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

FILED

SEP 23 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. MEDICAL LICENSE NO. 23029	)	
Defendant.	)	

VOLUNTARY SURRENDER OF LICENSE IN LIEU OF PROSECUTION

State of OKLA)
)
OKLA County)

I, Mark Edward Reiheld, M.D., being of lawful age and after first being duly sworn, depose and state as follows:

1 I hereby voluntarily surrender my Oklahoma medical license no. 23029.

2. The surrender of my license is freely and voluntarily made. I have not been subject to any coercion or duress, and I am fully aware of the consequences of the surrender of my license.

3. I am the subject of a Complaint before the Oklahoma State Board of Medical Licensure and Supervision involving allegations that if proven, would constitute grounds for disciplinary action by the Board.

4 The allegations to which I have plead guilty are as follows:

A. 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.** A review of Defendant's records reveals that Defendant kept no chart on Patient JBW to show (a) that he performed a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, (b) that he obtained a full history of the patient, (c) that he ordered appropriate tests, and (d) that he established a legitimate medical need for the medications. Defendant did not maintain any office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

B. 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.** A review of Defendant's records reveals that Defendant kept no chart on Patient RDW to show that he established a legitimate medical need for the medications. Defendant did not maintain an office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

C. 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.** A review of Defendant's records reveals that Defendant kept no chart on Patient BDW to show that he established a legitimate medical need for the medications. Defendant did not maintain an office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

D. 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.** A review of Defendant's records reveals that Defendant kept no chart on Patient JDW to show (a) that he ordered appropriate tests, (b) that he performed a complete examination on this patient prior to prescribing the controlled dangerous drugs, and (c) that he established a legitimate medical need for the medications. Defendant did not maintain an office record which accurately reflected the evaluation, treatment and medical necessity of treatment of the patient.

E. 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.

F. 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. A review of Defendant's records reveals that Defendant kept no chart on Patient SFW to show (a) that he ordered appropriate tests, (b) that he performed a complete physical examination on this patient prior to prescribing the controlled dangerous drugs, and (c) that he established a legitimate medical need for the medications. Defendant did not

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

G. 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.** A review of Defendant's records reveals that Defendant kept no chart on Patient DHW to show (a) that he ordered appropriate tests, (b) that he performed an adequate physical examination, and (c) that he established a legitimate medical need for the medications. Defendant did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

H. 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. A review of Defendant's records reveals that Defendant kept no chart on Patient BMW to show (a) that he ordered appropriate tests, (b) that he performed an adequate physical examination, and (c) that he established a legitimate medical need for the medical treatment. Defendant did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

I. 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. A review of Defendant's records reveals that Defendant kept no chart on Patient JHW to show (a) that he reviewed or acknowledged test results, and (b) that he established a legitimate medical need for the medical treatment. Defendant did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

J. 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. A review of Defendant's records reveals that Defendant kept no chart on Patient DRW to show (a) that he obtained appropriate tests, and (b) that he established a legitimate medical need for the medical treatment. Defendant did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

K. 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. A review of Defendant's records reveals that Defendant kept no chart on Patient SRW to show that he established a legitimate medical need for the medical treatment. Defendant did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

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

A. 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).

B. 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).

5. I hereby submit my wallet card and wall certificate as evidence of my intent to surrender my license.

6. I hereby agree that I will not apply for reinstatement of my Oklahoma medical license for a minimum of one year from the entry of the Order Accepting Voluntary Surrender in Lieu of Prosecution, and that if the Board ever reinstates my Oklahoma medical license, it will be under terms of probation to be set by the Board at the time of reinstatement.

7. As a condition to accepting my surrender of license in lieu of prosecution, I acknowledge that the Board may require me to pay all costs expended by the Board for any legal fees and costs, and any investigation, probation and monitoring fees, including but not limited to staff time, salary and travel expense, witness fees and attorney fees.

DATED this 20th day of Sept, 2004.

Mark Edward Reiheld MD
Mark Edward Reiheld, M.D.

Subscribed and sworn before me this 20th day of Sept., 2004.

Margaret McLeod
Notary Public

My commission expires on August 11, 2007

ACCEPTED:

Gerald Zumwalt MD
Gerald C. Zumwalt, M.D.
Secretary
Oklahoma State Board of Medical
Licensure and Supervision

Date: 9-24-04