BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **WARREN L. MOODY III, M.D.** Holder of License No. 31152 For the Practice of Medicine In the State of Arizona.	Case No. MD-07-0874A **CONSENT AGREEMENT FOR DECREE OF CENSURE AND PRACTICE RESTRICTION**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Warren L. Moody III, M.D. ("Respondent"), the parties agree to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter and has done so or chooses not to do so.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement or any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver, express or implied, of the Board's statutory authority or jurisdiction regarding any other pending or future investigation, action or proceeding. The acceptance of this Consent Agreement does not preclude any other agency, subdivision or officer of this State from instituting other civil or criminal proceedings with respect to the conduct that is the subject of this Consent Agreement.

6. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the acceptance of the Consent Agreement. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. If the Board does not adopt this Consent Agreement, it will not be used by the Board as an admission of wrongdoing by Respondent, or in any other manner in future Board proceedings. In addition, Respondent will not assert as a defense that the Board's consideration of this Consent Agreement constitutes bias, prejudice, prejudgment or other similar defense.

9. This Consent Agreement, once approved and signed, is a public record that will be publicly disseminated as a formal action of the Board and will be reported to the National Practitioner Data Bank and to the Arizona Medical Board's website.

10. If any part of the Consent Agreement is later declared void or otherwise unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force and effect.

11. Any violation of this Consent Agreement constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter") and 32-1451.

12. Respondent has read and understands the conditions of probation.

Warren L Moody III MD

WARREN L. MOODY III, M.D.

Dated: 1/14/09

REVIEWED AS TO FORM:

Daniel P. Jantsch

DANIEL P. JANTSCH, ESQ.

Dated: JAN. 15, 2009

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 31152 for the practice of allopathic medicine in the State of Arizona.

I Improper Prescribing and Dispensing

3. On September 21, 2007, the Board was contacted by a Walgreen's pharmacist, S.B., regarding suspicious prescriptions written by Respondent to an individual, W. F., for Vicodin. It was alleged that W.F. was not a patient of the medical clinic for which the prescriptions were written; and that Respondent, on several occasions, picked up and paid for the prescriptions he had written for W.F. In addition, the pharmacist alleged that Respondent called to refill at least one prescription early (before the previous prescription should have been consumed).

4. On September 21, 2007, immediately after receiving the complaint from the pharmacist, Board staff contacted Respondent and requested that he appear for an investigational interview at the Board. Respondent agreed, and appeared the same day. During this interview, Respondent admitted writing prescriptions for controlled substances to W.F. and members of W.F.'s family, including J.F. Respondent also admitted writing prescriptions for his art instructor, J.P. Respondent stated that these persons were friends of his, not patients.

5. The Board obtained a pharmacy survey from Walgreen's detailing the prescriptions Respondent wrote for these three individuals:

6. Between March 6, 2006 and March 22, 2007, Respondent wrote 21 prescriptions for J.F. including the following controlled substances: Seroquel, Lunesta, hydrocodone, diazepam (Valium), Cymbalta, alprazolam (Xanax) and Ambien. Respondent admitted

that he met and befriended J.F. while Respondent was treating him for substance abuse issues at Scottsdale Treatment Institute ("STI"). However, at the time these prescriptions were written, J.F. was no longer a patient of Respondent's, rather they were friends. Respondent admitted he had no medical records to document these prescriptions.

7. Between May 24, 2006 and September 7, 2007, Respondent wrote 8 prescriptions for W.F., a relative of J.F., including the following controlled substances: diazepam (Valium), zolpidem (Ambien), and hydrocodone. In addition, Respondent admitted picking up and paying for a prescription for W. F. early (before the last prescription should have run out). Respondent admitted he had no medical records to document these prescriptions, and clarified that W. F was a friend (as opposed to a patient). Respondent also claimed he had written only one prescription for W.F. for hydrocodone, which contradicted the pharmacy records.

8. Between June 24, 2006 and September 7, 2007, Respondent wrote 15 prescriptions for J.P. including the following controlled substances: carisoprodol and oxycodone. Respondent admitted he had no medical records to document these prescriptions, but stated that J.P. was a friend (as opposed to a patient).

9. The Board later discovered that Respondent had also written 9 prescriptions to another friend, E.S., between January 20, 2006 and January 17, 2007, for Diazepam (Valium) and Naltrexone. Respondent met and befriended E.S. when they were both in treatment for substance abuse issues at Assisted Recovery Centers of America ("ARCA"). Respondent admitted he had no medical records to document these prescriptions.

10. In a June 26, 2008 interview with Board Staff, Respondent stated that he had been granted a special Drug Enforcement Agency ("DEA") registration to prescribe Suboxone. To obtain this registration, he was required to take a special course. However, Respondent maintained that he did remember the prescribing practices for Suboxone in

general, including how many prescriptions for Suboxone he could write for a patient with only one examination.

II Respondent's Fitness to Practice Medicine: Personal Substance Abuse and Mental Health Issues

11. Respondent first entered outpatient treatment for alcohol abuse at ARCA on April 7, 2005.

12. Dr. Walker diagnosed Respondent with alcohol abuse and ordered detox. Respondent initially attended substance abuse counseling sessions (both group and one-on-one) at ARCA from April 11, 2005 through June 8, 2005.

13. Respondent relapsed and re-entered treatment at ARCA on January 4, 2006. Between January and March of 2006 Respondent was seen by psychiatrist Emerson Bueno, M.D., at API's insistence.

14. Although Respondent was being seen at ARCA for his alcohol abuse during the same time he saw Dr. Bueno, Respondent did not disclose this to Dr. Bueno, instead stating, "I don't drink."

15. During a September 21, 2007 investigational interview at the Board, Respondent denied drinking any alcohol for the previous 5-7 years, denied ever having been in "rehab" or "detox" for alcohol or drug abuse, and denied having been on antidepressants since his residency (1992-1996).

16. During this interview, Respondent was repeatedly asked to describe the medications he was taking. Initially, Respondent stated that he had only taken ibuprofen. Immediately after being informed that he would be drug tested the same day, Respondent disclosed he had been prescribed Vicodin approximately 6-8 weeks earlier, but maintained he had not taken Vicodin recently.

17. Respondent's September 21, 2007 urine sample tested positive for Vicodin (Hydrocodone, a DEA Schedule III controlled substance), indicating more recent use than Respondent had reported.

18. On September 25, 2007, when confronted with the positive drug test for Vicodin, Respondent stated that he forgot to inform Board staff that he had taken Vicodin one day before the interview for pain from a tattoo.

19. Respondent has never produced medical records to indicate that his admitted use of Vicodin on September 20, 2007 was prescribed or authorized by a physician for tattoo pain relief.

20. Based on Respondent's interview with Board staff and his positive urine test, he was ordered to complete a residential substance abuse evaluation on September 25, 2007.

21. On October 8, 2007, Respondent presented to the Betty Ford Center ("BFC") for a substance abuse evaluation.

22. The BFC evaluators noted that Respondent's demeanor was "remarkably bland" with regard to his concerning prescribing practices. However, when evaluators confronted Respondent and stated that "he must have been aware of ethical prescribing practices since he had attended a mandatory Suboxone information conference in the recent past which dedicated a significant portion of time to prescription ethics," Respondent "exploded in a tirade of rage directed at (a BFC evaluation team) member" who had pointed this out. The BFC report further stated that, "(Respondent's) attack was totally unexpected and quite alarming in its intensity." Respondent left BFC shortly after this "tirade."

23. On October 11, 2007, BFC sent Board staff the Preliminary Clinical Diagnostic Evaluation discharge summary indicating that Respondent had refused to sign a release form allowing BFC staff to contact Respondent's family and employer, thus BFC was

unable to complete the evaluation. The BFC Evaluation team unanimously concluded that Respondent was not currently fit to practice medicine.

24. The BFC preliminary report noted that Respondent denied drinking any alcohol since 2003, and denied any abuse of pain medications. Respondent also denied any history of depression or other psychiatric problems.

25. On October 15, 2007, Board staff was contacted by Respondent's current employer, Michael Carlton, M.D., who stated, *inter alia*, that he had terminated Respondent's employment due to Respondent requesting narcotics prescriptions from multiple coworkers and his repeated late appearances for work.

26. After receiving the transcript of the Board staff interview with Dr. Carlton, BFC diagnosed Respondent with opioid dependence in a final report, dated November 6, 2007. BFC recommended that Respondent be required to successfully complete 90 days of residential treatment at a Board-approved facility, be discharged from treatment with staff approval, and be enrolled in Board's Monitored Aftercare Program ("therapeutic monitoring program"). The BFC report also recommended that Respondent's cognitive function be assessed prior to any return to practice.

27. Respondent checked himself into Hazelden Springbrook, a Board-approved facility, on December 31, 2007. Initially, Respondent requested treatment but within days changed his mind and, as the Hazelden final report states, "at patient request" a multidisciplinary team evaluation was begun.

28. During Hazelden's assessment, Respondent denied any past abuse of substances and claimed he had essentially no alcohol use as an adult. Respondent also claimed he had no prior psychiatric or psychological treatment or past use of antidepressants, tranquilizers, etc.

29. The results of the Hazelden evaluation, completed February 11, 2008, were inconclusive. The report states that Hazelden staff had, "serious concerns about (Respondent's) judgment and (Respondent's) medical practices," and notes "significant professional boundary issues."

III Respondent's False Statements

A. 2006 Board Application for Renewal of Licensure

30. In the confidential questionnaire attachment to his 2006 application for renewal of licensure with the Board, dated December 1, 2007, Respondent answered "NO" to question number 2, which states: "Are you now or since your last renewal (2 years prior, in 2004) been addicted to or abused any chemical substance including alcohol?" Respondent had, in fact, been diagnosed and treated for alcohol abuse at ARCA in 2005 and early 2006.

31. Respondent also answered "NO" to question number 3, which states: "Are you now being treated or since your last renewal have you been treated or evaluated for a drug or alcohol addiction or participated in a rehabilitation program?" Respondent again failed to disclose his treatment at ARCA.

32. Respondent initialed the confidential application page which states that, "(f)ailure to properly answer these questions or disclose alcohol, substance abuse or other issues can result in Board disciplinary action."

B. Board Investigational Interview: September 21, 2007

33. At his initial investigational interview with Board staff on September 21, 2007, Respondent asserted that no one had "ever said anything to (him) in the past about drinking." However, within the previous 2 ½ years, Respondent had been in treatment at ARCA twice for alcohol abuse.

34. Respondent also denied ever having been to rehab or detox as a patient.

35. Respondent denied he had never been seen by a psychiatrist. However, Respondent was, in fact, under the care of Dr. Bueno 1 ½ years earlier, January – March of 2006.

36. Respondent falsely asserted in this September 2007 Board staff interview that he had never experienced a problem with alcohol.

37. Nine months later, during a June 26, 2008 Board Staff interview, Respondent admitted that he had failed to inform Staff of his alcohol abuse; and also admitted failing to inform evaluators at BFC and Hazelden of his previous treatment for alcohol abuse at ARCA.

C. Statements to Clinical Evaluators

38. During Respondent's Board-ordered substance abuse evaluation at the BFC in early October, 2007, Respondent reported to multiple BFC evaluators during numerous clinical interviews that he had not used alcohol since 2003. Respondent also repeatedly denied any psychiatric therapy or psychotherapy, and denied any psychiatric diagnosis.

39. Respondent was also dishonest and misleading about his substance abuse and psychiatric history during his self-initiated (non-Board-ordered) evaluation at Hazelden Springbrook.

40. Respondent stated to Hazelden evaluators that he essentially had no use of alcohol as an adult. Additionally, Respondent told the Hazelden team that he had no prior psychiatric or psychological treatment and no past use of antidepressants, tranquilizers, etc.

D. Statements during June 26, 2008 Board Staff Interview

41. While under oath, during a June 26, 2008 Board Staff interview, Respondent initially asserted that he enrolled for treatment at ARCA in 2005 primarily because he was depressed, and that he was concerned he might begin to abuse alcohol. In separate

interviews, ARCA staff informed Board Staff that they do not treat depression at ARCA, rather they treat alcoholism.

42. Respondent described his use of alcohol as one glass a night for one month prior to his initial enrollment at ARCA. However, ARCA physician Dr. Walker's records indicate that Respondent self-reported drinking two liters of wine per night. When questioned, Respondent specifically denied drinking even one bottle of wine per night.

43. Respondent minimized his treatment at ARCA, stating that he only attended treatment at ARCA for one treatment course, for a few months. However, Dr. Walker's medical records reflect that Respondent returned to ARCA in January, 2006 for a relapse of alcohol abuse.

44. Respondent denied being disciplined or even having serious problems with his previous employer, API. However, API's records reflect that Respondent was initially terminated for cause after having been ordered to see a psychiatrist for a self-reported "nervous breakdown," after failing to report for work on multiple dates, and then appearing for work in a disheveled and unstable state. API records reflect that Respondent was notified of his termination personally, by telephone, and in writing. API later rescinded the termination and allowed Respondent to resign.

45. Respondent also denied any problems with his other employer, IPC. Respondent's statements contradict IPC's records, which indicate numerous performance problems which ultimately resulted in Respondent's termination without cause on April 16, 2005.

IV Interference with the Board's Investigation: Respondent's Tampering with Witnesses and Conspiracy to Destroy Evidence

46. On June 18, 2008 Board staff sent a subpoena to ARCA for production of Respondent's treatment records as part of its investigation into Respondent's ability to safely practice medicine.

47. Board staff eventually discovered that after Ms. Rogers had received the Board's subpoena and confirmed Respondent's participation at ARCA, she telephoned Respondent and informed him of the Board's investigation.

48. In a Board interview on June 25, 2008 and in a document written shortly after the incident, Ms. Rogers asserted that Respondent directed her to destroy his treatment file at ARCA and to lie to Board staff by stating that he was not a patient there.

49. Ms. Rogers admits she complied with Respondent's orders by destroying his main ARCA treatment file and by lying to Board staff in the second June 18, 2008 telephone call (in which she claimed Respondent was not a patient).

50. On or about June 26, 2008, Respondent contacted two additional witnesses involved with his treatment at ARCA and also asked them to lie to Board staff about his treatment at ARCA. Specifically, Respondent asked ARCA Executive Director Mr. Vacovsky and ARCA psychologist Dr. Emmett Velten (who had treated Respondent) to tell Board staff that he was being treated for depression, rather than alcohol abuse.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction of the subject matter hereof and over Warren L. Moody III, M.D., the holder of license number 31152, for the practice of allopathic medicine in the State of Arizona.

1. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient."); A.R.S. § 32-1401(27)(f) ("[h]abitual intemperance in the use of alcohol or habitual substance abuse."); A.R.S. § 32-1401(27)(g) ("[u]sing controlled substances except if prescribed by another physician for use during a prescribed course of treatment."); A.R.S. § 32-1401(27)(j) ("[p]rescribing, dispensing or administering any controlled substance or

prescription-only drug for other than accepted therapeutic purposes."); A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.); A.R.S. § 32-1401(27)(dd) ("[f]ailing to furnish information in a timely manner to the board.); A.R.S. § 32-1401(27)(jj) ("[k]knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.); and A.R.S. § 32-1401(27)(ss) ("[p]rescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. . .).

ORDER

1. Respondent is issued a Decree of Censure.

2. Respondent shall not practice clinical medicine or any medicine involving direct patient care, and is prohibited from prescribing any form of treatment including prescription medications.

3. Respondent shall undergo a residential evaluation at a Board Staff approved facility. Respondent is responsible for all expenses related to the evaluation and/or treatment. Respondent shall sign consent to release all confidential evaluation and/or treatment records to the Board. Respondent shall comply with any recommendations made by the evaluation facility and approved by Board Staff including any recommendation that he undergo and successfully complete further residential treatment at a Board approved facility.

4. Following successful completion of the evaluation and any recommended residential treatment, Respondent is then eligible to be monitored under the Board's Monitored Aftercare Program.

5. Following successful completion of the evaluation and any recommended residential treatment, Respondent may petition the Board to terminate the practice restriction.

6. This Order is the final disposition of case number MD-07-0874A.

DATED AND EFFECTIVE this 4TH day of February, 2009.

(SEAL)

ARIZONA MEDICAL BOARD

By: Lisa S. Wynn
Executive Director

ORIGINAL of the foregoing filed
this 4th day of February, 2009 with:

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9545 E. Doubletree Ranch Road
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this 4th day of February, 2009 to:

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