State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
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July 10, 2024

Case number: 24-CRF-0133

James H Thomas, M.D.
3001 Highland Ave, Ste B
Cincinnati OH 45219
Jhtmd49@mac.com

Dear Doctor Thomas:

In accordance with Chapter 119., Ohio Revised Code, you are hereby notified that the State Medical Board of Ohio [Board] intends to determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation for one or more of the following reasons:

(1) In your routine course of your practice from in or around 1997 to in or around 2022, you provided care and treatment for Patients 1 through 10, as identified on the attached Patient Key. **(The Patient Key is confidential and to be withheld from public disclosure.)** You failed to appropriately treat and/or failed to appropriately document your treatment of these patients.

(2) Specific examples of such treatment and/or conduct identified in paragraph (1) include, but are not limited to, the following:

(a) Since December 2015, until at least in or around May 2022, you provided care and treatment for Patient 1, for conditions that included Bipolar 1 Disorder, ADHD, Post Traumatic Stress Disorder (PTSD) and Dissociative Identity Disorder. In the course of your treatment of Patient 1, your documentation of symptoms warranting and supporting medication therapy was inadequate throughout the treatment course. Further, you continued to prescribe an alternative psychostimulant when there was evidence of Patient 1 misusing the prescribed Adderall, and you continued to prescribe the psychostimulant despite assessing Patient 1 with symptoms possibly caused or exacerbated by this medication therapy. Further, you prescribed Zoloft over daily FDA maximum without supporting documentation. Further, you failed to obtain and/or failed to document Patient 1's weight, a bloodwork assessment for evidence of metabolic syndrome, or an Abnormal Involuntary Movement Scale [AIMS] exam despite prescribing an antipsychotic medication for extended period of time. Further, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to

provide continuity of care if needed. Further, you failed to obtain past treatment records for collateral information and failed to refer Patient 1 to her primary care provider and/or neurologist when appropriate. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(b) Since in or about February 2004, until at least in or about May 2022, you provided care and treatment for Patient 2, for conditions that included Bipolar 1 Disorder and ADHD. In the course of your treatment of Patient 2 your documentation of symptoms warranting and supporting medication therapy was inadequate throughout the treatment course. Further, you continued to prescribe a psychostimulant despite assessing Patient 2 with symptoms possibly caused or exacerbated by this medication therapy. Further, you failed to obtain and/or failed to document Patient 2's weight, a bloodwork assessment for evidence of metabolic syndrome, or an AIMS exam until September 2011 despite prescribing an antipsychotic medication since March 2004. Further, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you failed to obtain past treatment records for collateral information and failed to refer Patient 2 to his primary care provider and/or specialty provider when appropriate. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the times and frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(c) Since in or about May 2009, until at least in or about May 2021, you provided care and treatment for Patient 3, for conditions that included Major Depressive Disorder, Generalized Anxiety Disorder and Agoraphobia. In the course of your treatment of Patient 3, your documentation of symptoms warranting and supporting medication therapy was inadequate throughout the treatment course. Further, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you failed to obtain and/or failed to document Patient 3's weight, a bloodwork assessment for evidence of metabolic syndrome, despite prescribing antipsychotic medication for an extended period of time. Further you failed to obtain or failed to document obtaining past treatment records for collateral information. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the times and frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(d) Since in or about December 1996, until at least in or about July 2021, you provided care and treatment for Patient 4, for conditions that included Adjustment Disorder with Anxiety and Depression and ADHD. In the course of your treatment of Patient 4, your documentation to support diagnoses and treatment plan

including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further you failed to obtain or failed to document obtaining past treatment records for collateral information. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the times and frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(e) Since in or about October 2014, until at least in or about May 2022, you provided care and treatment for Patient 5, for conditions that included ADHD, Depressive Disorder and PTSD. In the course of your treatment of Patient 5, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you prescribed controlled substances to Patient 5 for extended periods of time despite her reporting a history of substance use issues. Further, you failed to obtain Patient's 5's weight or appropriately order bloodwork to evaluate evidence of metabolic syndrome despite prescribing antipsychotic medication for extended period of time. Further, you documented conducting and billed for several appointments with Patient 5 while she was located in the State of Florida starting in September 2017. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the times and frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(f) Since in or about July 2016, until at least in or about November 2021, you provided care and treatment for Patient 6, for conditions that included ADHD and Bipolar Disorder. In the course of your treatment of Patient 6, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you prescribed controlled substances to Patient 6 for extended periods of time despite his reporting a history of substance use issues. Further, you failed to obtain Patient's 6's weight or appropriately order bloodwork to evaluate evidence of metabolic syndrome or complete an AIMS exam despite prescribing antipsychotic medication for extended period of time. Further, you failed to obtain and/or failed to document obtaining an OARRS review, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(g) Since in or about March 2004, until at least in or about April 2022, you provided care and treatment for Patient 7, for conditions that included Bipolar Disorder, ADHD and Major Depressive Disorder. In the course of your treatment of Patient 7, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you failed to obtain Patient's 7's weight. Further, except for once in March 2017, you failed to appropriately order bloodwork to evaluate evidence of metabolic syndrome, and you also failed to complete an AIMS exam despite prescribing antipsychotic medication from in or about April 2004 through May 2022. Further you failed to obtain or failed to document obtaining past treatment records for collateral information. Further, you failed to obtain and/or failed to document obtaining an OARRS review, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(h) Since in or about February 2008, until at least in or about May 2022, you provided care and treatment for Patient 8, for conditions that included Bipolar Disorder, ADHD and Intermittent Explosive Disorder. In the course of your treatment of Patient 8, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you prescribed Adderall, Ritalin and Effexor above the daily maximum dosage recommended by the manufacturer, and these dosage levels are unsupported by clinical documentation. Further, you continued to prescribe psychostimulants despite repeated occurrences of misuse and Patient 8's reporting of active binge use of alcohol and cannabis. Further, you failed to appropriately order bloodwork to evaluate evidence of metabolic syndrome despite prescribing antipsychotic medication. Further you failed to obtain or failed to document obtaining past treatment records for collateral information. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the times and frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(i) Since in or about March 2017, until at least in or about April 2019, you provided care and treatment for Patient 9, for conditions that included ADHD and PTSD. In the course of your treatment of Patient 9, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you prescribed Adderall, Focalin XR and Zoloft above the daily maximum dosage recommended by the manufacturer, and these dosage levels are unsupported by clinical documentation. Further, you continued to prescribe psychostimulants despite repeated occurrences of overuse and reports of misuse. Further, you failed to obtain Patient's 9's weight or appropriately order bloodwork to evaluate evidence of metabolic syndrome or complete an AIMS exam despite prescribing

antipsychotic medication for extended period of time. Further you failed to obtain or failed to document obtaining past treatment records for collateral information. Further, you failed to obtain and/or failed to document obtaining an OARRS review at the times and frequency required, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

(j) Since in or about November 2015, until at least in or about June 2018, you provided care and treatment for Patient 10, for conditions that included ADHD, Bipolar Disorder and PTSD. In the course of your treatment of Patient 10, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course- to the degree of a covering provider not being able to clearly determine care plan to be able to provide continuity of care if needed. The progress notes were unmodified across multiple visits. Further, you failed to obtain Patient's 6's weight or appropriately order bloodwork to evaluate evidence of metabolic syndrome or adequately complete an AIMS exam despite prescribing antipsychotic medication for extended period of time. Further you failed to obtain or failed to document obtaining past treatment records for collateral information. Further, you failed to obtain and/or failed to document obtaining an OARRS review, random toxicology screens, pill counts or a controlled substance agreement despite prescribing controlled substances.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through (j) above, individually and/or collectively, constitute "[f]ailure to maintain minimal standards applicable to the selection or administration of drugs, or failure to employ acceptable scientific methods in the selection of drugs or other modalities for treatment of disease," as that clause is used in Section 4731.22(B)(2), Ohio Revised Code.

Further, your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2) (a) through (j) above, individually and/or collectively, constitute a "departure from, or the failure to conform to, minimal standards of care of similar practitioners under the same or similar circumstances, whether or not actual injury to a patient is established," as that clause is used in Section 4731.22(B)(6), Ohio Revised Code.

Additionally, your acts, conduct, and/or omissions that occurred on or after December 31, 2015, as alleged in paragraphs (1) and (2)(a) through (j) above, individually and/or collectively, constitute "violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provisions of this chapter or any rule promulgated by the board," as that clause is used in Section 4731.22(B)(20), Ohio Revised Code, to wit: Standards and Procedures for Review of "Ohio Automated Rx Reporting System" (OARRS), Rule 4731-11-11, Ohio Administrative Code, as currently in effect.

Furthermore, for any violations that occurred on or after September 29, 2015, the Board may impose a civil penalty in an amount that shall not exceed twenty thousand dollars, pursuant to Section 4731.225, Ohio Revised Code. The civil penalty may be in addition to any other action the Board may take under section 4731.22, Ohio Revised Code.

Pursuant to Chapter 119., Ohio Revised Code, you are hereby advised that you are entitled to a hearing in this matter. If you wish to request such hearing, the request must be made in writing

and must be received in the offices of the State Medical Board within thirty days of the time of service of this notice.

You are further advised that, if you timely request a hearing, you are entitled to appear at such hearing in person, or by your attorney, or by such other representative as is permitted to practice before this agency, or you may present your position, arguments, or contentions in writing, and that at the hearing you may present evidence and examine witnesses appearing for or against you.

In the event that there is no request for such hearing received within thirty days of the time of service of this notice, the State Medical Board may, in your absence and upon consideration of this matter, determine whether or not to limit, revoke, permanently revoke or suspend your license or certificate, or refuse to grant or register or issue the license or certificate for which you have a pending application in accordance with Section 9.79 of the Ohio Revised Code, or refuse to renew or reinstate your license or certificate to practice medicine and surgery, or to reprimand you or place you on probation.

Please note that, whether or not you request a hearing, Section 4731.22(L), Ohio Revised Code, provides that "[w]hen the board refuses to grant or issue a license or certificate to practice to an applicant, revokes an individual's license or certificate to practice, refuses to renew an individual's license or certificate to practice, or refuses to reinstate an individual's license or certificate to practice, the board may specify that its action is permanent. An individual subject to a permanent action taken by the board is forever thereafter ineligible to hold a license or certificate to practice and the board shall not accept an application for reinstatement of the license or certificate or for issuance of a new license or certificate."

Copies of the applicable sections are enclosed for your information.

Sincerely,

Kim G. Rothermel MD

Kim G. Rothermel, M.D.
Secretary

KGR/MAP/lv
Enclosures

Via email: Jhtmd@ix.netcom.com

IN THE MATTER OF JAMES H. THOMAS, M.D.

24-CRF-0133

JULY 10, 2024, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY AND MAINTAINED IN CASE RECORD FILE.