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

In the Matter of

CHARISE LANETTE VALENTINE, M.D.
License No. 43-01-053752,

File No. 43-17-148752

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.

MCL 333.7311(6) provides that a controlled substance license is automatically void if a licensee's license to practice is suspended or revoked under Article 15.

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: 7/16/18, 2018

By: Cheryl Wykoff Pezon, Director
Bureau of Professional Licensing

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ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs, by Cheryl Wykoff Pezon, Director, Bureau of Professional Licensing, complains against Respondent Charise Lanette Valentine, 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 violations of the Public Health Code.

2. Respondent holds a Michigan license to practice medicine and holds a current controlled substance license.

3. 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 upon service of the accompanying *Order of Summary Suspension*.

4. MCL 333.7311(6) provides that a controlled substance license is automatically void if a licensee's license to practice is suspended or revoked under Article 15.

5. Hydrocodone is an opioid. Hydrocodone combination products (e.g., Norco), are Schedule 2 controlled substances due to their high potential for abuse.

6. Oxycodone and oxycodone combination products are opioid schedule 2 controlled substances. These medications are used to treat pain and are commonly abused and diverted.

7. Oxymorphone, a schedule 2 controlled substance, is an opioid used to treat pain, and is a commonly abused and diverted drug. Oxymorphone 40 mg is the most commonly abused and diverted strength of oxymorphone.

8. Promethazine with codeine syrup is a schedule 5 controlled substance prescribed for treating cough and related upper respiratory symptoms. Codeine/promethazine syrup is rarely indicated for any other health condition, and is particularly ill-suited for long-term treatment of chronic pain. Codeine/promethazine syrup is a highly sought-after drug of abuse, and is known by the street names "lean," "purple drank," and "sizzurp."

9. The Centers for Disease Control and Prevention (CDC) guidelines for opioid prescribing direct providers to avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

10. The CDC's guidelines for opioid prescribing direct providers to use "extra precautions" when prescribing opioids with a daily morphine milligram equivalent (MME) of 50 or more. Those guidelines also direct providers to "avoid or carefully justify" increasing dosage to a daily MME of 90 or more.

11. At all relevant times, Respondent practiced medicine in southeast Michigan.

12. The Department reviewed data from the Michigan Automated Prescription System (MAPS), the State of Michigan's prescription monitoring program, which gathers data regarding controlled substances prescribed dispensed in Michigan. MAPS data revealed that Respondent authorized the following numbers of prescriptions for the following commonly abused and diverted controlled substances:

Drug	*# Prescriptions (% of Total CS Prescriptions)*		
	2016	2017	1/1/2018 through 2/25/2018
(a) Hydrocodone-acetaminophen 7.5-325	281 *(28.44%)*	243 *(6.94%)*	24 *(6.12%)*
(b) Hydrocodone-acetaminophen 10-325	174 *(17.61%)*	161 *(4.60%)*	28 *(7.14%)*
(c) Oxycodone 30 mg	36 *(3.64%)*	1,911 *(54.60%)*	234 *(59.69%)*
(d) Oxymorphone 40 mg	5 *(0.51%)*	563 *(16.09%)*	67 *(17.09%)*
(e) Total, (a) - (d)	496 ***(50.20%)***	2,878 ***(82.22%)***	353 ***(90.05%)***
(f) Total Controlled Substances	988	3,500	392

13. The Department found that Respondent was the among the highest-ranked prescribers of the following commonly abused and diverted controlled substances among all Michigan prescribers in the following quarters of 2017 and 2018:

Drug	2017 Rank Q1	2017 Rank Q2	2017 Rank Q3	2017 Rank Q4	2018 Rank Q1
Oxycodone 30 mg	10	6	5	6	9
Oxycodone (all strengths)	44	34	34	39	44
Oxymorphone 40 mg	10	9	5	5	9
Oxymorphone (all strengths)	17	12	6	8	12

14. On March 16 and March 23, 2018, in interviews with a Department investigator, Respondent provided the following information:

a. Respondent practices medicine for about four hours a day, two or three days a week at Orthopedic Medical Building, Inc., a pain management clinic in Oak Park, Michigan. Respondent treats ten to twelve patients a day. Respondent began practicing at this clinic around March 2017.

b. Respondent practices one day a week at Advanced Medical Practice in Southfield, Michigan treating adult neurologic patients.

c. Respondent owns Glory Visiting Physicians, treating around 20 patients a week. Respondent indicated these patients are homebound neurologic patients.

d. Respondent stated she almost exclusively prescribes oxycodone and oxymorphone during her part-time practice at Orthopedic Medical Building, Inc. and does not prescribe these two drugs at her other practice locations.

e. Respondent stated that for the patients she prescribed oxymorphone 40 mg tablets, carrying an MME daily dose equivalent of 240.00, the exam would indicate a necessity for that dose and there would be a secondary opinion in the medical records from an orthopedic provider.

f. Respondent indicated she almost exclusively prescribes oxycodone and oxymorphone because patients come to her on these medications.

g. Respondent indicated she was familiar with the State of Michigan's guidelines on prescribing controlled substances, CDC recommendations for opioid prescribing for pain, CDC recommendations on concurrent prescribing of opioids and benzodiazepines, CDC recommendations on morphine milligram equivalent (MME) dosing, and the drug combination known as the Holy Trinity.

h. Respondent indicated she tells patients the goal is to lower the amount of prescribed opioids and get patients off opioids. Respondent stated she recommends non-opioid treatments to patients.

i. Respondent stated she believed oxymorphone and oxycodone were highly abused and diverted controlled substances. Respondent further indicated that if a patient is receiving promethazine with codeine, she will not treat the patient because they are likely drug addicts. Contrary to Respondent's statement, MAPS data indicated Respondent authorized multiple prescriptions for promethazine with codeine in 2017 and 2018.

j. Respondent indicated that she refers pain patients at Orthopedic Medical Building, Inc. to orthopedic doctors and physical therapy. If patients do not follow up, Respondent will discharge them from the practice.

k. Respondent stated that MAPS reports are run every time a patient is treated. Respondent also stated that some of the MAPS reports are run under another provider's name at Orthopedic Medical Building, Inc.

l. Respondent indicated urine drug screens are done every time a patient is treated. Respondent stated will she will not prescribe to patients who have illicit drugs on urine drug screen results.

m. Respondent stated x-rays and/or MRI imaging must be done, or else she will not treat the patient. Respondent will give patients a few visits to complete these tests before discharging them.

n. Respondent indicated she attempts to get patients' previous medical records and, if she does, she reviews them prior to treating patients.

o. Respondent indicated she documents plans and goals in patient charts and documents controlled substances prescribed by other providers.

15. As part of an investigation of Respondent's prescribing practices, the Department received and analyzed medical records for eight of Respondent's patients.

16. An expert reviewed the Department's investigative materials, including the applicable MAPS data and the individual medical files Respondent produced and discovered the following concerns regarding Respondent's practice of medicine:

a. Regarding the Department's data showing Respondent's high percentage of oxycodone 30 mg and oxymorphone 40 mg prescribing, the expert noted that while there are individual patient scenarios in which Respondent's prescribing of these medications may be appropriate, it strained credulity to suggest it was occurring with this frequency in Respondent's practice. The expert went on further to note that the absolute number of oxycodone 30 mg prescriptions is difficult to explain in the context of legitimate medical practices.

b. The expert noted that Respondent appears to prescribe oxycodone 30 mg by default, prescribing this medication initially to seven of the eight patients reviewed. The expert found this was concerning for the following reasons:

i. Several of the patients reviewed were opioid-naïve, and oxycodone 30 mg is an overly high dose for these patients.

ii. Oxycodone 30 mg has a short duration of action, around 4-6 hours. All of Respondent's patients were being treated for chronic pain, where a longer acting form would likely be more appropriate. The expert did not see evidence of Respondent titrating the dose to a longer-acting medication.

iii. Oxycodone has a high potential for abuse and diversion.

c. The expert noted when Respondent prescribed oxymorphone, another drug with high abuse potential, she generally chose the highest available dose and prescribed 30-day supplies after the initial patient visit, when supporting documentation was not available.

d. Respondent's medical records lack key historical information, rarely contain outside records of prior treatment, contain largely inadequate physical exams, and generally do not comment on specific causes of pain.

e. Respondent failed to adequately explain medication choices, even when dramatic changes were made.

f. Outside of in-office urine drug screens, it generally did not appear that Respondent performed or documented necessary exams, tests, labs, or x-rays. Most test reports in patient records were ordered by other physicians.

g. Respondent's medical records do not meet acceptable standards for the treatment of chronic pain. Deficiencies include:

i. Respondent's evaluations of patients are inadequate.

ii. Respondent does not exhaust non-opioid treatments before prescribing opioids.

iii. Respondent's medical records do not contain risk-benefit evaluations and Respondent does not meaningfully document patient responses to medications or the presence or absence of side effects.

iv. Respondent prescribes 30-day supplies of medications at initial visits and with starting new medications.

v. Respondent frequently prescribes medications carrying MMEs exceeding 90.00 without a stated rationale and increases or decreases doses in an overly rapid fashion.

vi. In multiple instances, Respondent prescribed opioids to patients concurrently receiving benzodiazepines or their equivalent without justifying the excess risk this combination carries.

vii. While medical records contained MAPS reports and urine drug toxicology for most patients, Respondent generally did not comment on or address irregularities when they occurred.

17. The expert discovered deficiencies in the individual medical files Respondent produced, in addition to those noted above. Deficiencies include, but are not limited to:

Patient BB

(a) Patient BB's medical record contains inadequate history for a patient being managed for chronic pain.

(b) Respondent failed to adequately pursue or document non-opioid treatments.

(c) Respondent inappropriately prescribed opioids to patient BB. Patient BB had not been prescribed opioids in approximately six months, and Respondent started patient BB on oxycodone 30 mg, which carries a MME of 90.00. Respondent failed to document a rationale for the strength or type of medication. The expert indicated this prescribing pattern had a high likelihood of serious side effects.

(d) Respondent failed to document any assessment of the impact oxycodone had on patient BB's functionality or pain, or whether there were any side effects.

(e) Respondent discharged patient BB after two visits without documenting the reason in the medical record. The record does not provide for any urgently needed care during the transition period or include any information Respondent provided patient BB guidance to seek treatment elsewhere. The expert noted patient BB's dismissal may constitute patient abandonment.

Patient CN

(f) Patient CN's medical record lacks outside records, contains an insufficient initial history, and the only study in the record has nonspecific findings that may be seen in pain-free individuals.

(g) Respondent failed to adequately pursue non-opioid therapies before prescribing opioids, inappropriately selected the opioid form and dose

for a presumably opioid-naïve patient and failed to assess the impacts or side effects of the medication.

(h) Respondent did not explain patient CN's termination from the practice and inappropriately handled the discharge.

Patient LR

(i) Patient LR's medical records lacked outside records, and the MRI included had findings that overlapped with individuals without pain. Histories and exams were insufficient in the context of patient LR's care.

(j) Non-opioid treatments were not tried before prescribing opioids.

Patient SC

(k) Respondent did not appear to maintain a medical record for patient SC. Respondent stated in her interview that patient SC is a patient seen by Glory Visiting Physicians. Respondent reviewed prescriptions for patient SC and verified that the prescriptions were written by her.

(l) The expert noted patient SC's MAPS report showed Respondent prescribed combinations of medications that carry a substantial risk of patient injury or overdose. The expert also noted patient SC's MAPS report showed a long-standing pattern of doctor shopping.

Patient WA

(m) Patient WA's medical record contained an inadequate history and exam and an absence of outside records.

(n) Respondent did not adequately attempt non-opioid therapy before prescribing patient WA opioids. While Respondent did eventually refer patient WA to physical therapy, this did not occur until approximately two months after Respondent had been prescribing patient WA opioids, and it is not clear whether patient WA attended.

(o) Patient WA's MRI study had findings that overlap with healthy individuals and did not identify a discrete pain generator.

(p) The form and dose of opioids Respondent prescribed to patient WA were questionable based on patient WA not filling a prescription for opioids approximately three months prior to Respondent prescribing and the high dose Respondent prescribed. The expert also found the fact that patient WA had seven different prescribers in the year prior to treating with Respondent to be a red flag.

(q) Patient WA's urine drug screen on or around July 25, 2017 showed an absence of prescribed medication. Respondent failed to address this

inconsistency, and Respondent continued to prescribe patient WA oxycodone.

(r) MAPS reports ran on September 22, 2017 and November 21, 2017 showed that patient WA was receiving opioid prescriptions from other providers. Respondent failed to address this in her notes, even though it is a violation of Respondent's controlled substance agreement. Respondent continued to prescribe patient WA oxycodone.

(s) Respondent later reduced patient WA's oxycodone dose but failed to address why she reduced the medication as there was no apparent improvement from prior visits.

Patient EB

(t) Respondent's history and exam did not contain sufficient information for the expert to determine whether opioid treatment was indicated. Basic information about patient EB's pain history and prior treatments are absent and the record contained no outside records. The MRI findings in the record are of uncertain significance, as similar findings may be seen in patients without pain.

(u) Respondent prescribed patient EB high-dose opioids at the first visit.

(v) Respondent inappropriately escalated patient EB's opioid dose, nearly tripling the daily MME without documenting the reasoning in the record. The expert noted that this increase was especially risky due to concurrent zolpidem use. It does not appear that Respondent considered risks from this interaction.

(w) At a June 2017 visit, patient EB complained of worsening lower back pain. Patient EB was known to have an active cancer diagnosis, and in this context, the expert noted that new or increased skeletal pain warranted an evaluation for bone metastases. Respondent failed to order studies or defer to patient EB's oncologist.

(x) In July 2017, patient EB's urine toxicology was inappropriately positive for oxycodone. Respondent failed to order confirmatory testing to rule out a false positive possibly caused by patient EB's oxymorphone treatment. Respondent did not document why she did not do this.

(y) Patient EB received controlled substances from other providers throughout the time Respondent treated her, despite having a controlled substance agreement with Respondent. Respondent failed to comment on this until approximately nine months into patient EB's treatment and continued prescribing patient EB opioids. Respondent did not document a discussion with patient EB about this.

(z) Respondent discharged patient EB without stating a reason in the record.

Patient TC

(aa) Respondent's initial note is deficient in key information needed to appropriately evaluate patient TC for controlled substance treatment. At patient TC's first visit, Respondent prescribed her oxycodone 30 mg. Respondent did not document the rationale for prescribing this medication.

(bb) Follow-up visit notes do not document benefits from the opioid treatment or the presence or absence of side effects.

(cc) Despite recommendations from patient TC's surgeon to wean patient TC off opioids post-operation, Respondent increased patient TC's opioid dose, without an explanation in the record, six weeks post-operation, and after patient TC's surgeon stated he felt patient TC was doing well enough to return to work.

Patient SE

(dd) Patient SE's medical record does not include adequate histories and Respondent did not obtain outside records beyond an emergency department visit. Patient SE's MRI studies show abnormalities which overlap with what is seen in healthy individuals without pain, and Respondent's exam documentation is insufficient to determine whether patient SE's pain complaints correlate with the MRI findings.

(ee) Respondent prescribed patient SE sixty oxycodone 30 mg tablets at the first visit, without any rationale for this specific choice, despite patient SE being opioid naïve.

(ff) At the following visit, Respondent changed patient SE's treatment from oxycodone 30 mg, carrying a daily MME of 90.00, to oxymorphone 40 mg, carrying a daily MME of 240.00 without documenting a rationale or the effectiveness or side effects of the medication changes.

(gg) In September 2017, Respondent indicated she was reducing patient SE's oxymorphone dose without providing a reason. MAPS data shows Respondent did not reduce the dose and did not address this in the medical record for subsequent visits.

(hh) Patient SE's August 2017 urine drug screen was inconsistent with her prescribed medications. Respondent failed to order confirmatory testing or comment on the result. The next month, patient SE's urine drug screen was entirely negative for opioids, and similarly Respondent failed to order confirmatory testing or comment on the discrepancy.

COUNT I

Respondent's conduct constitutes a violation of a general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, or a condition, conduct, or practice that impairs, or may impair, the ability safely and skillfully to 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 constitutes obtaining, possessing, or attempting to obtain or possess a controlled substance or drug without lawful authority, and/or 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 all Complaint allegations. 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: 7/16/18, 2018

By: Cheryl Wykoff Pezon, Director
Bureau of Professional Licensing

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