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

In the Matter of

SOLOMON ADU-BENIAKO, M.D.
License Nos. 53-15-023991
53-15-074308
53-15-074578,

File No. 53-18-149382

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 Pharmacy pursuant to MCL 333.7314(2), the Department finds that the public health, safety, and welfare requires emergency action.

Therefore, IT IS ORDERED that Respondent's controlled substance license and drug control-location licenses are 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: 1/19, 2018

By: Cheryl Wykoff Rezon, Acting Director
Bureau of Professional Licensing

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ADMINISTRATIVE COMPLAINT

The Michigan Department of Licensing and Regulatory Affairs by Cheryl Wykoff Pezon, Acting Director, Bureau of Professional Licensing, complains against Respondent Solomon Adu-Beniako, M.D. as follows:

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

2. The Board administers the controlled substance provisions in Article 7 of the Code, MCL 333.7101 - .7545, and is empowered to discipline licensees for Article 7 violations under MCL 333.7311.

3. After consultation with the Board Chairperson, the Department found that the public health, safety, and welfare requires emergency action. Therefore, pursuant to MCL 333.7314(2), the Department summarily suspended Respondent's controlled substance license and drug control-location licenses, effective on the date the accompanying Order of Summary Suspension was served.

4. MCL 333.7333(1) provides that good faith prescribing occurs in the regular course of professional treatment to or for an individual who is under the treatment by the practitioner for a pathology or condition other than that individual's physical or psychological dependence upon or addiction to a controlled substance, except as provided in Article 7.

5. Respondent holds an active controlled substance license and active drug control-location licenses. Respondent also has an active Michigan medicine license[1] and an active drug treatment program prescriber license.

6. Alprazolam (e.g. Xanax), a schedule 4 controlled substance, is a benzodiazepine used to treat anxiety disorders and panic disorder. Alprazolam is a commonly abused and diverted drug, particularly in its 1 mg and 2 mg dosages.

7. Buprenorphine/naloxone (Suboxone) is an opioid schedule 3 controlled substance commonly used in opioid dependence treatment. Suboxone is known as "prison heroin," and is commonly abused and diverted.

8. 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.

9. Codeine preparations (e.g., codeine/promethazine syrup) are schedule 5 controlled substances 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

[1] The Department has also filed an Administrative Complaint against Respondent before the Board of Medicine Disciplinary Subcommittee for the conduct alleged here. *Solomon Adu-Beniako, M.D.*, No. 43-17-145786.

street names "lean," "purple drank," and "sizzurp."

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

11. Oxycodone (e.g., Percocet), a schedule 2 controlled substance, is an opioid used to treat pain, and is commonly abused and diverted.

12. At all relevant times, Respondent was engaged in private practice in southeast Michigan.

13. 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. MAPS data for the period between January 1, 2016 and October 31, 2016, revealed that Respondent authorized the following number of prescriptions for the following commonly abused and diverted controlled substances:

		# Prescriptions	*% of Total CS Prescriptions*
(a)	Hydrocodone/Acetaminophen combination products	819	45.17%
(b)	Promethazine-Codeine Syrup	684	37.73%
(c)	Alprazolam 1 mg	107	5.90%
(d)	Oxycodone 30 mg	95	5.24%
(e)	Total, (a) - (d)	1,705	**94.04%**
(f)	Total Controlled Substances	1,813	

14. MAPS data for the period between January 1, 2017 and December 31, 2017 revealed that Respondent authorized the following number of prescriptions for the following commonly abused and diverted controlled substances:

	# Prescriptions	% of Total CS Prescriptions
(a) Hydrocodone/Acetaminophen combination products	3,934	44.18%
(b) Promethazine-Codeine Syrup	3,355	37.68%
(c) Alprazolam 1 mg	319	3.58%
(d) Oxycodone 30 mg	470	5.27%
(e) Total, (a) - (d)	8078	**90.73%**
(f) Total Controlled Substances	8,903	

15. MAPS data for the period between quarter four of 2016 to quarter 3 of 2017 revealed that Respondent was a top prescriber[2] for the following commonly diverted and abused controlled substances:

Drug	Licensee's 2016 Q4 Rank	Licensee's 2017 Q1 Rank	Licensee's 2017 Q2 Rank	Licensee's 2017 Q3 Rank
(a) Promethazine-Codeine Syrup	1	1	1	1
(b) Hydrocodone 10 mg	49	11	28	24
(c) Oxycodone 30 mg	71	28	26	93
(d) Oxymorphone 40 mg	-	-	37	21
(e) Carisoprodol	-	-	-	33

16. Approximately 30.83% of controlled substance prescriptions issued by Respondent between January 1, 2016 and December 31, 2016 were paid for by patients with cash. Approximately 23.64% of controlled substance prescriptions issued by Respondent between January 1, 2017 and December 31, 2017 were paid for by patients with cash. The state average of patients paying cash for controlled substance medications is less than 10%. The high proportion of patients paying cash for controlled substance medications is indicative of prescriptions filled for the purpose of drug

[2] Rankings (from highest prescriber) are for Respondent's primary Drug Enforcement Administration (DEA) registration. In addition to these numbers, Respondent ranked 18th in Quarter 2 of 2017 and 26th in Quarter 3 of 2017 for promethazine-codeine syrup prescriptions prescribed on a second DEA registration.

diversion.

17. In November 2014 and October 2016, the Department sent correspondence to Respondent notifying him that his patient was displaying "doctor shopping" behaviors, meaning the patient was obtaining controlled substance prescriptions from multiple providers.

18. In answering the October 2016 doctor-shopping letter and in a May 2017 interview with a Department investigator, Respondent affirmed that he obtains MAPS reports on his patients.

19. MAPS data indicated that several of Respondent's patients travelled long distances to Respondent's facilities to obtain prescriptions, including:

a) Three patients from the Escanaba/Gladstone, Michigan area, all receiving prescriptions for buprenorphine/ naloxone (approximately 420 miles);

b) One patient from Cincinnati, Ohio receiving prescriptions for oxymorphone 40 mg and hydrocodone-acetaminophen 10-325 mg (approximately 270 miles);

c) One patient from Ludington, Michigan receiving prescriptions for promethazine with codeine and hydrocodone-acetaminophen 10-325 mg (approximately 240 miles); and

d) One patient from Middletown, Ohio receiving prescriptions for oxymorphone 40 mg and hydrocodone-acetaminophen 10-325 mg (approximately 240 miles).

20. In the May 2017 interview with a Department investigator, Respondent indicated he was familiar with the CDC guidelines discouraging the co-prescribing of opioids and benzodiazepines.

21. MAPS data revealed that Respondent prescribed combinations of

opioids and benzodiazepines to 25 patients in December 2017 and to 8 patients thus far in January 2018.

22. MAPS data revealed that between January 1, 2017 and December 31, 2017, Respondent prescribed controlled substances to 938 unique patients. Respondent prescribed a combination of promethazine with codeine and hydrocodone-acetaminophen 10-325 mg to 420, or 44.78%, of those patients. Pattern prescribing is indicative of prescriptions issued for the purpose of drug diversion.

23. In the May 2017 interview with a Department investigator, Respondent claimed that most of his patients have coughs and thus he prescribes them promethazine with codeine. He indicated that he initially authorizes an 8-ounce bottle and reduces the volume to 4 ounces for subsequent prescriptions.

24. In contrast, MAPS data revealed that Respondent continuously issues prescriptions for 8-ounce bottles of promethazine with codeine to several patients.

25. As part of an investigation into Respondent's prescribing practices, the Department received and analyzed medical records of six of Respondent's patients: BS[3], JJ, LL, MO, MB, and SK.

26. An expert reviewed the individuals' medical records and discovered the following deficiencies in Respondent's management of patient care:

(a) Respondent's medical records fail to provide sufficient clinical detail. Respondent's medical decision-making is not documented, and there is no sense of longitudinal process or progress.

(b) Respondent does not consistently perform or document appropriate exams, tests, labs, x-rays, or referrals. Exams often do not reflect detail appropriate to the clinical problem. Imaging history and use of advanced imaging is

[3] Patients are identified by their initials.

limited or absent.

(c) Neurological and musculoskeletal examinations of patients with back pain are often the same from patient to patient; or, for a patient, from encounter to encounter.

(d) Plain radiographs are sometimes performed without a clear indication, and their impact on the patient's care is not described in reports.

(e) The rationale and need for laboratory tests is often unclear, results are not discussed in the medical record, and their impact on patient care is not clear.

(f) Respondent did not properly monitor patients being treated with opioids. To illustrate, patients received controlled substance prescriptions from multiple providers during their treatment with Respondent.

(g) Respondent did not appropriately and recurrently evaluate and document the efficacy, risks, benefits, and need for long-tern treatment with opioids.

(h) The frequency, strength, and medications chosen by Respondent suggest no individualized treatment plan. Patients were generally treated with the same opioid preparation at the same frequency without a rationale provided in the medical record.

(i) Patient medical records contain little information regarding clinical efficacy, suggesting that treatment choices were arbitrary and not individualized.

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

Patient BS

(a) Patient BS was involved in a motor vehicle crash; however, Respondent's medical record does not contain details on that incident, such as details of prior treatment or clear documentation of the nature of patient BS's injuries to his back, hand, and knee.

(b) Diagnoses such as anxiety and erectile dysfunction were noted in patient BS's medical record without an appropriate history or examination documented by Respondent.

(c) Respondent prescribed medication to patient BS without appropriate history, examination, and relevant decision making.

(d) Respondent failed to properly monitor Respondent's controlled substance pharmacological treatment.

(e) Respondent refers to patient BS's drug screens in the medical record; however, no results are noted in the medical record.

Patient JJ

(f) The care provided to patient JJ and Respondent's documentation did not reflect the exercise of due care in the practice of medicine.

(g) Respondent failed to obtain appropriate history for patient JJ's initial complaints of cough and low back pain, and initiated tests and therapies without appropriate clinical justification.

(h) Respondent did not obtain a MAPS report for patient JJ until approximately five months after Respondent began treating patient JJ. Had Respondent obtained a MAPS report for JJ, he would have observed a concerning pattern of JJ obtaining controlled substances from multiple providers.

Patient LL

(i) Respondent did not obtain an adequate history regarding patient LL's complaints of back pain and sore throat with difficulty swallowing. For the latter complaint, Respondent inappropriately initiated antibiotic therapy and a codeine-containing cough syrup.

(j) Respondent did not appropriately document the rationale for or appropriately monitor patient LL's controlled substance pharmacological treatment.

(k) Respondent did not obtain a MAPS report for patient LL, which would have shown a pattern of extensive controlled substance treatment by multiple providers.

(l) Respondent documented the performance of multiple drug screens, but the results and their interpretations do not appear in patient LL's medical record.

(m) Patient LL's response to treatment and further medical decision making by Respondent were not adequately addressed in the medical record.

Patient MO

(n) Patient MO's initial presentation to Respondent was strikingly similar to that of patient LL, with a sore throat, difficulty swallowing, productive cough, and low back pain. Respondent did not obtain an appropriate history for either set of complaints.

(o) Respondent prescribed codeine-containing cough syrup for patient MO's throat and cough complaint and controlled substance pharmacological treatment for patient MO's low back pain, with documentation of intent to provide long-term controlled substance treatment.

(p) Respondent delayed obtaining a MAPS report for patient MO. The MAPS report would have shown Respondent that MO received controlled substance treatment from multiple providers, as well as undisclosed treatment with a stimulant.

(q) Drug screens were documented as ordered, but the results do not appear in patient MO's medical record.

Patient MB

(r) Respondent's treatment of patient MB exhibited several deficiencies, including inadequate history, long-term controlled substance pharmacological treatment initiated at the first visit, use of codeine-containing syrups without appropriate clinical indication, and inadequate evaluation for and monitoring of controlled substance pharmacological treatment.

(s) Patient MB's medical record regarding her urine drug screens was inadequate.

(t) Respondent did not obtain a MAPS report for patient MB until later in patient MB's treatment, when Respondent had concerns about prescription pad theft and prescription forgery at the practice. Patient MB's MAPS report would have shown a history of buprenorphine use by patient MB and receipt of controlled substance prescriptions by multiple providers.

(u) Patient MB's previous prescription for buprenorphine required specific investigation and evaluation, and Respondent failed to appropriately address this.

Patient SK

(v) Respondent provided care to patient SK over two visits, one of which was for an acute injury. Patient SK's histories were incomplete, and patient SK's controlled substance pharmacological treatment related care and documentation was deficient.

(w) Respondent did not obtain a MAPS report at patient SK's first visit, which would have shown a pattern of patient SK receiving controlled substances from multiple providers for treatment of undisclosed conditions.

28. The expert also analyzed MAPS data for three other patients: PL, LS, and JP. The expert found that Respondent prescribed each patient controlled substances over several years, with each patient receiving prescriptions for multiple controlled substances simultaneously. Additionally, the patients were obtaining controlled substance prescriptions from multiple other providers concurrently with Respondent's prescribing. The expert opined that the MAPS reports for these patients strongly suggest that controlled substances were being obtained for other than legitimate medical use.

29. In the aforementioned May 2017 interview with a Department investigator, Respondent claimed his DEA registration number had been compromised, and fraudulent prescriptions were being issued in his name. He indicated that he would be contacting the DEA immediately about the fraudulent prescriptions and to obtain a new DEA registration number.

30. As of January 18, 2018, Respondent has yet to request a new DEA registration number.

COUNT I

Respondent failed to maintain effective controls against diversion of controlled substances to other than legitimate and professionally recognized therapeutic, scientific, or industrial uses, in violation of MCL 333.7311(1)(e).

COUNT II

Respondent's conduct constitutes a failure to prescribe in good faith, contrary to MCL 333.7405(1)(a), in violation of MCL 333.7311(1)(f).

RESPONDENT IS NOTIFIED that, pursuant to MCL 333.16231(8), Respondent has 30 days from the date of receipt of this complaint to answer this complaint in writing and to show compliance with all lawful requirements for retention of the license. Respondent shall submit the response 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: 1/19, 2018

By: Cheryl Wykoff Pezon, Acting Director
Bureau of Professional Licensing

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