State Medical Board of Ohio

30 E. Broad St., 3rd Floor
Columbus, Ohio 43215
(614) 466-3934
www.med.ohio.gov

September 11, 2024

Case number: 24-CRF-0168

Rodney E. Vivian, M.D.
8253 Jakaro Drive
Cincinnati, Ohio 45255
Rpilot1032@aol.com

Dear Doctor Vivian:

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 2005 to in or around 2023, you provided care and treatment for Patients 1 through 5, 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 July 2018, until at least in or around August 2023, you provided care and treatment for Patient 1, for Attention-deficit/hyperactivity disorder [ADHD]. In the course of your treatment of Patient 1, you failed to coordinate care with Patient 1's other care providers despite evidence of multiple prescriptions for opiates and Patient 1's self-report of other medications from other providers. Further, you prescribed Adderall over daily FDA maximum without supporting documentation or data support. Further, you continued to prescribe very high doses of Adderall when there was evidence of Patient 1 misusing the prescribed Adderall. Further, you failed to perform blood pressure tests and to obtain or document heart rates, failed to adequately obtain or document weight, failed to obtain or document urine drug screens and failed to adequately respond to red flags regarding possible drug abuse.

(b) Since in or about December 2005, until at least in or about February 2023, you provided care and treatment for Patient 2, for conditions that included Major Depressive Disorder and ADHD. In the course of your treatment of Patient 2, you failed to conduct office visits at the appropriate frequency. Further, you failed to obtain mental status exams at the appropriate frequency and failed to obtain vital

signs. Despite Patient 2's report that outside providers were prescribing him Cymbalta, Lyrica, Fentanyl, Percocet and nortriptyline, you failed to obtain past treatment records for collateral information. Your documentation of symptoms warranting and supporting medication therapy was inadequate throughout the treatment course. Further, you continued to prescribe Xanax despite assessing Patient 2 with symptoms possibly caused or exacerbated by this medication therapy, such as multiple episodes of falling. Further, your documentation to support diagnoses and treatment plan including medication therapies was inadequate throughout the treatment course. Further, you prescribed Adderall, above the daily maximum dosage recommended by the FDA, and these dosage levels were unsupported by clinical documentation.

(c) Since in or about August 2020, until at least in or about February 2023, you provided care and treatment for Patient 3, for conditions that included Bipolar Disorder, ADHD and Generalized Anxiety Disorder [GAD]. In the course of your treatment of Patient 3, you failed to obtain weight and vital signs after the initial patient appointment during the entirety of the treatment. Further, despite concern that the patient had an active cannabis and alcohol use disorder, you failed to inquire or failed to document inquiring about any other substance use after the intake appointment or seek to confirm with an OARRS report or conduct a urine drug screening. Further, you failed obtain a mental status exam, interim substance use history or mood destabilization history. Further, you conducted office visits with Patient 3 as infrequently as twice a year, without consistent documentation of interval hypomanic/manic symptoms, mental status exams or risk assessments at every appointment. Further, you failed to provide proper oversight of the use of Celexa with follow-ups scheduled to assess for the need to titrate the medication.

(d) Since in or about July 2017, until at least in or about September 2022, you provided care and treatment for Patient 4 for ADHD. In the course of your treatment of Patient 4, you failed to coordinate care with the patient's other providers and continued to prescribe stimulants despite Patient 4's history of strokes, concurrent comorbidities and known cardiovascular issues. Further, you prescribed higher does than recommended of Methylphenidate and Adderall. Further, you failed to adequately perform blood pressure readings, only taking a blood pressure reading one time in five years. Further, you failed to a regularly update the medication lists or lab values to understand Patient 4's changes in health status over the course of his treatment, and you failed to routinely screen for other substance use. Further, you failed to perform adequate mental status examinations and risk assessments; and you failed to assess Patient 4's interim mood, anxiety or psychosis.

(e) Since in or about July 2020, until at least in or about April 2023, you provided care and treatment for Patient 5 for ADHD. In the course of your treatment of Patient 5 who was a four-year old child at the beginning of treatment, you performed a mental status examination on his first visit; however, you failed to perform a mental status examination again over the course of Patient 5's treatment. Further, you failed to document if Patient 5 was present at another appointment over the nearly three years that he was being prescribed stimulants, including methylphenidate liquid and clonidine. Further, you failed to conduct a

risk assessment for any follow-up appointments throughout care. Further, despite receiving reports from Patient 5's mother that the patient's symptoms were worsening, you failed to perform a full assessment or consider an alternative or additional diagnoses. Further, you failed to obtain Patient 5's weight and vital signs during the entirety of the treatment, which is particularly pertinent when prescribing stimulants to a child.

Your acts, conduct, and/or omissions as alleged in paragraphs (1) and (2)(a) through (e) 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.

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, M.D.
Secretary

KGR/MAP/lv
Enclosures

Via Email: Rpilot1032@aol.com

IN THE MATTER OF RODNEY F. VIVIAN, M.D.

24-CRF-0168

SEPTEMBER 11, 2024, NOTICE OF OPPORTUNITY FOR HEARING - PATIENT KEY

SEALED TO PROTECT PATIENT CONFIDENTIALITY