STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF PROFESSIONAL LICENSING
BOARD OF MEDICINE
DISCIPLINARY SUBCOMMITTEE

In the Matter of

MOHAMMAD DERANI, M.D.
License No. 43-01-045768,

File No. 43-16-141086

Respondent.

ORDER OF SUMMARY SUSPENSION

The Department filed an *Administrative Complaint* against Respondent as provided by the Public Health Code, MCL 333.1101 *et seq*, the rules promulgated under the Code, and the Administrative Procedures Act, MCL 24.201 *et seq*.

After careful consideration and after consultation with the Chairperson of the Board of Medicine pursuant to MCL 333.16233(5), the Department finds that the public health, safety, and welfare requires emergency action.

Therefore, IT IS ORDERED that Respondent's license to practice medicine in the state of Michigan is SUMMARILY SUSPENDED, commencing the date this *Order* is served.

Under Mich Admin Code, R 792.10702, Respondent may petition for the dissolution of this *Order* by filing a document clearly titled **Petition for Dissolution of Summary Suspension** with the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909.

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 8-17, 2017

By: Kim Gaedeke, Director
Bureau of Professional Licensing

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ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs by Kim Gaedeke, Director, Bureau of Professional Licensing, complains against Respondent Mohammad Derani, M.D. as follows:

1. The Michigan Board of Medicine is an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.* Pursuant to MCL 333.16226, the Board's Disciplinary Subcommittee (DSC) is empowered to discipline licensees for Code violations.

2. After consultation with the Board Chairperson, the Department found that the public health, safety, and welfare requires emergency action. Therefore, pursuant to MCL 333.16233(5), the Department summarily suspended Respondent's license to practice medicine in the state of Michigan, effective on the date the accompanying *Order of Summary Suspension* was served.

3. Respondent holds a Michigan license to practice medicine. Respondent also holds a controlled substance license and a drug control license.

4. At the times relevant to this Complaint, Respondent practiced from Dearborn Medical Clinic, a private medical office in Dearborn, Michigan.

5. Alprazolam is a benzodiazepine schedule 4 controlled substance. Concurrent use of opioids and benzodiazepines carries a substantial overdose risk, and many authorities, including the federal Centers for Disease Control and Prevention, discourage their co-prescription. Alprazolam is a commonly abused and diverted drug, particularly in its 1 mg and 2 mg dosages. Benzodiazepines are poorly suited for the long-term treatment of any condition.

6. Carisoprodol (Soma) is a muscle relaxant and a schedule 4 controlled substance. Carisoprodol has significant potential for abuse, dependence, overdose, and withdrawal, particularly when used in conjunction with opioids and benzodiazepines. It is indicated only for short-term use.

7. Codeine preparations (e.g., codeine/promethazine syrup) are schedule 5 controlled substances prescribed for treating acute cough and related upper respiratory symptoms. Codeine/promethazine syrup is ill suited for long-term treatment of any condition. Codeine/promethazine syrup is a highly sought-after drug of abuse and is known by the street names "lean," "purple drank," and "sizzurp."

8. Hydrocodone, and combination products including hydrocodone (e.g., Lorcet, Norco), are schedule 2 controlled substances. Hydrocodone and hydrocodone combination products are commonly abused and diverted drugs.

9. Phentermine is an anorectic schedule 4 controlled substance that produces amphetamine-like effects. Phentermine is the most widely prescribed and most frequently diverted anorectic drug.

10. Oxycodone is a commonly abused and diverted schedule 2 controlled substance.

11. When used in combination, opioids, muscle relaxants, and benzodiazepines can produce a feeling of euphoria. These combinations are highly desired for diversion and abuse and have the street name "Holy Trinity."

12. Complainant reviewed data from the Michigan Automated Prescription System (MAPS), the State of Michigan's prescription monitoring program, which gathers data regarding controlled substances dispensed in Michigan.

13. MAPS data revealed that Respondent ranked among Michigan's highest-volume prescribers of commonly abused and diverted controlled substances in 2015 and during the first three quarters of 2016:

Drug	Licensee's 2015 rank	Licensee's 2016 Q1 rank	Licensee's 2016 Q2 rank	Licensee's 2016 Q3 rank	Licensee's 2016 Q4 rank
(a) Alprazolam 1 mg	N/R	6	5	3	4
(b) Carisoprodol	6	6	3	4	2
(c) Codeine/promethazine syrup	73	51	18	20	11
(d) Hydrocodone combination products	49	25	16	17	9
(e) Hydrocodone combination products 10 mg	N/R	12	5	7	4
(f) All controlled substances	N/R	78	38	43	19

14. MAPS data for 2015 and for the first three quarters of 2016 revealed that Respondent authorized the following number of prescriptions for the following commonly abused and diverted controlled substances:

	2015		2016		2017 thru August 14	
(a) Alprazolam 1 and 2 mg	1888	22.42%	2265	18.91%	1591	19.07%
(b) Carisoprodol	802	9.52%	1200	12.02%	818	9.81%
(c) Codeine/promethazine syrup	304	3.61%	568	4.74%	212	2.54%
(d) Hydrocodone combination products	3598	42.74%	5078	42.40%	3630	43.51%
(e) Oxycodone 30 mg	59	0.7%	66	0.55%	46	0.55%
(f) Total, (a) - (e)	6651	**78.99%**	9177	**76.62%**	6297	**75.49%**
(g) Total Controlled Substances	**8418**	100%	**11976**	100%	**8342**	100%

Respondent averaged authorizing more than ***forty-three*** controlled substance

prescriptions on every workday between January 1, 2015 and August 14, 2017.

15. Nearly twenty-two percent (22%) of the controlled substance prescriptions Respondent wrote between January 1, 2015 and August 14, 2017 were filled by patients who paid cash for their medications. The state average for cash payment is less than ten percent (10%). The high proportion of patients paying cash for controlled substance medications is indicative of prescriptions filled for the purpose of drug diversion.

16. Between January 1, 2015 and August 14, 2017, nearly 10% of the controlled substance prescriptions Respondent wrote were for patients who traveled from Flint, Michigan, more than 70 miles away. Patients traveling a significant distance to obtain controlled substance prescriptions is indicative of prescriptions filled for the purpose of drug diversion.

17. As part of an investigation of Respondent's prescribing practices, the Department received and analyzed medical records of ten (10) of Respondent's patients.

18. An expert reviewed the individual medical files Respondent produced and discovered the following deficiencies consistently across files:

(a) Respondent's files systemically failed to document critical patient data, including the conditions under treatment, examinations or assessments performed, Respondent's impressions, or the basis for his treatment decisions.

(b) Patient files did not contain controlled substance agreements.

(c) In many cases, appropriate studies were not obtained despite being strongly indicated.

(d) Respondent failed to document referral to physical therapy or to specialty evaluation.

(e) In the few instances where urine drug screens (UDSs) were performed, Respondent did not follow up on unexpected results.

19. Upon review of the individual medical files, the expert found Respondent engaged in the following consistent inappropriate and dangerous practices related to the prescription of controlled substances, in addition to those noted above:

(a) Respondent did not perform adequate pain assessments.

(b) Respondent did not pursue evaluation of underlying causes of pain.

(c) Respondent failed to assess functional impacts of reported symptoms.

(d) Respondent failed to assess for addiction or risk of future addiction.

(e) Respondent failed to attempt therapies other than controlled substances.

(f) Respondent failed to tailor therapies to specific patients and did not document patient-specific judgments about appropriate drug therapy.

(g) Respondent failed to assess benefits of prescribed therapies.

(h) Respondent consistently ordered high-risk treatment with multiple controlled substances without clear, individualized justifications or recognition of risks involved.

(i) Respondent failed to take adequate safeguards to identify medication misuse, abuse, or diversion.

(j) Respondent routinely prescribed benzodiazepines without a diagnosis of anxiety or other clinical justification.

(k) Respondent routinely prescribed alprazolam to patients for long periods, despite its contraindication for long-term use and despite the availability of effective, non-addictive treatment alternatives.

(l) Respondent often prescribed codeine/promethazine syrup for long periods, despite its unsuitability as a long-term treatment for any condition and its desirability for diversion.

(m) Respondent often simultaneously prescribed benzodiazepines and phentermine, despite the opposing effects of those drugs.

(n) Respondent often prescribed long courses of carisoprodol, even though carisoprodol is only indicated for short-term use.

20. The expert discovered the following deficiencies in the individual medical files Respondent produced, in addition to those noted above:

Patient AB[1]

(a) Respondent failed to investigate the medical conditions that underlay Patient AB's reported pain and neuropathy.

(b) Respondent never considered therapies other than controlled substances for pain or anxiety.

(c) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(d) Respondent prescribed benzodiazepines along with phentermine, despite phentermine's anxiogenic effects.

(e) Respondent did not document a reaction to Patient AB's report of memory problems, which could have been caused by her multidrug therapy.

(f) Respondent prescribed Patient AB a high-risk combination of opioids and benzodiazepines without documented consideration of the particular risks of that therapeutic approach.

(g) Respondent did not document ordering a UDS for Patient AB.

(h) Respondent did not document checking MAPS reports for Patient AB.

(i) Respondent did not comment or further assess Patient AB for potential substance abuse given Patient AB's report of marijuana use.

Patient CB

(j) Respondent failed to investigate the medical conditions that underlay Patient CB's reported pain and cough.

(k) Respondent never considered therapies other than controlled substances.

(l) Respondent prescribed Patient CB a high-risk combination of opioids, benzodiazepines, and carisoprodol without documented consideration of the particular risks of that therapeutic approach.

(m) Respondent did not document ordering a UDS for Patient CB.

(n) Respondent did not document checking MAPS reports for Patient CB. A MAPS report would have revealed that Patient CB received controlled substance prescriptions from multiple prescribers while under Respondent's care.

[1]Patients are identified by their initials.

Patient YB

(o) Respondent failed to investigate the medical conditions that underlay Patient YB's reported pain.

(p) Respondent never considered therapies other than controlled substances for pain, anxiety, or chronic obstructive pulmonary disease.

(q) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(r) Respondent prescribed Patient YB a high-risk combination of opioids, benzodiazepines, and carisoprodol without documented consideration of the particular risks of that therapeutic approach.

(s) Respondent did not document ordering a UDS for Patient YB.

(t) Respondent did not document checking MAPS reports for Patient YB. A MAPS report would have revealed that Patient YB received controlled substance prescriptions from multiple prescribers while under Respondent's care.

Patient KD

(u) Respondent failed to investigate the medical conditions that underlay Patient KD's reported pain, or an MRI showing probable goiter.

(v) Respondent never considered therapies other than controlled substances for pain.

(w) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(x) Respondent prescribed Patient KD a high-risk combination of opioids, benzodiazepines, and phentermine without documented consideration of the particular risks of that therapeutic approach.

(y) Respondent did not document ordering a UDS for Patient KD.

(z) Respondent did not document checking MAPS reports for Patient KD.

Patient BJ

(aa) Respondent failed to investigate the medical conditions that underlay Patient BJ's reported pain.

(bb) Respondent documented no clinical justification for Respondent's prescription of benzodiazepines and phentermine.

(cc) Respondent never considered therapies other than controlled substances for pain.

(dd) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(ee) Respondent prescribed Patient BJ a high-risk combination of opioids, benzodiazepines, and phentermine without documented consideration of the particular risks of that therapeutic approach.

(ff) Respondent failed to document follow up on a blood test with substantially abnormal results.

(gg) Respondent did not document a response to a UDS that returned a negative result for all tested controlled substances.

(hh) Respondent did not document checking MAPS reports for Patient BJ. A MAPS report would have revealed that Patient BJ received controlled substance prescriptions from multiple prescribers while under Respondent's care.

Patient JJ

(ii) Respondent did not adequately document a workup of Patient JJ, including prior treatments, pain severity, and functional impact of pain.

(jj) Respondent never considered therapies other than controlled substances for pain.

(kk) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(ll) Respondent prescribed Patient JJ a high-risk combination of opioids, benzodiazepines, and carisoprodol without documented consideration of the particular risks of that therapeutic approach.

(mm) Respondent did not document ordering a UDS for Patient JJ.

(nn) Respondent did not document checking MAPS reports for Patient JJ.

Patient AL

(oo) Respondent did not investigate the medical conditions that underlay Patient AL's reported pain, and did not obtain an adequate medical history.

(pp) Respondent never considered therapies other than controlled substances for pain.

(qq) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(rr) Respondent prescribed Patient AL a high-risk combination of opioids and carisoprodol without documented consideration of the particular risks of that therapeutic approach.

(ss) Respondent did not document ordering a UDS for Patient AL.

(tt) Respondent did not document checking MAPS reports for Patient AL.

Patient TM

(uu) Respondent failed to investigate the medical conditions that underlay Patient TM's reported pain and failed to obtain an adequate medical history.

(vv) Respondent documented no clinical justification for Respondent's prescription of benzodiazepines and phentermine.

(ww) Respondent prescribed benzodiazepines along with phentermine, despite phentermine's anxiogenic effects.

(xx) Respondent never considered therapies other than controlled substances for pain.

(yy) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(zz) Respondent prescribed Patient TM a high-risk combination of opioids and benzodiazepines without documented consideration of the particular risks of that therapeutic approach.

(aaa) Respondent did not document a response to a UDS that returned a negative result for all tested controlled substances.

(bbb) Respondent did not document checking MAPS reports for Patient TM. A MAPS report would have revealed that Patient TM received buprenorphine from an addiction specialist at the same time that Respondent was prescribing controlled substances to Patient TM.

Patient DP

(ccc) Respondent failed to investigate the medical conditions that underlay Patient DP's reported pain, and failed to obtain an adequate medical history.

(ddd) Respondent documented no clinical justification for Respondent's prescription of codeine/promethazine syrup.

(eee) Respondent never considered therapies other than controlled substances for pain.

(fff) Respondent did not document any evaluation of the effectiveness or side effects of the prescribed controlled substance therapy.

(ggg) Respondent prescribed Patient DP a high-risk combination of opioids and benzodiazepines without documented consideration of the particular risks of that therapeutic approach.

(hhh) Respondent did not document ordering a UDS for Patient DP.

(iii) Respondent did not document checking MAPS reports for Patient DP.

Patient CS

(jjj) Respondent failed to document the functional impact of Patient CS's reported pain, previous non-opioid therapies attempted, or an assessment for substance abuse. There is no documented clinical justification for Respondent's prescription of benzodiazepines.

(kkk) Respondent does not document a response to Patient CS's report of "serious" disability, which suggests the prescribed therapy was ineffective.

(lll) Respondent never considered therapies other than controlled substances for pain.

(mmm) Respondent prescribed Patient CS a high-risk combination of opioids and benzodiazepines without documented consideration of the particular risks of that therapeutic approach.

(nnn) Respondent did not document ordering a UDS for Patient CS.

(ooo) Respondent did not document checking MAPS reports for Patient CS.

COUNT I

Respondent's conduct constitutes a violation of a general duty, consisting of negligence or failure to exercise due care, or a condition, conduct, or practice that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession in violation of MCL 333.16221(a).

COUNT II

Respondent's conduct fails to conform to minimal standards of acceptable, prevailing practice for the health profession in violation of MCL 333.16221(b)(i).

COUNT III

Respondent's conduct, as set forth above, constitutes selling, prescribing, giving away, or administering drugs for other than lawful diagnostic or therapeutic purposes, in violation of MCL 333.16221(c)(iv).

RESPONDENT IS NOTIFIED that, pursuant to MCL 333.16231(8), Respondent has 30 days from the date of receipt of this Complaint to answer it in writing and to show compliance with all lawful requirements for retention of the license. Respondent shall submit the written answer to the Bureau of Professional Licensing, Department of Licensing and Regulatory Affairs, P.O. Box 30670, Lansing, MI 48909.

Respondent's failure to submit an answer within 30 days is an admission of the allegations in this complaint. If Respondent fails to answer, the Department shall transmit this complaint directly to the Board's Disciplinary Subcommittee to impose a sanction pursuant to MCL 333.16231(9).

MICHIGAN DEPARTMENT OF
LICENSING AND REGULATORY AFFAIRS

Dated: 8-17, 2017

By: Kim Gaedeke, Director
Bureau of Professional Licensing

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