not demonstrate even a superficial attempt to meet the
4 standard of care.

5 38. Dr. Peairs determined that Dr. Mohr's medical records were inadequate because
6 they did not include the rationale for treatment and did not include any meaningful
7 information related to GW's response to treatment. Dr. Peairs' opinion is that the records
8 were not sufficient to allow another doctor to assume treatment of GW.

9 **Dr. Mohr's Testimony**

10 39. Dr. Mohr testified that he could not dispute any of the testimony provided by Drs.
11 Holland, Ruskin, and Peairs.

12 40. Dr. Mohr acknowledged that there were shortcomings in his work, that he was not
13 a specialist in pain management, and that he was unprepared for what he faced when he
14 was practicing in the pain management area.

15 41. Many of Dr. Mohr's patients had no insurance and were covered only by the
16 Arizona Health Care Cost Containment System. According to Dr. Mohr, these patients
17 could not afford to see other doctors and he was acting out of compassion when treating
18 them.

19 42. Dr. Mohr testified that he has no desire to get back into pain management and
20 acknowledged that he is not adequately trained to do so.

21 43. Dr. Mohr requested that he be allowed to continue practicing, albeit with a practice
22 restriction.

23 **Case MD-11-0197A**

24 44. Dr. Mohr and the Board entered an Order for Letter of Reprimand and Probation
25 and Consent to Same (the "Consent Order") that was effective August 11, 2010. Under
the terms of that Consent Order, Dr. Mohr was required to complete the PACE prescribing
course and the PACE record keeping course by February 11, 2011.

45. The Consent Order resolved Cases MD-09-1053A and MD-09-1576A that involved
allegations that Dr. Mohr had engaged in inappropriate prescribing. In the Consent Order,
Dr. Mohr acknowledged that he had not met the standard of care when prescribing

1 OxyContin, oxycodone, and other opioids to eight patients who were the subjects of
2 Cases MD-09-1053A and MD-09-1576A.

3 46. In an email dated January 23, 2011, Dr. Mohr requested that he be given an
4 extension of time to complete the required PACE courses because he did not have the
5 financial resources required to take the courses. Dr. Mohr's request was not granted.

6 47. The Board instituted the complaint in case MD-11-0197A when Dr. Mohr did not
7 complete the PACE courses as required under the terms of the Consent Order.

8 48. On February 25, 2011, Dr. Mohr and the Board entered into an Interim Order for
9 Practice Restriction and Consent to the Same in which Dr. Mohr acknowledged that he
10 had not completed the required PACE courses.

11 49. Dr. Mohr has subsequently completed the required PACE courses, but the date of
12 completion is not in the record.

13 **Case MD-11-1134A**

14 50. The complaint in Case MD-11-1134A was initiated when the Arizona Department
15 of Health Services ("ADHS") informed the Board that Dr. Mohr had written Medical
16 Marijuana Certifications for 266 patients in which he attested that he reviewed the
17 patients' profiles on the Arizona Pharmacy Board's Controlled Substances Prescription
18 Monitoring Program ("CSPMP") database.

19 51. At the time he wrote the 266 Certifications, Dr. Mohr was not registered with the
20 CSPMP, and he was not eligible for registration.

21 52. Dr. Mohr acknowledges that he did not access the CSPMP database, but asserts
22 that ADHS personnel informed him that it was not necessary to check the database before
23 writing Certifications.

24 **CONCLUSIONS OF LAW**

25 1. The Board has jurisdiction over Dr. Mohr and the subject matter in this case.

2. The Board has the burden of persuasion. A.R.S. § 41-1092.07(G)(2).

3. The burden of proof on all issues is that of the preponderance of the evidence.
A.A.C. R2-19-119(A).

4. A preponderance of the evidence is "[e]vidence which is of greater weight or more
convincing than the evidence which is offered in opposition to it; that is, evidence which as

1 a whole shows that the fact sought to be proved is more probable than not." BLACK'S LAW
2 DICTIONARY 1182 (6th ed. 1990).

3 5. Drs. Holland, Ruskin, and Peairs provided credible testimony showing that Dr.
4 Mohr failed to maintain adequate records and that he engaged in conduct that might be
5 harmful or dangerous to his patients and the public. Dr. Mohr did not dispute any of this
6 testimony, and he acknowledged that he was not adequately trained for the pain
7 management practice he engaged in. The preponderance of the evidence shows that Dr.
8 Mohr violated A.R.S. § 32-1401(27)(e) and (27)(q).

9 6. Dr. Mohr did not complete the PACE courses as required under the terms of the
10 Consent Order. The preponderance of the evidence shows that Dr. Mohr violated A.R.S.
11 § 32-1401(27)(r).

12 7. Dr. Mohr signed 266 Certifications in which he attested that he had reviewed the
13 CSPMP database for each patient, even though he had not done so. Even if Dr. Mohr
14 was informed that he was not required to check the database, this does not excuse his
15 actions in attesting that he had done so when he had not. The preponderance of the
16 evidence shows that Dr. Mohr violated A.R.S. § 32-1401(27)(t).

17 8. The preponderance of evidence shows that Dr. Mohr violated A.R.S. § 32-
18 1401(27) (e), (27)(q), (27)(r) and (27)(t), which violations constitute acts of unprofessional
19 conduct. Consequently discipline against Dr. Mohr's license is appropriate. See A.R.S. §
20 32-1451(M).

21 9. As a factor in aggravation, the Board introduced evidence showing that Dr. Mohr
22 has previously been subject to discipline for prescribing violations. See Exhibits 41 and
23 42.

24 10. The Board argues that revocation of Dr. Mohr's license is appropriate based on
25 the nature and number of violations. The preponderance of evidence supports the
Board's position and, consequently, Dr. Mohr's license should be revoked.

ORDER

IT IS ORDERED that on the effective date of the Final Order entered in this
matter, Darryl J. Mohr, M.D.'s License No. 11224 is revoked.

1 Executed copy of the foregoing
mailed by U.S. Mail this
2 17 day of April, 2012 to:

3 Darryl J. Mohr, M.D.
Address of Record
4
5 Anne Froedge
Assistant Attorney General
Office of the Attorney General
6 CIV/LES
1275 W. Washington
7 Phoenix, AZ 85007

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9 # 2609656

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