IN AND BEFORE THE OKLAHOMA STATE BOARD
OF MEDICAL LICENSURE AND SUPERVISION
STATE OF OKLAHOMA

FILED
FEB 12 2004
OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION

STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 03-08-2708**
MARK EDWARD REIHELD, M.D., LICENSE NO. 23029,	)	
Defendant.	)	

COMPLAINT

COMES NOW the Plaintiff, the State of Oklahoma ex rel. the Oklahoma State Board of Medical Licensure and Supervision (the "Board"), by and through its attorney, Elizabeth A. Scott, Assistant Attorney General, and for its Complaint against the Defendant, Mark Edward Reiheld, M.D., alleges and states as follows:

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.*

2. Defendant, Mark Edward Reiheld, M.D., holds Oklahoma license no. 23029.

3. From August 1, 2002 until September 8, 2003, Defendant wrote or authorized 172 prescriptions for controlled dangerous drugs to Patient JBW for alleged back pain. These prescriptions include eighty-six (86) prescriptions for Demerol, Duragesic Patch, Methadone, Roxicet and Oxycodone, Schedule II controlled dangerous drugs, for a total of 1197 dosage units, twenty-nine (29) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 2580 dosage units, and fifty-seven (57) prescription for Ambien, Carisoprodol, Pentazocine, Alprazolam and Diazepam, Schedule IV controlled dangerous drugs, for a total of 5295 dosage units, for an average of **23.32 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he failed to obtain a full history of the patient, that he did not order appropriate tests, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

4. From August 12, 2002 until August 26, 2003, Defendant wrote or authorized 78 prescriptions for controlled dangerous drugs to Patient RDW for alleged back pain and kidney stones. These prescriptions include forty-four (44) prescriptions for Demerol, Roxicet, Endocet and Oxycodone, Schedule II controlled dangerous drugs, for a total of 3585 dosage units, seven (7) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 570 dosage units, and twenty-seven (27) prescriptions for Carisoprodol, Alprazolam and Diazepam, Schedule IV controlled dangerous drugs, for a total of 2530 dosage units, for an average of **18.32 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he did not establish a legitimate medical need for the medications and he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

5. From August 5, 2002 until September 8, 2003, Defendant wrote or authorized 34 prescriptions for controlled dangerous drugs to Patient BDW for alleged back pain. These prescriptions include sixteen (16) prescriptions for Oxycodone, a Schedule II controlled dangerous drug, for a total of 3780 dosage units, one (1) prescription for Hydrocodone, a Schedule III controlled dangerous drug, for 180 dosage units, sixteen (16) prescriptions for Carisoprodol and Temazepam, Schedule IV controlled dangerous drugs, for 920 dosage units, and one (1) prescription for Diphenoxylate, a Schedule V controlled dangerous drug, for 20 dosage units, for an average of **12.73 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he did not establish a legitimate medical need for the medications and did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

6. From August 6, 2002 until August 5, 2003, Defendant wrote or authorized 52 prescriptions for controlled dangerous drugs to Patient JDW for alleged back pain. These prescriptions include sixteen (16) prescriptions for Oxycodone, a Schedule II controlled dangerous drug, for a total of 3120 dosage units, four (4) prescriptions for Mytussin AC Syrup, a Schedule III controlled dangerous drug, for 192 dosage units, thirty (30) prescriptions for Temazepam and Alprazolam, Schedule IV controlled dangerous drugs, for 1770 dosage units, and two (2) prescriptions for Diphenoxylate, a Schedule V controlled dangerous drug, for 40 dosage units, for an average of **14.07 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that he did not order appropriate tests, that he failed to perform a complete examination on this patient prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

7. From March 10, 2003 until September 3, 2003, Defendant wrote or authorized 15 prescriptions for controlled dangerous drugs to Patient RRW for alleged ankle pain. These prescriptions include twelve (12) prescriptions for Roxicet, a Schedule II controlled dangerous drug, for a total of 1225 dosage units, two (2) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 120 dosage units, and one (1) prescription for Pentazocine, a Schedule IV controlled dangerous drug, for a total of 100 dosage units, for an

average of **8.87 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that in April 2003, the patient's orthopedic physician recommended that he cease taking narcotic pain medication. However, Defendant continued to prescribe narcotics to the patient.

8. From August 12, 2002 until September 9, 2003, Defendant wrote or authorized 44 prescriptions for controlled dangerous drugs to Patient SFW for alleged back and neck pain. These prescriptions include twenty-one (21) prescriptions for Oxycontin, Methadone and Oxycodone, Schedule II controlled dangerous drugs, for a total of 4650 dosage units, twenty-three (23) prescriptions for Carisoprodol, Alprazolam, Diazepam and Temazepam, Schedule IV controlled dangerous drugs, for a total of 1302 dosage units, for an average of **15.70 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that the patient claimed that his medications were stolen several times, yet Defendant continued to prescribe to him. Additionally, the patient dictated what drugs he wanted and how often he wanted them. Defendant's chart additionally reveals that he did not order appropriate tests, that he failed to perform a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

9. From August 2, 2002 until September 5, 2003, Defendant wrote or authorized 51 prescriptions for controlled dangerous drugs to Patient DHW for alleged back pain. These prescriptions include twenty-nine (29) prescriptions for Hydrocodone, MyTussin AC and Acetaminophen/Codeine, Schedule III controlled dangerous drugs, for a total of 1463 dosage units, and twenty-two (22) prescriptions for Carisoprodol, Diazepam and Propoxyphene, Schedule IV controlled dangerous drugs, for a total of 1460 dosage units, for an average of **7.59 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that Defendant did not order appropriate tests, that he failed to perform an adequate physical examination, that he did not establish a legitimate medical need for the medications, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

10. From August 1, 2002 until September 9, 2003, Defendant wrote or authorized 37 prescriptions for controlled dangerous drugs to Patient BMW for alleged Reflex Sympathetic Dystrophy and anxiety. These prescriptions include twenty-two (22) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 1590 dosage units, and fifteen (15) prescriptions for Alprazolam, a Schedule IV controlled dangerous drug, for a total of 900 dosage units, for an average of **6.38 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that the patient claimed she lost her medications, that she smelled of alcohol on examination, and that her physical examination was not consistent with RSD. However, Defendant continued to prescribe controlled dangerous drugs to the patient. Additionally, Defendant's chart reveals no history to support the patient's alleged panic attacks, and no history or physical relating to the alleged RSD. Defendant's chart reveals that Defendant did not order appropriate tests, that he failed to perform an adequate physical examination, that he did not establish a legitimate medical need for the medical treatment, and that he did not

maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

11. From August 6, 2003 until July 17, 2003, Defendant wrote or authorized 29 prescriptions for controlled dangerous drugs to Patient JHW for alleged chronic back pain. These prescriptions include fifteen (15) prescriptions for Hydrocodone, a Schedule III controlled dangerous drug, for a total of 2962 dosage units, and fourteen (14) prescriptions for Diazepam, a Schedule IV controlled dangerous drug, for a total of 1260 dosage units, for an average of **12.24 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that while Defendant claims to be treating this patient for back pain, the patient's MRI showed no abnormalities. Additionally, the patient revealed a history of fatty alcohol hepatitis. However, Defendant continued to prescribe Hydrocodone to the patient. Defendant's chart reveals that Defendant ignored test results, that he did not establish a legitimate medical need for the medical treatment, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

12. From March 6, 2003 until September 25, 2003, Defendant wrote or authorized 7 prescriptions for Hydrocodone to Patient DRW, a 13-year old child, for alleged headaches. The patient had been taking Ritalin 15 mg. twice a day for 2-3 years and had developed headaches. Defendant's chart reveals that although no MRI was ever obtained and the patient was never sent to a neurologist to determine the reason for the headaches, Defendant continued to prescribe Hydrocodone to the child. Defendant's chart reveals that Defendant did not obtain appropriate tests, that he did not establish a legitimate medical need for the medical treatment, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

13. From August 8, 2002 until September 12, 2003, Defendant wrote or authorized 25 prescriptions for controlled dangerous drugs to Patient SRW for alleged back pain. These prescriptions include fourteen (14) prescriptions for Oxycodone, a Schedule II controlled dangerous drug, for a total of 2220 dosage units, and eleven (11) prescriptions for Diazepam and Temazepam, Schedule IV controlled dangerous drugs, for a total of 780 dosage units, for an average of **7.5 dosage units per day of controlled dangerous drugs.** Defendant's chart on this patient reveals that Defendant never performed a physical examination on the patient's back, nor did he order appropriate tests. Defendant's chart additionally reveals that he did not establish a legitimate medical need for the medical treatment, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

14. Defendant is guilty of unprofessional conduct in that he:

A. Engaged in dishonorable or immoral conduct which is likely to deceive, defraud or harm the public in violation of 59 O.S. §509(9) and OAC 435:10-7-4(11).

B. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(14) and OAC 435:10-7-4(39).

C. Prescribed a drug without sufficient examination and establishment of a valid physician patient relationship in violation of 59 O.S. §509(13).

D. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509(19) and 435:10-7-4(41).

E. Violated a state or federal law or regulation relating to controlled substances in violation of OAC 435:10-7-4(27), 63 O.S. §2-404 and OAC 475:25-1-3.

F. Prescribed, dispensed or administered a controlled substance or narcotic drugs in excess of the amount considered good medical practice, or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standards in violation of 59 O.S. 509(17).

G. Engaged in the indiscriminate or excessive prescribing, dispensing or administering of controlled or narcotic drugs in violation of OAC 435:10-7-4(1).

H. Committed gross or repeated negligence in the practice of medicine and surgery in violation of OAC 435:10-7-4(15).

I. Prescribed, dispensed or administered controlled substances or narcotic drugs in excess of the amount considered good medical practice or prescribed, dispensed or administered controlled substances or narcotic drugs without medical need in accordance with published standard in violation of OAC 435:10-7-4(2) and (6).

Conclusion

WHEREFORE, the Plaintiff respectfully requests that the Board conduct a hearing, and, upon proof of the allegations contained herein, impose such disciplinary action as authorized by law, up to and including suspension or revocation and any other appropriate action with respect to Defendant's medical license, and an assessment of costs and attorney's fees incurred in this action as provided by law.

Respectfully submitted,

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