BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **RAGHAV MOHINDRA, M.D.** Holder of License No. 41238 For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-20-0249A, MD-20-0955A, and MD-21-0110A** **ORDER FOR LETTER OF REPRIMAND AND PROBATION; AND CONSENT TO THE SAME**

Raghav Mohindra, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Letter of Reprimand and Probation; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

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 41238 for the practice of allopathic medicine in the State of Arizona.

MD-20-0249A

3. The Board initiated case number MD-20-0249A after receiving a complaint regarding Respondent's care and treatment of a 91-year-old female patient ("DB") alleging failure to properly care for and treat patient's bleeding cut or boil in groin; inappropriate referral to a gynecology and for a vaginal ultrasound; and inappropriately prescribed empiric medications including Rocephin and Kenalog injections.

4. During the investigation, the Board requested Medical Consultant ("MC") review of Respondent's care and treatment of DB and three additional patients. The MC identified deviations from the standard of care for Respondent's care of two of the additional patients reviewed (DV and LW).

5. DB was a resident at an Assisted Living Facility where Respondent had seen DB professionally since at least January 2019 and provided geriatric care.

6. On March 14, 2020, DB presented to Respondent's office. DB had experienced a recurring, draining cyst in the buttock/perineal area for several months. Respondent's note described DB's complaint as vaginal bleeding. A second physical complaint in the note included nasal congestion and rhinorrhea accompanied by Respondent's exam demonstrating wheezing. Respondent diagnosed DB with viral bronchitis and prescribed, for immediate usage: an injection of ceftriaxone, an injection of triamcinolone, levofloxacin 500mg orally daily for 7 days, valacyclovir one gram orally each day for 3 days, and methylprednisolone 4mg, 21 tablets, to be taken orally as directed.

7. DV was a 55-year-old male patient who established care with Respondent on July 13, 2020. DV had a medical history of hypothyroidism, hyperlipidemia, hypertension, and diabetes. Respondent ordered initial lab work, and DV's results showed an A1C of 9.6, triglycerides of 259, and vitamin D of 23.6. DV's blood pressure was 134/94. The patient did not return for a follow-up.

8. LW was a 77-year-old male patient who established care with Respondent in May 2019. LW had a medical history of COPD, hypertension, hyperlipidemia, hypothyroidism, and chronic kidney disease. LW's medication list included morphine sulfate 15mg four times daily, clonazepam 0.5mg twice daily, and gabapentin 300mg four times daily. Respondent additionally counseled LW to follow a high protein diet.

9. The standard of care requires a physician to appropriately evaluate and treat a patient. Respondent deviated from this standard of care by failing to appropriately evaluate and treat DB's respiratory complaint.

10. The standard of care requires a physician to prescribe medications that fit the patient's physical, laboratory, and imaging findings. Respondent deviated from the

standard of care for Patient DB by inappropriately prescribing a combination of antibiotics, steroids, and an antiviral for viral bronchitis in a geriatric patient.

11. The standard of care requires a physician to address abnormal vital signs. Respondent deviated from the standard of care for Patient DV by failing to document discussion of the patient's high blood pressure.

12. The standard of care prohibits a physician from prescribing opioids and benzodiazepines without a clinical rationale. Respondent deviated from the standard of care for Patient LW by prescribing clonazepam and morphine sulfate concurrently without documenting a clinical rationale.

13. There was the potential for patient harm in that Patient DB was at risk of future antimicrobial resistance, and adverse drug reactions. Patient DV was at risk of unmanaged disease processes. Patient LW was at risk of injury or death caused by concurrent use of opiates and benzodiazepines.

MD-20-0955A

14. The Board initiated case number MD-20-0955A after receiving a complaint regarding Respondent's care and treatment of a 35-year-old male patient ("NM") alleging failure to properly care for and treat patient, inappropriate discharge, interfering with medication regiments prescribed by other providers, and failure to properly communicate with the patient.

15. On September 1, 2020, NM presented to Respondent's office to establish care. NM had a medical history of severe anxiety, bipolar disorder, chronic pain from compression fractures, arthritis, muscle weakness, memory issues, early dementia, and IgG lamda smoldering myeloma that have left him disabled. NM was also seeing a psychiatrist on a monthly basis who had been working with him on issues of depression and anxiety for the past year. The psychiatrist had been adjusting his clonazepam and

fluoxetine during that time. Respondent refilled NM's metoprolol tartrate and famotidine. Respondent made a referral to rheumatology. Respondent's assessment note indicated that therapy was needed to restore the patient's ability to walk without a walker as well as noting the use of an assistive device to leave home safely.

16. On September 3, 2020, NM had a telehealth visit with Respondent to discuss the patient's anxiety. NM had been on a stable regimen of clonazepam 1mg four times daily for anxiety prescribed by his psychiatrist. Respondent increased the clonazepam to 2mg four times daily.

17. On September 10, 2020, NM had a telehealth visit with Respondent. NM requested a letter stating that he was dependent on clonazepam and would require hospitalization if he did not have access to the medication. Respondent noted NM's report of results of an MRI of the brain that NM stated showed "severe deviation symptoms." The assessment included diagnoses of Asperger's Syndrome as well as muscle weakness, hyperlipidemia, and anxiety.

18. On September 11, 2020, NM presented to Respondent's office. NM requested allergy testing and Respondent provided NM with a referral as requested. NM had been seen by his psychiatrist the day before where she stopped prescribing the clonazepam based on the rationale that his anxiety was medical and not psychiatric.

19. On September 15, 2020, NM had a telehealth visit with Respondent to discuss laboratory results that showed a mildly low sodium at 130. NM stated that he needed an increased dose of clonazepam. NM reported that he was following with a rheumatologist but noted that, "they do not follow with people with history of chronic pain and are followed by pain management physician". Respondent advised that he continue with pain management physician. Respondent had visits with NM in the office on September 17, 2020 and a telehealth visit on September 22, 2017.

20. On September 24, 2020, NM presented to Respondent's office for complaints of anxiety. NM requested a change to his clonazepam regimen as the current dosing did not feel adequate. NM was given samples of Trintellix, and Viibryd. Respondent noted that the patient needed 100% assistance with walking, grooming, bathing, transfers, and bladder/bowel incontinence.

21. On September 29, 2020, NM had a telehealth visit with Respondent for a refill of clonazepam 2mg #150.

22. On September 30, 2020, NM presented to Respondent's office. Respondent increased the clonazepam to 2mg six times daily. Additionally, NM's pain physician stopped the hydrocodone/acetaminophen and started hydromorphone 4mg four times daily.

23. On October 5, 2020, NM was seen by Respondent in the office and reported doing well on the clonazepam.

24. On October 8, 2020, NM had a telehealth visit with Respondent to discuss the allergy test results. NM tested weakly positive for a salmon allergy. NM also expressed concern about his pain regimen and said his pain doctor would not increase the hydromorphone. Respondent made a referral to a different pain specialist for a second opinion.

25. On November 3, 2020, Respondent discharged NM from his practice due to his disruptive behavior toward office staff. NM was provided a letter stating that Respondent and other providers in the office would only see him in emergency situations for the next 30 days.

26. On January 25, 2021, NM entered supervised detoxification from opiates and benzodiazepines at the urging of his psychiatrist. Subsequently, NM was weaned off opiates and the clonazepam was decreased to 4mg daily.

27. The standard of care requires a physician to confer with the patient's psychiatrist when assuming the responsibility of prescribing clonazepam and other psychiatric medications. Respondent deviated from the standard of care by increasing the patient's clonazepam and adding other psychiatric medications without documenting a clinical rationale or conferring with the patient's psychiatrist.

28. The standard of care requires a physician to monitor a patient by querying the CSPMP and obtain a urinary drug screen prior to prescribing controlled substances. Respondent deviated from the standard of care by failing to monitor the patient by querying the CSPMP or obtain a urinary drug screen prior to prescribing controlled substances.

29. There was actual patient harm in that NM developed a high level of clonazepam dependency.

30. There was potential for patient harm in that NM was at risk for addiction, overdose and death.

MD-21-0110A

31. The Board initiated case number MD-21-0110A after receiving a complaint regarding Respondent's care and treatment of a 61-year-old male patient ("RS") alleging failure to properly care for and treat patient with fatigue and intense pain, failure to order appropriate tests including labs and CT scans, failure to document patient's complaints or phone conversations, and failure to diagnose kidney cancer which resulted in the patient's death.

32. On July 7, 2017, RS presented to Respondent's office to establish care. RS had a medical history of diabetes mellitus type 2, hypothyroidism, hypertension, hyperlipidemia, hypogonadism, elevated PSA, narcolepsy depression, and obstructive sleep apnea. RS had recently started using a CPAP and wanted to quit smoking. RS's BMI

was 40. RS had a very mildly elevated blood pressure. Respondent ordered allergy skin testing, thyroflex, spirometry, EKG, balance testing, and a full preventative work-up. Respondent also prescribed RS Chantix.

33. On August 3, 2017, RS presented to Respondent's office with complaints of worsening fatigue and depression. RS's weight was 207.6. RS's lab results showed mild anemia (Hgb 12 .6), moderate hematuria, and PSA 5.6 w/ 7% free. A urine culture was negative. Respondent attributed the fatigue to a Vitamin B12 deficiency. A B12 injection was administered. The hematuria was noted to be asymptomatic. Respondent recommended follow-up in 3-6 months.

34. On August 30, 2017, RS presented to Respondent's office with complaints of severe fatigue, poor quality sleep, and worsening depression. RS's weight was 198. RS's heart rate was 106. Respondent documented assessment and plan included angina pectoris and shortness of breath. Respondent ordered an echocardiogram, lexiscan stress test, and pulmonary stress test. Respondent attributed RS's fatigue partially to tobacco use. Respondent prescribed Trintellix and Ritalin.

35. On September 6, 2017, RS called Respondent's office requesting an increase of the citalopram. The request was reviewed and approved by another provider in Respondent's office and citalopram was increased to 40mg daily.

36. On January 8, 2018, RS returned to his previous primary care physician with complaints of gross hematuria, severe fatigue, and pain. On January 11, 2018, RS was admitted to a Hospital where he was diagnosed with renal cell carcinoma which led to his demise approximately two months later.

37. The standard of care requires a physician to evaluate asymptomatic hematuria in a high-risk patient. Respondent deviated from the standard of care by failing to evaluate hematuria in a high-risk patient.

38. There was actual patient harm in that RS expired.

39. There was potential for patient harm in that RS was at risk for decreased quality of life and length of life due to delay in diagnosing kidney cancer; possible missed diagnosis of prostate cancer; and exacerbation of "angina pectoris" due to Ritalin.

Other Information

40. During the Board's investigation, Respondent participated in an investigational interview with Board staff. Respondent reported practice changes in response to DB's case including improved communication with patients and their families and hiring a consultant company to assist with medical record reviews and clinical documentation. Additionally, Respondent reported additional staff training regarding medication reconciliation.

41. On January 23, 2021, Respondent completed an intensive, virtual continuing medical education ("CME") course in physician patient communication from a Board approved provider for 8 Category I CME credit hours.

42. On January 25-27, 2021, Respondent completed an intensive, virtual CME course in physician prescribing with a Board approved provider for 27 Category I CME credit hours.

43. On January 28-29, 2021, Respondent completed an intensive, virtual CME course in medical recordkeeping with a Board approved provider for 17 Category I CME credit hours.

44. On February 7 and March 1, 2023, Respondent underwent a competency assessment with a Board approved Evaluating Facility. The Facility determined that Respondent's performance was consistent with a Pass-Category 3 and made recommendations for practice monitoring and completion of additional CME.

CONCLUSIONS OF LAW

a. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

b. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate records on a patient.").

c. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r)("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on Probation for a period of 2 years with the following terms and conditions:

a. Continuing Medical Education

Respondent shall within 6 months of the effective date of this Order, complete the Medical Recordkeeping (MR-17) course offered by Professional Boundaries, Inc. ("PBI"). Respondent shall within thirty days of the effective date of this Order submit satisfactory proof of enrollment with Board staff. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical licensure.

Within 30 days of successful completion of the PBI CME, Respondent shall enroll in the post-CME maintenance and accountability seminars (MAS-12) and successfully complete them. Respondent shall comply with any and all requirements and practice recommendations made by his PBI faculty as well as follow any and all recommendations

made for further education and/or remediation by PBI, subject to the approval of the Board or its staff. Respondent shall provide Board staff with proof that she successfully completed all seminars. Respondent shall sign any and all consents or releases necessary to allow for PBI to communicate to the Board directly and furnish PBI's "AIR" Letter after completion of the required CME. Respondent shall be responsible for the expenses of participation in the maintenance and accountability seminars, and shall notify the Board staff of enrollment in them. Respondent shall not revoke any release prior to successful completion of the CME and maintenance and accountability seminars.

At his own expense, Respondent shall complete no less than 50 hours of Category I CME for each year of this Order in topics recommended by the Facility in its Report. Respondent shall submit quarterly reports to Board staff regarding the CME completed towards this requirement, including course descriptions and certificates of completion. Respondent shall maintain course related materials and promptly provide them on request of Board staff. Board staff retains sole discretion to approve Respondent's completed courses.

Additionally, within 30 days of the date of this Order, Respondent shall review the UCSD Practical Guide to Clinical Medicine and within 60 days of the date of this Order, Respondent shall read the book *How Doctors Think* by Jerome Groopman, M.D.

b. <u>Practice Monitor</u>

Within 30 days from the date of this Order, Respondent shall submit the name of a Practice Monitor who is a physician licensed in good standing with the Board for approval by Board staff. The Practice Monitor shall affirm that they have reviewed the Facility's Report and agree to provide monitoring and mentoring in accordance with the Facility's recommendations. The Practice Monitor shall select and retrospectively review a minimum of 10 of Respondent's charts on a quarterly basis. Additionally, the Practice

Monitor shall meet with Respondent at least bi-weekly (every two weeks) for mentoring. The Practice Monitor shall report to the Board on a quarterly basis regarding Respondent's progress, the results of the chart reviews and Respondent's safety to practice. Respondent is responsible for all costs related to the Practice Monitor, including any costs related to the preparation of the quarterly reports.

c. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

d. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State for longer than 30 consecutive days or for any reason should Respondent stop practicing medicine in Arizona for longer than 30 consecutive days, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Periods of residence or practice outside Arizona of greater than 30 consecutive days or periods of non-practice within Arizona of greater than 30 consecutive days, will not apply to the reduction of the probationary period.

e. Probation Termination

Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 30 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order and be accompanied by a report from the Practice Monitor that Respondent has remediated the deficiencies identified by the

Facility and that he is safe to practice without additional monitoring. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

3. The Board retains jurisdiction and may initiate new action against Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s)

DATED AND EFFECTIVE this 4th day of January, 2023.

ARIZONA MEDICAL BOARD

By _____
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

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

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent in this Order 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.

6. Notwithstanding any language in this Order, this Order does not preclude in any way any other State agency or officer or political subdivision of this state from instituting proceedings, investigating claims, or taking legal action as may be appropriate now or in the future relating to this matter or other matters concerning Respondent, including but not limited to, violations of Arizona's Consumer Fraud Act. Respondent acknowledges that, other than with respect to the Board, this Order makes no representations, implied or otherwise, about the views or intended actions of any other state agency or officer or political subdivisions of the State relating to this matter or other matters concerning Respondent.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. 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. This Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

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

10. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

11. Any violation of this Order constitutes unprofessional conduct and may result in disciplinary action. A.R.S. § § 32-1401(27)(s) ("[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 acknowledges that, pursuant to A.R.S. § 32-2501(16), he cannot act as a supervising physician for a physician assistant while his license is on probation.

13. ***Respondent has read and understands the conditions of probation.***

RAGHAV MOHINDRA, M.D.

DATED: 12/07/2023

EXECUTED COPY of the foregoing mailed this 4th day of January, 2023 to:

Raghav Mohindra, M.D.
Address of Record

Lauren Weinzweig, Esq.
The Nelson Law Group, PLLC
21 West Coolidge Street
Phoenix, Arizona 85013
Attorney for Respondent

ORIGINAL of the foregoing filed this 4th day of January, 2023 with:

Arizona Medical Board
1740 West Adams, Suite 4000
Phoenix, Arizona 85007

Michelle Robles
Board staff