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

In the Matter of
MOHAN VISWA KAZA, M.D.
License No. 43-01-075190
/

Complaint No. 43-21-003127

CONSENT ORDER AND STIPULATION

CONSENT ORDER

A superseding administrative complaint was filed with the Disciplinary Subcommittee of the Board of Medicine on June 12, 2024, charging Mohan Viswa Kaza (Respondent) with having violated sections 16221(a), 16221(b)(i), 16221(b)(vi), and 16221(v) of the Public Health Code, MCL 333.1101 *et seq.*

The parties have stipulated that the Disciplinary Subcommittee may enter this consent order. The Disciplinary Subcommittee has reviewed the stipulation contained in this document and agrees that the public interest is best served by resolution of the outstanding complaint. Therefore, the Disciplinary Subcommittee finds that the allegations of fact contained in the complaint are true and that Respondent has violated sections 16221(a), 16221(b)(i), 16221(b)(vi), and 16221(v) of the Public Health Code.

Accordingly, for these violations, IT IS ORDERED:

Respondent's license is LIMITED for a minimum period of one year commencing on the effective date of this order. Reduction of the limitation period

shall occur only while Respondent is employed as a physician. The details of the limitation are as follows:

A. SUPERVISION. Respondent's practice shall be only under the general supervision of one or more licensed or registered health professionals approved in advance by the Board Chairperson or the Chairperson's designee. When requesting approval of a proposed supervisor, Respondent shall provide a copy of the proposed supervisor's curriculum vitae to the Department. Respondent shall provide a copy of this order and the complaint dated June 12, 2024, to the proposed supervisor before requesting approval of the supervisor. Respondent shall not work in any capacity for which a medical license is required until Respondent receives written confirmation from the Department that the proposed supervisor was approved.

"General supervision" means the oversight or participation in Respondent's work by a supervisor, with continuous availability of direct communication between Respondent and the supervisor in person or by radio, telephone, facsimile, electronic mail, or other communication device. The supervisor shall review Respondent's practice on a regularly scheduled basis, shall provide consultation to Respondent, shall review patient records generated by Respondent on a regularly scheduled basis, and shall further educate Respondent in the performance of his functions.

B. SUPERVISION CHANGE. Respondent shall report to the Department, in writing, any and all changes in Respondent's medical employment or medical supervision within 15 days of such change.

Respondent shall provide copies of this order and the complaint dated June 12, 2024, to each successor employer and supervisor. The successor supervisor shall be knowledgeable of Respondent's history and shall continue to file reports with the Department advising of Respondent's work performance, as set forth above.

If Respondent's employment change requires Respondent to have a license to practice medicine, Respondent shall, prior to the change in employment, submit to the Department written correspondence requesting approval of the proposed successor supervisor.

Respondent shall not commence employment in a capacity for which a medical license is required until Respondent has received written notification from the Department confirming that the proposed supervisor has been approved.

Reclassification of Respondent's limited license shall not be automatic, but Respondent may petition for reclassification of the limited license upon conclusion of the limitation period. In the event Respondent petitions for reclassification of the license, the petition shall be in accordance with section 16249 of the Public Health Code and Mich Admin Code, R 792.10712. Under these provisions, Respondent must demonstrate that he (1) will practice the profession safely and competently within the area of practice and under conditions stipulated by the Disciplinary Subcommittee, and (2) should be permitted in the public interest to so practice.

Respondent is placed on PROBATION for a minimum period of 1 year to run concurrent with the period of limitation. Respondent shall be automatically discharged from probation upon reclassification of his limited license to full and unlimited status, provided that the Department has received satisfactory written evidence of Respondent's successful compliance with the terms and conditions provided below. If Respondent fails to complete any term or condition of probation as set forth in this order, Respondent will be in violation of Mich Admin Code, R 338.1632 and section 16221(h) of the Public Health Code. The terms and conditions of the probation are as follows:

A. SUPERVISOR REPORTS. Respondent's supervisor shall file reports with the Department, as further provided below, advising of his work performance. If, at any time, Respondent fails to comply with minimal standards of acceptable and prevailing

practice, or appears unable to practice with reasonable skill and safety, his supervisor shall immediately notify the Department.

B. REPORT OF NON-EMPLOYMENT. If, at any time during the period of probation, Respondent is not employed as a physician, he shall file a report of non-employment with the Department. Respondent shall file this report within 15 days after becoming unemployed. Respondent shall continue to file reports of non-employment on a quarterly basis until he returns to practice as a physician. If Respondent subsequently returns to practice as a physician, he shall notify the Department of this fact within 15 days after returning to practice. If Respondent is required to work under supervision as a term of limitation imposed by this order, then Respondent must notify the Department before returning to work and must not return to work until a supervisor is approved, as required by the terms of limitation.

C. MONITORING AGREEMENT. Respondent has entered into a disciplinary monitoring agreement with the Health Professional Recovery Program (HPRP). Respondent shall comply with the terms of the monitoring agreement. The duration of the monitoring agreement may exceed the period of probation.

All information and documentation acquired by HPRP in developing and implementing a monitoring agreement shall be made available to the Department upon request to establish Respondent's compliance or noncompliance with the monitoring agreement and this order.

If Respondent fails to comply with the terms of the monitoring agreement, HPRP shall immediately notify the Department in writing.

Upon Respondent's successful completion of the monitoring agreement, HPRP shall promptly notify the Department in writing.

D. CONTINUING EDUCATION CREDITS. Respondent shall successfully complete the course titled Professional Boundaries (PB 24) offered by PBI Education; the PROBE: Ethics and Boundaries Program offered by CPEP, or a comparable continuing education course, which shall be pre-approved by the Chairperson of the Board or the Chairperson's designee. These credit hours shall not count toward the number of credit hours required for license renewal. Respondent must seek and obtain advance

approval of the continuing education courses from the Chairperson of the Board or the Chairperson's designee. Respondent shall submit requests for approval of a course and proof of successful completion of a course to the Department by email to BPL-Monitoring@michigan.gov.

E. REPORTING PROCEDURE. Unless otherwise provided above, all reports required by the terms of probation shall be filed on a quarterly basis, the first report to be filed at the end of the third month of probation, and subsequent reports every three months until Respondent is discharged from probation. In addition to receiving reports as required above, the Department or its authorized representative may periodically contact the reporting individuals or agencies to inquire of Respondent's progress. By accepting the terms of this consent order and stipulation, Respondent has authorized the release of all necessary records and information.

F. COMPLIANCE WITH THE PUBLIC HEALTH CODE. Respondent shall comply with all applicable provisions of the Public Health Code and rules promulgated under the Public Health Code.

Respondent is FINED $2,725.00 to be paid by check, money order, or cashier's check made payable to the State of Michigan (with complaint number 43-21-003127 clearly indicated on the check or money order), and shall be payable within 18 months of the effective date of this order. The timely payment of the fine shall be Respondent's responsibility. Respondent shall mail the fine to: Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, Enforcement Division, Compliance Section, P.O. Box 30189, Lansing, Michigan 48909.

Respondent shall direct all communications, except fines, required by the terms of this Order to: BPL-Monitoring@michigan.gov.

Respondent shall be responsible for all costs and expenses incurred in complying with the terms and conditions of this consent order.

Respondent shall be responsible for the timely compliance with the terms of this consent order, including the timely filing of any documentation. Failure to comply within the time limitations provided will constitute a violation of this order.

If Respondent violates any term or condition set forth in this order, Respondent will be in violation of Mich Admin Code, R 338.1632, and section 16221(h) of the Public Health Code.

This order shall be effective 30 days from the date signed by the Chairperson of the Disciplinary Subcommittee or the Disciplinary Subcommittee's authorized representative, as set forth below.

Signed on January 15, 2025

MICHIGAN BOARD OF MEDICINE

By Lauran Brown for
Chairperson
Disciplinary Subcommittee

STIPULATION

The parties stipulate as follows:

1. Respondent does not contest the allegations of fact and law in the complaint. Respondent understands that, by pleading no contest, he does not admit the truth of the allegations but agrees that the Disciplinary Subcommittee may treat the allegations as true for resolution of the and any subsequent administrative proceedings related hereto (e.g., any application for reinstatement of license by Respondent) and may enter an order treating the allegations as true.

2. Respondent understands and intends that, by signing this stipulation, he is waiving the right under the Public Health Code, rules promulgated under the Public Health Code, and the Administrative Procedures Act of 1969, MCL 24.201 et seq., to require the Department to prove the charges set forth in the complaint by presentation of evidence and legal authority, and to present a defense to the charges before the Disciplinary Subcommittee or its authorized representative.

3. The Disciplinary Subcommittee may enter the above consent order, supported by Board conferee Bridget Lorenz, M.D. Dr. Lorenz or an attorney from the Licensing and Regulation Division may discuss this matter with the Disciplinary Subcommittee in order to recommend acceptance of this resolution.

4. The parties considered the following factors in reaching this agreement:

A. The amount of the fine considers the cost of the continuing education course.
B. Respondent wishes to resolve this matter without the need for or expense of a hearing.

By signing this stipulation, the parties confirm that they have read, understand, and agree with the terms of the consent order.

AGREED TO BY:

/s/ Alyssa R. Coast
Alyssa R. Coast (P82677)
Assistant Attorney General
Attorney for Complainant
Dated: 12/18/2024

AGREED TO BY:

Mohan Viswa Kaza, M.D.
Respondent

Dated: 12/17/24

Eric T. Ramar (P77713)
Attorney for Respondent
Dated: 12/17/24

Aaron J. Kemp (P55238)
Attorney for Respondent
Dated: 12/17/2024

LF: 2023-0376164-A/Kaza, Mohan Viswa MD/003127/COS/2024-12-16

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
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DISCIPLINARY SUBCOMMITTEE

In the Matter of

MOHAN VISWA KAZA, M.D.
License No. 43-01-075190
_____/

Complaint No. 43-21-003127
(consolidated with 43-23-000527)

FIRST SUPERSEDING ADMINISTRATIVE COMPLAINT

Assistant Attorney General Alyssa R. Coast, on behalf of the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing (Complainant), files this first superseding complaint against Mohan Viswa Kaza, M.D. (Respondent), alleging upon information and belief as follows:

1. The Board of Medicine, an administrative agency established by the Public Health Code, MCL 333.1101 *et seq.*, is authorized to find that a licensee has violated the Code and impose sanctions through its Disciplinary Subcommittee under the Code.

2. Respondent is currently licensed to practice medicine and holds a controlled substance license pursuant to the Code. At all relevant times, Respondent practiced as a psychiatrist in private practice at Better Mental Health PLLC in Troy, Michigan.

Disciplinary History

3. On April 10, 2015, the Department executed an Order of Summary Suspension and an Administrative Complaint against Respondent's license based

on 2013 and 2014 alcohol-related convictions and failure to report the convictions to the Department within 30 days. On September 8, 2015, the Disciplinary Subcommittee issued a final order dissolving the previously issued summary suspension and suspending Respondent's license for a minimum period of one day until he underwent an evaluation by Health Professional Recovery Program (HPRP).

4. On October 18, 2016, the Department executed an Order of Summary Suspension and an Administrative Complaint based Respondent's failure to comply with his HPRP monitoring agreement. On January 18, 2017, the Disciplinary Subcommittee issued a final order dissolving the summary suspension and suspending Respondent's license for a minimum period of three months, until he contacted HPRP and underwent an evaluation. Upon reinstatement, Respondent was placed on probation with terms.

5. On August 25, 2017, the Department executed an Order of Summary Suspension and an Administrative Complaint based Respondent's failure to comply with his HPRP monitoring agreement. Specifically, it was alleged Respondent was mailing Adderall prescriptions to patients prior to receiving HPRP approval to practice. On August 1, 2018, the Disciplinary Subcommittee issued a final order dissolving the summary suspension and suspending Respondent's license for a minimum period of one day until he underwent an HPRP evaluation, completed 10 hours of continuing education on prescribing, and paid a $5,000.00 fine. Upon reinstatement, Respondent was placed on probation for a minimum period of two

years, requiring compliance with his HPRP monitoring agreement, if applicable, and compliance with the Public Health Code. Respondent successfully completed the terms of this agreement on September 26, 2020.

ARTICLE 7 PROVISIONS

6. Amphetamine salts (e.g., Adderall) is a schedule 2 controlled substance, which means it has a high potential for abuse and may lead to severe psychic or physical dependence. MCL 333.7213.

7. Buprenorphine-naloxone (e.g., Suboxone), is a schedule 3 controlled substance, which means it has a potential for abuse less than the substances listed in schedules 1 and 2, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence. MCL 333.7216.

8. Klonpin or clonazepam, is a is a schedule 4 controlled substance, which means it has a low potential for abuse relative to substances in schedule 3, and abuse of the substance may lead to limited physical dependence or psychological dependence relative to the substances in schedule 3. MCL 333.7217.

9. Lyrica and promethazine with codeine are schedule 5 controlled substances, which means the substance has low potential for abuse relative to the controlled substances listed in schedule 4, and the substance has limited physical dependence or psychological dependence liability relative to the controlled substances listed in schedule 4 or the incidence of abuse is such that the substance should be dispensed by a practitioner. MCL 333.7219.

10. Section 7303a(4) of the Code provides that before prescribing or dispensing to a patient a controlled substance in a quantity that exceeds a 3-day supply, a licensed prescriber shall obtain and review a report concerning that patient from the electronic system for monitoring schedule 2, 3, 4, and 5 controlled substances established under section 7333a.

11. The Michigan Automated Prescription System (MAPS) is the electronic system established under 7333a of the Code to monitor schedule 2, 3, 4 and 5 controlled substances dispensed in the state.

ARTICLE 15 PROVISIONS

12. Section 16221(a) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to, or supervision of employees or other individuals, whether or not injury results, or any conduct, practice, or condition that impairs, or may impair, the ability to safely and skillfully engage in the practice of the health profession.

13. Section 16221(b)(i) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for personal disqualifications, consisting of incompetence, which is defined in section 16106(1) of the Code to mean a departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for a health profession, whether or not actual injury to an individual occurs.

14. Section 16221(b)(vi) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for personal disqualifications, consisting of lack

of good moral character, which is defined in MCL 338.41 to mean the propensity on the part of the person to serve the public in the licensed area in a fair, honest, and open manner.

15. Section 16221(v) of the Code authorizes the Disciplinary Subcommittee to sanction a licensee for a violation of section 7303a(4) or (5) of the Code.

16. Section 16226 of the Code authorizes the Disciplinary Subcommittee to impose sanctions against persons licensed by the Board if, after an opportunity for a hearing, the Disciplinary Subcommittee determines that a licensee violated one or more of the subdivisions contained in section 16221 of the Code.

FACTUAL ALLEGATIONS

John Doe 1 (Patient is de-identified to protect confidentiality)

17. On September 26, 2020, Respondent saw John Doe 1 for an initial evaluation for possible attention deficit disorder (ADD) and anxiety. John Doe 1 reported taking lyrica[1] and suboxone[2] and reported previous diagnoses for ADD and opioid dependence. At this time, Respondent recommended starting John Doe 1 on clonidine[3], lithium[4], and klonopin[5] without obtaining any previous records or otherwise confirming John Doe's reported diagnoses. Respondent continued to treat John Doe 1 until on or around January 2022.

[1] Lyrica is prescription-only, controlled substance used to treat pain caused by nerve damage.
[2] Suboxone is a prescription-only, controlled substance used to treat opioid dependence.
[3] Clonidine is a prescription-only, non-controlled medication used to treat high blood pressure
[4] Lithium is prescription-only, non-controlled mood stabilizing medication.
[5] Klonpin or clonazepam is prescription-only, controlled substance used to prevent and control seizures.

18. Respondent's records for John Doe 1 demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the June 30 and August 12, 2021 appointments.

b. Respondent's notes in the "today" section are identical for the December 17, 2021 and the January 17, 2022 appointments.

19. According to his records, although Respondent routinely discussed the side effects of clonidine with John Doe 1, he failed to discuss the possible side effects of the other medications he prescribed.

20. Respondent failed to discuss the potential impact alcohol and marijuana use might have on John Doe 1's treatment.

21. Respondent failed to provide adequate documentation to support his rationale for various diagnoses, treatments, or for prescribing the amounts and patterns of controlled substances he prescribed John Doe 1.

22. Although Respondent documented concerns that John Doe 1 was a poor historian it does not appear he considered the role the multiple controlled substance prescription John Doe 1 received from other providers might have played on his mental status.

23. On September 26, October 3, October 14, November 12, December 9, and December 18, 2020; January 5, February 2, March 4, April 5, May 3, June 2, June 30, August 12, September 15, November 19, November 22, December 17, 2021; and January 17, 2022, Respondent noted drug screens that showed "lithium levels,

thyroid, and creatinine." However, there is no evidence in the medical record that these tests occurred.

24. In a March 24, 2022 interview with a Department investigator, Respondent stated that he has no protocols in place for routine urine drug screening and stated that urine drug screening is not useful because patients can take their medication in the few days prior to a screen and then test positive for expected drugs. Respondent said that he is sure some patients are diverting medications, but he cannot police everyone.

25. From September 16, 2020 until on or about June 2, 2021, Respondent prescribed John Doe 1 lithium. Although he documented performing labs to obtain a lithium blood level, there is no evidence he actually did so. Respondent also failed to provide an adequate rationale for prescribing lithium.

Jane Doe 2 (Patient is de-identified to protect confidentiality)

26. On May 28, 2019, Jane Doe 2 had an initial evaluation with Respondent. She reported that she sought treatment for ADD and opiate dependence. At this appointment, Respondent prescribed suboxone and dextroamphetamine[6] tablets without obtaining any previous records or otherwise confirming her reported diagnoses. There is not an adequate basis to support the listed diagnoses.

27. In her initial evaluation, the patient stated that she was buying drugs

[6] Dextroamphetamine is used to treat attention deficit hyperactivity disorder (ADHD).

without a prescription. Respondent did not document any rationale for prescribing Jane Doe 2 controlled substances despite her admission and does not otherwise address whether the patient had a concurrent substance abuse issue.

28. On or around May 14, 2020, Respondent included in his "history of present illness" notes that the patient thought that the lithium was helping her. At the June 18, 2020 appointment, Respondent noted that Jane Doe 2 "reports no issues with the lithium." However, Respondent did not begin prescribing Jane Doe 2 lithium until July 15, 2020.

29. Respondent failed to provide an adequate rationale for prescribing lithium. Respondent failed to perform labs to obtain a lithium blood level.

30. Respondent failed to check MAPS every time that he wrote Jane Doe 2 a prescription for a controlled substance.

31. On December 18, 2019; January 21, February 19, March 15, Aril 17, May 14, June 18, July 15, July 29, and August 11, 2020, Respondent documented a plan for drug testing, however, there is no evidence in the medical record that these tests occurred.

32. On July 31, 2019, Respondent documented that he ordered a urine drug screen, but there is no evidence in the medical record that this test occurred.

33. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with patient Jane Doe 2, he failed to discuss the possible side effects of the other medications he prescribed.

34. Respondent's records for Jane Doe 2 demonstrate that Respondent

copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the July 15 and July 29, 2020 appointments.

b. Respondent's notes in the "today" section are identical for the November 17, December 15, and December 22, 2021 appointments.

c. Respondent's notes in the "today" section are identical for the January 20 and February 17, 2022 appointments.

Patient M.B. (initials used for confidentially)

35. M.B. was referred to Respondent by a friend. M.B. sought care for PTSD[7]. M.B. had an appointment which occurred in Respondent's home. M.B. paid Respondent $300.00 for this appointment.

36. During the appointment, the only thing Respondent asked M.B., was when his ADHD started, before prescribing him Adderall. Respondent also yelled at M.B. and was combative during the appointment.

Patient D.C.

37. On April 2, 2021, Patient D.C. had an initial evaluation with Respondent. He sought treatment for ADD, chronic neck pain, and feelings of anxiety and depression. D.C.'s appointments occurred in Respondent's home. During the initial appointment, D.C. reported buying drugs off of "the street". Despite this admission, Respondent prescribed D.C. dextroamphetamine tablets

[7] PTSD stands for Post Traumatic Stress Disorder, which is a mental health condition that develops following a traumatic event characterized by intrusive thoughts about the incident, recurrent distress/anxiety, flashback and avoidance of similar situations.

without obtaining any previous records or otherwise confirming the reported diagnoses. There is also not an adequate basis to support the listed diagnoses.

38. Respondent further failed to check MAPS every time that he wrote D.C. a prescription for a controlled substance.

39. Respondent documented that he prescribed D.C. lithium but failed to take labs to obtain a lithium blood level.

40. At the April 2, April 16, April 28, May 26, June 25, July 19, August 17, September 14, October 19, November 16, and December 14, 2021, January 12, and March 9, 2022 appointments, Respondent noted "drug screens, lithium level, thyroid, creatinine." However, there is no evidence in the medical record that these tests occurred.

41. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "[h]istory of present illness" section are identical for the April 2 and April 16 appointments.

b. Respondent's notes in the "today" section are identical for the November 16 and December 14, 2021 appointments.

c. Respondent's notes in the "today" section are identical for the January 12 and March 9, 2022 appointments.

42. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with D.C., he failed to discuss the possible side effects of the other medications he prescribed.

Patient M.C.

43. On May 12, 2020, M.C. saw Respondent for an initial appointment where she sought care for ADD and anxiety. At this appointment, Respondent prescribed dextroamphetamine tablets without obtaining any previous records or otherwise confirming her reported diagnoses. There is not an adequate basis to support the listed diagnoses.

44. At the June 10 and July 8, 2020, appointments, M.C. stated that she could not get her Clonidine prescription filled so she was taking her boyfriend's Clonidine. Respondent failed to document an intervention strategy for this diversion.

45. At the June 10, October 28, November 25, and December 23, 2020; January 19, February 16, March 16, and April 15, 2021, appointments Respondent suggested that M.C. take lithium, which she declined. M.C. did not report symptoms that would support being prescribed lithium.

46. Respondent failed to check MAPS every time that he wrote M.C. a prescription for a controlled substance.

47. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with M.C., he failed to discuss the possible side effects of the other medications he prescribed.

48. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the December 23, 2020 and the January 19, 2021 appointments.

b. Respondent's notes in the "today" section are identical for the February 16 and March 16, 2021 appointments.

c. Respondent's notes in the "today" section are identical for the June 9 and July 7, 2021 appointments.

d. Respondent's notes in the "today" section are identical for the August 7 and September 4, 2021 appointments.

e. Respondent's notes in the "today" section are identical for the January 27 and March 23, 2022 appointments.

John Doe 3[8]

49. On September 19, 2021, John Doe 3 had an initial evaluation with Respondent where he sought care for ADHD and a prescription for suboxone. At this appointment, Respondent prescribed suboxone and dextroamphetamine tablets without obtaining any previous records or otherwise confirming the reported diagnoses. There is not an adequate basis to support the listed diagnoses.

50. During the initial evaluation, John Doe 3 reported that he had been buying Adderall off the streets. Respondent failed to document why he decided to prescribe controlled substances despite this admission and he failed to address whether this patient had a concurrent substance abuse issue.

51. Respondent failed to check MAPS every time that he wrote John Doe 3 a prescription for a controlled substance.

52. At the September 19, October 4, November 14, November 15, December 13, 2021; January 9, February 13, and March 14, 2022, appointments,

[8] In the investigation report for file number 43-23-000527, this patient is referred to as John Doe 1. However, there was already a John Doe 1 in the investigation report for file number 43-21-003127. John Doe 1 from file number 43-23-000527 is herein referenced as John Doe 3.

Respondent noted "drug screens, lithium level, thyroid, creatinine." There is no evidence in the medical record these tests ever occurred.

53. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with John Doe 3, he failed to discuss the possible side effects of the other medications he prescribed.

54. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the November 14 and December 13, 2021 appointments.

b. Respondent's notes in the "today" section are identical for the February 13 and March 14, 2022 appointments.

Jane Doe 1

55. On May 7, 2020, Jane Doe 1 had an initial evaluation with Respondent to be evaluated for ADD. At this appointment, Respondent prescribed dextroamphetamine tablets without obtaining any previous records or otherwise confirming her reported diagnoses. There is not an adequate basis to support the listed diagnoses.

56. At the initial appointment Respondent wrote a prescription for lithium. His notes do not indicate symptoms or a diagnosis to support prescribing this medication. Respondent failed to perform labs to obtain a lithium blood level.

57. At the August 23, 2021 appointment Respondent noted that the patient may be diverting suboxone with her boyfriend. Respondent failed to document an intervention strategy.

58. Respondent failed to check MAPS every time that he wrote Jane Doe 1 a prescription for a controlled substance.

59. At the May 20, June 16, July 22, August 19, September 16, October 14, November 11, and December 3, 2020; January 6, February 4, March 3, March 31, April 28, May 27, June 18, July 26, August 23, September 15, September 20, October 20, November 17, and December 16, 2021; February 14, and April 14, 2022, appointments Respondent noted "drug screens, lithium level, thyroid, creatinine." However, there is no evidence in the medical record that these tests occurred.

60. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with Jane Doe 1, he failed to discuss the possible side effects of the other medications he prescribed.

61. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the January 6 and February 4, 2021 appointments.

b. Respondent's notes in the "today" section are identical for the March 3 and 31, 2021 appointments.

c. Respondent's notes in the "today" section are identical for the August 23 and September 20, 2021 appointments.

d. Respondent's notes in the "today" section are identical for the February 14 and April 14, 2022 appointments.

John Doe 2

62. On June 3, 2019, John Doe 2 had an initial appointment with Respondent for continuity of care and treatment for reported ADD. At this

appointment, Respondent prescribed dextroamphetamine tablets without obtaining any previous records or otherwise confirming the reported diagnoses. There is not an adequate basis to support the listed diagnoses.

63. At the June 30, July 31, and October 22, 2019 appointments, John Doe 2 stated that he buys pains medicine off of "the streets." At the August 18 and September 22, 2021, appointments John Doe 2 reported he ran out of suboxone and used heroin instead. Respondent failed to document why he decided to prescribe controlled substances despite these admissions, and he failed to address whether this patient had a concurrent substance abuse issue.

64. On October 22, 2019, Respondent started the patient on lithium without medical support or rationale. Respondent further failed to perform labs to obtain a lithium blood level.

65. At the July 31 and August 21, 2019 appointments, Respondent noted a urine drug screen to be done at the next appointment. However, there is no evidence in the medical record that these tests occurred.

66. At the October 22 and November 22, 2019 appointments, Respondent noted an oral screen at the next appointment and ordered labs for lithium, T3, T4, and creatinine. However, there is no evidence in the medical record that these tests occurred.

67. On August 4, September 1, September 29, November 30, and December 30, 2020; February 8, March 9, April 6, May 4, June 7, July 6 and 30, August 18, September 22, October 26, November 23, and December 21, 2021;

January 19, February 16, and March 16, 2022, Respondent noted an oral swab to be done at the next appointment. However, there is no evidence in the medical record that these tests occurred.

68. Respondent failed to check MAPS every time that he wrote John Doe 2 a prescription for a controlled substance.

69. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the August 18 and September 22, 2021 appointments.

b. Respondent's notes in the "today" section are identical for the February 16 and March 16, 2021 appointments.

Patient E.D.G.

70. On December 1, 2019, E.D.G. had an initial appointment with Respondent for continuation of treatment for ADD. At this appointment, Respondent prescribed lorazepam and dextroamphetamine tablets without obtaining any previous records or otherwise confirming the reported diagnoses. There is not an adequate basis to support the listed diagnoses.

71. Respondent began prescribing lithium at the initial appointment without medical support or rationale. Respondent failed to perform labs to obtain a lithium blood level.

72. Based on his documentation it appears that the January 23, 2020 and February 19, 2020, appointments took place at Starbucks.

73. According to his records, from approximately December 1, 2019 to July 8, 2020, Respondent routinely discussed the side effects of Clonidine and Adderall. However, he failed to discuss the possible side effects of the other medications he prescribed. Beginning on or around August 5, 2020, Respondent failed to document that he discussed any medication side effects with the patient.

74. Respondent failed to check MAPS every time that he wrote E.D.G. a prescription for a controlled substance.

75. For all appointments from December 1, 2019 to March 23, 2022, Respondent noted "drug screen, lithium level, thyroid, creatinine" but failed to include a copy of the results or a summary of the results in the patient's medical record.

76. At the January 27, 2022 appointment, Respondent advised the patient, "if his daughter showed signs of ADHD – they could try to give a clonidine at night for a couple days to see if it helps her focus more." Respondent improperly gave medical advice for an individual who was not his patient and improperly recommended that patient E.D.G. give his medication to someone else.

77. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes for the chief complaint and history of present illness are identical for the December 1 and 26, 2019, and January 23, 2020 appointments.

b. Respondent's notes in the "today" section are identical for the February 16 and March 16, 2021 appointments.

c. Respondent's notes in the "today" section are identical for the December 23, 2020 and January 19, 2021 appointments.

d. Respondent's notes in the "today" section are identical for the February 16 and March 16, 2021 appointments.

e. Respondent's notes in the "today" section are identical for the April 15 and May 13, 2021 appointments.

f. Respondent's notes in the "today" section are identical for the June 9 and July 7, 2021 appointments.

g. Respondent's notes in the "today" section are identical for the August 7 and September 4, 2021 appointments.

h. Respondent's notes in the "today" section are identical for the January 27 and March 23, 2022 appointments.

Patient J.W.

78. On July 13, 2020, J.W. had an initial appointment with Respondent to obtain Suboxone and Adderall for his reported ADHD. At this appointment, Respondent prescribed diazepam and dextroamphetamine tablets without obtaining any previous records or otherwise confirming the reported diagnoses. There is not an adequate basis to support the listed diagnoses.

79. At the October 6, 2020 appointment, Respondent noted that J.W. may be sharing his Valium with his spouse. At this same appointment, Respondent further noted that J.W. wanted his Valium increased to 20 mg per day and would not agree to keep it at 10 mg, and Respondent increased it to 15 mg. During the January 4, 2021 appointment, J.W. again stated that his wife takes his Valium, Despite this, Respondent again increased J.W.'s Valium prescription. At the March 1, 2021 and April 26, 2021 appointments, J.W. again reported sharing medications

with his wife. At the September 22, 2021 appointment, Respondent noted a pattern of early fills. Respondent failed to document an intervention strategy for this admitted diversion.

80. At the July 13, August 10, and September 8, 2020 appointments, Respondent noted "drug screens, lithium level, thyroid, creatinine." but failed to include a copy of the results or a summary of the results in the patient's medical record. Respondent made no mention of ordering labs or drug screens in any other appointments.

81. At the August 24, 2021 appointment, Respondent suggested that the patient start on lithium. Respondent then prescribed lithium at the September 22, 2021 appointment. Respondent failed to provide adequate rationale or a supporting diagnosis for prescribing lithium. Respondent failed to perform labs to obtain a lithium blood level.

82. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with J.W., he failed to discuss the possible side effects of the other medications he prescribed.

83. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes are identical for the "today" section for January 4 and the February 1, 2021 appointments.

b. Respondent's notes for the "today" section are identical for the April 26 and May 24, 2021 appointments.

c. Respondent's notes in the "today" section are identical for the September 22 and October 19, 2021 appointments.

d. Respondent's notes in the "today" section are identical for the February 15 and March 15, 2022 appointments.

84. On July 17, 2023, J.W. participated in an interview with the Bureau investigator and reported that his appointments occurred at Respondent's home. Respondent accepted only cash payments or Venmo[9]. Respondent failed to order tests or conduct any drug screening. Throughout the patient-physician relationship J.W. said that Respondent pushed Adderall and Clonidine. Respondent sent J.W. text messages that were unprofessional and inappropriate.

Patient A.K.

85. On June 20, 2020, A.K. had an initial appointment with Respondent for his reported chronic cough, back pain, depression, and anxiety. At this appointment, Respondent prescribed promethazine with codeine syrup without obtaining any previous records or otherwise confirming the reported diagnoses. There is not an adequate basis to support the listed diagnoses.

86. At the initial appointment, on June 20, 2020, Respondent also prescribed A.K. lithium. However, Respondent failed to perform labs to obtain a lithium blood level.

87. At the July 27, 2020 appointment, Respondent included in his notes, "warning no more promethazine-codeine, serious violation noted."[10] Despite that,

[9] Venmo is an application on a smart phone that allows users to send and receive money.
[10] Promethazine with codeine is a controlled substance prescribed for treating cough and related upper respiratory symptoms. Promethazine with codeine syrup is rarely indicated for any other health condition and is particularly ill-suited for long-term treatment of chronic pain. Promethazine with codeine syrup is a highly sought after drug of abuse.

he wrote A.K. a prescription for promethazine-codeine at the July 27, 2020, as well as at subsequent appointments on October 30, December 3, December 23, 2020, January 11, 2021, February 11, and March 11, 2021.

88. According to his records, although Respondent routinely discussed the side effects of Clonidine and Adderall with A.K., he failed to discuss the possible side effects of the other medications he prescribed.

89. On June 30, July 27, August 10, October 30, December 3, and December 27, 2020; January 11, February 11, March 8, March 23, and April 20, 2021, Respondent noted for a drug screen to be done at the next appointment. However, he failed to include a copy of the results or a summary of the results in the patient's medical record.

90. Respondent's records demonstrate that Respondent copied and pasted notes for multiple appointments. By way of example:

a. Respondent's notes in the "today" section are identical for the March 23 and April 20, 2020 appointments.

91. On July 17, 2023, A.K. participated in an interview with the Bureau investigator and reported that appointments occurred at Respondent's home. Respondent preferred to be paid in cash. Respondent failed to order lab work. Respondent called and texted the patient numerous times accusing him of getting Respondent banned from several pharmacies. A.K. no longer sees Respondent for care.

Patient C.S.

92. On September 6, 2023, C.S. participated in an interview with the

Bureau investigator. C.S. sought treatment from Respondent for bi-polar disorder, depression, and anxiety.

93. C.S. found Respondent through an online search. She called the listed phone number to make an appointment. Respondent sent her a text message to set up an appointment date and time. C.S. went to Respondent's home for her initial evaluation. When she arrived, she texted Respondent because she was early. Respondent scolded her for texting him.

94. C.S. said that the appointment was held in a sunroom in the back of Respondent's home. During the appointment, C.S. said that three different people came and spoke to Respondent, asking him to re-write their adderall prescriptions.

95. During the appointment Respondent demonstrated unprofessional behavior, including offering C.S. lithium from a basket full of many different pharmacy prescription pill bottles.

96. As a result of the appointment, C.S. filed a police report.

Patient K.A.

97. Starting on or around April 2021, Patient K.A saw Respondent for appointments at his home in Southfield, Michigan. During the initial appointment, Respondent was being flirty and made K.A. feel uncomfortable.

98. Beginning on April 27, 2021, Respondent prescribed Lorazepam and Adderall.

99. Respondent diagnosed K.A. with bipolar disorder and prescribed her lithium. However, he did not do any screening or diagnostic tests in order to diagnose.

100. During an appointment, Respondent gave K.A. Adderall tablets from his personal prescription vial.

101. Respondent treated K.A. until approximately June 2023.

102. During the course of the patient-physician relationship Respondent acted strangely during appointments and threatened to decrease K.A.'s adderall dosage if she did not respond to his text messages.

103. Respondent exchanged a number of text messages with K.A. that were personal in nature, including inviting her to visit his home in San Diego, California.

104. When K.A. reached out to schedule an appointment Respondent replied with vulgarity and threatening messages.

105. Respondent only accepted payment in cash or by Venmo. In the Venmo transaction, he asked K.A to state in the description of payment that it was for "groceries" or "pizza" and not for a "physician fee."

COUNT I

106. Respondent's conduct constitutes a violation of general duty, consisting of negligence or failure to exercise due care, including negligent delegation to or supervision of employees or other individuals, in violation of MCL 333.16221(a).

COUNT II

107. Respondent's conduct, as set forth above, demonstrates Respondent's "departure from, or failure to conform to, minimal standards of acceptable and prevailing practice for the health profession, whether or not actual injury to an individual occurs," and accordingly "incompetence," in violation of MCL 333.16221(b)(i).

COUNT III

108. Respondent's conduct as described above demonstrates a lack of good moral character in violation of section 16221(b)(vi) of the Code.

COUNT IV

109. Respondent failed to obtain and review a MAPS report before prescribing a patient a controlled substance in a quantity that exceeds a 3-day supply in violation of section16221(v) of the Code.

THEREFORE, Complainant requests that this complaint be served upon Respondent and that Respondent be offered an opportunity to show compliance with all lawful requirements for retention of the aforesaid licenses. If compliance is not shown, Complainant further requests that formal proceedings be commenced pursuant to the Public Health Code, the Administrative Procedures Act of 1969, MCL 24.201 *et seq*., and associated administrative rules.

RESPONDENT IS HEREBY NOTIFIED that, pursuant to section 16231(8) of the Public Health Code, Respondent has 30 days from receipt of this complaint to submit a written response to the allegations contained in it. Pursuant to section

16192(2) of the Code, Respondent is deemed to be in receipt of the complaint 3 days after the date of mailing listed in the attached proof of service. The written response shall be submitted by email to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing to BPL-DMS@michigan.gov, with a copy mailed to the undersigned assistant attorney general. If unable to submit a response by email, Respondent may submit by regular mail to the Department of Licensing and Regulatory Affairs, Bureau of Professional Licensing, P.O. Box 30670, Lansing, MI 48909, with a copy mailed to the undersigned assistant attorney general.

Pursuant to section 16231(9) of the Code, failure to submit a written response within the 30-day period shall be treated as an admission of the allegations contained in the complaint and shall result in transmittal of the complaint directly to the Board's Disciplinary Subcommittee for imposition of an appropriate sanction.

In the event Respondent's license is suspended or revoked, Respondent's controlled substance license shall be automatically void pursuant to section 7311(6) of the Public Health Code.

Respectfully submitted,

/s/ Alyssa R. Coast

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