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

In the Matter of

ZONGLI CHANG, M.D.
License No. 43-01-087633,

File No. 43-16-141933

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 of the Code.

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: 05/04, 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 Zongli Chang, 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. Respondent holds a Michigan license to practice medicine. Respondent also holds a 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 on the date the accompanying *Order of Summary Suspension* was served.

4. 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.

5. 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.

6. 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."

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

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

9. Oxymorphone is a commonly abused and diverted schedule 2 controlled substance. Oxymorphone 40 mg is the most commonly abused and diverted strength of oxymorphone.

10. Pregabalin is a medication used to treat epilepsy, neuropathic pain, fibromyalgia, and generalized anxiety disorder. Although classified as a schedule 5

controlled substance, pregabalin has potential for diversion and abuse due to its benzodiazepine-like effects.

11. Zolpidem is a sedative schedule 4 controlled substance with benzodiazepine-like effects.

12. 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."

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.

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

		2015	*% of 2015 CS Prescriptions*	*2016*	*% of 2016 CS Prescriptions*
(a)	Alprazolam 1 mg	992	8.50%	805	6.66%
(b)	Alprazolam 2 mg	799	6.85%	750	6.20%
(c)	Carisoprodol	2699	23.13%	3036	25.10%
(d)	Hydrocodone/apap products	3140	26.91%	3267	27.01%
(e)	Oxycodone 30 mg	737	6.32%	916	7.57%
(f)	Promethazine with codeine syrup	2376	20.36%	2412	19.94%
(g)	Total of (a) through (f)	10,743	***92.07%***	11,186	***92.48%***
(h)	Total Number of CS Prescriptions	11,668		12,096	

15. Respondent ranked among the top 2 prescribers of carisoprodol for 2015 and the first three quarters of 2016, and among the top 6 prescribers of promethazine with codeine syrup in the same period.

16. More than twenty seven percent (27%) of the controlled substance prescriptions Respondent wrote in 2015 were filled by patients who paid cash for their medications. In 2016, that percentage was more than twenty three percent (23%). The

state average for cash payment is approximately 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.

17. Each month, the Department sends warnings to providers who wrote a prescription to a "doctor shopper" -- a patient who had filled prescriptions from multiple providers in the previous month. Between March 2014 and December 2016, the Department notified Respondent on seven (7) different occasions that he had prescribed controlled substances to "doctor shoppers." The high number of "doctor shopper" warnings indicates Respondent is prescribing to individuals for other than legitimate medical purposes.

18. Respondent offers what he terms a "membership/concierge plan" for his patients. Respondent charges $200 for an initial patient visit, and $150 to $200 a month thereafter regardless of the number of patient visits.

19. As part of an investigation of Respondent's prescribing practices, the Department received and analyzed medical records of eleven (11) of Respondent's patients.

20. Of those 11 patients, nine received the "Holy Trinity" combination of opioids, muscle relaxants, and benzodiazepines, either from Respondent alone, or from simultaneous prescribing by Respondent and other prescribers.

21. None of Respondent's reviewed patient files contain controlled substance agreements with the patients.

22. Expert review of the individual medical files Respondent produced revealed the following deficiencies consistently across all files:

(a) Respondent's notations on patient files frequently appear to be "carried forward" from visit to visit with little variation, making it

difficult to determine whether entries reflect a cumulative description of care, or the care provided at any particular encounter.

(b) Documentation of evaluations are often identical from visit to visit or from patient to patient, suggesting Respondent did not perform them as documented.

(c) The large volume of documentation include little or no information contextualizing the clinical presentation of the patient

(d) Patient files lack adequate documentation of functional treatment goals, and provided inadequate evaluation of progress toward functional goals.

(e) Documentation often include repeated evaluation of systems that were not pertinent to the clinical context (e.g., repeated examination of patient's hearing).

(f) Examinations often contain findings inconsistent with reported symptoms (e.g., normal pulmonary findings for a patient complaining of labored breathing).

(g) Respondent's files do not adequately describe functional goals of therapy.

(h) Patient files lack substantial initial histories (including pain histories) or previous treatment details.

(i) Although Respondent documented recommendation of other therapeutic modalities for pain management, he recorded no follow-up (except for physical therapy).

(j) Patient files rarely included imaging studies or other diagnostic tests to assess patients complaining of chronic pain.

(k) Patient files lack documentation of individualized discussion with patients of risks and benefits associated with controlled substance therapy.

(l) Files include frequent unexplained internal inconsistencies in patient notes.

(m) Patient files lack documentation of appropriate referrals to pain management specialists.

(n) Patient files lack documentation that Respondent screened patients for the risk of diversion or abuse.

(o) Respondent did not document obtaining MAPS reports or urine drug screens (UDSs) to monitor patients for the risk of diversion or abuse.

(p) Respondent consistently prescribed dangerous combinations of opioids, benzodiazepines, and carisoprodol without documented consideration of the risk.

(q) Respondent prescribed some patients a long-term course of codeine/promethazine syrup even though the patients were already on significant doses of opioids.

(r) Respondent often administered injections of the anti-inflammatory drug ketorolac (Toradol) and the steroid dexamethasone even though both medications are available for oral administration and despite a lack of clinical justification for administration by injection.

23. Expert review of the individual medical files Respondent produced reviewed the following deficiencies, in addition to those noted above:

Patient EB[1]

(a) Respondent's notes lack adequate diagnostic testing or patient records to support or evaluate the diagnosis of chronic back and ankle pain.

(b) Many notes are handwritten and illegible.

(c) Although a prior diagnosis of diabetes is noted, Respondent's notes reflect insufficient attention to management of that condition.

(d) There are frequent unexplained internal inconsistencies in patient notes.

(e) Respondent's notes reflect several nearly identical indications of falls sustained by Patient EB during the course of Respondent's treatment. The nearly identical notations suggest they were "cut and pasted" and therefore make determination of actual timing impossible. Respondent does not note inquiry into the relationship of Patient EB's falls with her treatment with multiple controlled substances.

(f) Respondent often made medication dosage changes without a documented rationale, and without reflecting that fact in the patient record.

[1]Patients are identified by their initials.

(g) On March 20, 2012, without documented rationale or discussion of the risks, Respondent increased Patient EB daily morphine milligram equivalents (MME) of prescribed medications from 135 to 360.

(h) Respondent prescribed Patient EB pregabalin without documenting it in Patient EB's record.

(i) Respondent prescribed Patient EB a combination of opioids, carisoprodol, and alprazolam, without documented consideration of the substantial risks involved in coprescribing them, and even though MAPS reports showed that Patient EB was obtaining controlled substance prescriptions from other providers at the same time.

Patient MD

(j) There are frequent unexplained internal inconsistencies in patient notes, including inconsistent notations about the effectiveness of prescribed controlled substances for pain control and inconsistent notations about medication changes.

(k) Respondent prescribed Patient MD oxycodone even though the corresponding patient record indicates Patient MD was prescribed oxymorphone.

(l) On April 19, 2012, Respondent prescribed Patient MD 180 MME of oxycodone, while also maintaining concurrent prescriptions for carisoprodol and benzodiazepines, and without documented consideration of the substantial risks involved in coprescribing them.

(m) Respondent often made medication dosage changes without a documented rationale.

(n) Respondent began drug treatments for apparent respiratory issues without documentation of any underlying symptoms supporting the treatment or other inquiry in the patient record.

(o) Respondent's notes include repeated references to diabetes management and smoking cessation, although Patient MD is not noted as diabetic and is documented to be a nonsmoker.

Patient WG

(p) There are frequent unexplained internal inconsistencies in patient notes.

(q) Notes appear to be cut and pasted with minimal variation over the course of many visits.

(r) Respondent often made medication additions and changes without rationale and with insufficient and equivocal clinical documentation.

(s) Respondent prescribed Patient WG multiple controlled substances even though MAPS reports showed that Patient WG was obtaining controlled substance prescriptions from other providers at the same time.

Patient JD

(t) Respondent failed to document adequate evaluation of new complaints and changes in complaints.

(u) Respondent failed to document rationalization of the prescribed multiple controlled substance therapy or changes in the therapy.

(v) Respondent failed to obtain Patient JD's informed consent to multiple controlled substance therapy.

(w) Respondent frequently administered injected B12, dexamethasone, and Toradol without appropriate indication.

Patient KD

(x) Respondent failed to document rationalization of the prescribed multiple controlled substance therapy or changes in the therapy.

(y) Respondent failed to obtain Patient KD's informed consent to multiple controlled substance therapy.

(z) Notes appear to be cut and pasted with minimal variation, over the course of many visits.

(aa) Respondent frequently administered injected B12, dexamethasone, and Toradol without appropriate indication.

(bb) Although Respondent noted that Patient KD complains of shortness of breath and is on supplemental oxygen, Respondent made no diagnosis or plan for this compliant.

(cc) Respondent prescribed Patient KD a combination of opioids, carisoprodol, and alprazolam, without documented consideration of the substantial risks involved in coprescribing them, and even though MAPS reports showed that Patient KD was obtaining controlled substance prescriptions from other providers at the same time.

(dd) Respondent documented that Patient KD was in at least one car crash, but did not document consideration that Respondent's

prescribed multiple controlled substance therapy could have been a factor.

(ee) Respondent made insufficient inquiry into Patient KD's drug history. Respondent subsequently was placed on notice that Patient KD had a substance abuse history from an outside agency, after Respondent had prescribed Patient KD multiple controlled substances for several months.

Patient FM

(ff) Respondent prescribed medications without appropriate rationale or consideration of contraindications (e.g., Respondent prescribed the antibiotic Augmentin even though Patient FM reported a penicillin allergy).

(gg) Respondent prescribed Patient FM codeine/promethazine syrup without appropriate indication, and even though Patient FM was prescribed other opioid medications.

(hh) There are frequent unexplained internal inconsistencies in patient notes.

Patient GP

(ii) Respondent failed to document adequate evaluation of new complaints, changes in complaints, and treatment decisions based on those complaints.

(jj) Respondent failed to document rationalization of or risk/benefit analysis for the prescribed multiple controlled substance therapy or changes in the therapy.

(kk) Respondent failed to obtain Patient GP's informed consent to multiple controlled substance therapy.

(ll) Respondent prescribed Patient GP the controlled substance amphetamine phentermine for weight loss without documenting non-drug approaches to weight loss.

Patient DW

(mm) Respondent failed to document adequate evaluation of new complaints, changes in complaints, and treatment decisions based on those complaints.

(nn) Respondent often made medication additions and changes without rationale and with insufficient and equivocal clinical documentation.

(oo) There are frequent unexplained internal inconsistencies in patient notes.

(pp) Notes appear to be cut and pasted with minimal variation, over the course of many visits.

(qq) Respondent prescribed Patient DW pregabalin without documenting it in Patient DW's record.

(rr) Respondent frequently administered injected B12, dexamethasone, and Toradol without appropriate indication.

(ss) Respondent did not document obtaining or reviewing MAPS reports, which would have shown that Patient DW was obtaining controlled substance prescriptions from other providers at the same time.

Patient VM

(tt) Respondent failed to obtain meaningful clinical history from or perform any examination of Patient VM to support his conclusion to prescribe Patient VM multiple controlled substances.

Patient RR

(uu) Respondent failed to document adequate evaluation of new complaints, changes in complaints, and treatment decisions based on those complaints.

(vv) Respondent often made medication additions and changes without rationale and with insufficient and equivocal clinical documentation.

(ww) Respondent placed insufficient safeguards regarding the multiple controlled substance regimen he prescribed Patient RR, given Patient RR's documented substance abuse history.

(xx) Respondent learned in June 2012 that Patient RR was obtaining controlled substance prescriptions from other providers at the same time. However, Respondent continued to prescribe Patient RR controlled substances.

(yy) Respondent prescribed Patient RR 515 total MME of opioids, without documented consideration of the extraordinary risk associated with such a high dosage, or of the likelihood that Patient RR was diverting at least some of that medication.

COUNT I

Respondent's conduct constitutes a violation of a general duty, consisting of negligence or failure to exercise due care, 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 demonstrates Respondent's lack of a "propensity . . . to serve the public in the licensed area in a fair, honest, and open manner," MCL 338.41(1), and accordingly a lack of "good moral character," in violation of MCL 333.16221(b)(vi).

COUNT IV

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).

COUNT V

Respondent's conduct constitutes the promotion, for personal gain, of unnecessary drugs and/or treatments, and is therefore unprofessional conduct in violation of MCL 333.16221(e)(iii).

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: 05/04, 2017

By: Kim Gaedeke, Director
Bureau of Professional Licensing

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