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

STATE OF OKLAHOMA, *ex rel.* OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION,	)	
Plaintiff,	)	
v.	)	**Case No. 16-10-5374**
MARK REIHELD, M.D., LICENSE NO. MD 23029,	)	
Defendant.	)	

VERIFIED COMPLAINT

The State of Oklahoma, *ex rel.* Oklahoma State Board of Medical Licensure and Supervision ("Board"), for its Verified Complaint against Mark Reiheld, M.D. ("Defendant"), alleges and states as follows:

I. JURISDICTION

1. The Board has jurisdiction over the subject matter and 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. 59 O.S. 2011, § 480, *et seq.* and Okla. Admin. Code 435:5-1-1 *et seq.*

2. In Oklahoma, Defendant holds medical license no. 23029. The acts and omissions complained of herein were made while Defendant was acting as a physician pursuant to his medical license conferred upon him by the State of Oklahoma. Such acts and omissions occurred within the physical territory of the State of Oklahoma.

II. ALLEGATIONS OF UNPROFESSIONAL CONDUCT

3. This case was initiated as a result of two separate complaints being submitted to the Oklahoma State Board of Medical Licensure and Supervision regarding Defendant. On October 24, 2016, Oklahoma State Board of Medical Licensure and Supervision (OSBMLS) Investigator Larry Carter was assigned to investigate the two complaints.

4. One complaint came from a patient that was upset that Defendant no longer accepted Medicare and Medicaid causing the patient to have to pay $200.00 for each office visit, something the patient could not do on his fixed income.

5. The second complaint came from an Inspector Marty Hendrick with the Board of Pharmacy. Inspector Hendrick was informed by a pharmacist, that wishes to remain anonymous, that Defendant argued with and bullied the pharmacist in an attempt to get the pharmacist to fill several prescriptions for one of Defendant's patients.

   a. The argument began after normal business hours when one of Defendant's patients with an Arkansas driver's license brought in four (4) separate prescriptions for CDS (Oxycodone, MS Contin, Clonazepam, and Alprazolam), with the claim that the patient had filled similar prescriptions while living in Arkansas.

   b. The pharmacy technician also noted that all the prescriptions were written on a pad showing the Defendant's office to be in Ponca City, Oklahoma.

   c. The pharmacist checked the PMP system for both Oklahoma and Arkansas and found that the patient had no such prior prescriptions. The pharmacist refused to fill the prescriptions until they could be verified by Defendant.

   d. A short time later, Defendant went to the pharmacy and began arguing with the pharmacist. The pharmacist continued to refuse to fill the prescriptions despite Defendant claiming that he had just moved into an office next door to the pharmacy.

   e. The pharmacist did not disclose the patient name to Inspector Hendrick.

6. Chief OSBMLS Investigator Robert Duvall provided Investigator Carter several PMP reports for some of Defendant's patients. Three patients' files stood out from the rest.

   a. S.V. was identified as seeing five (5) physicians in addition to Defendant who initially prescribed to her on April 18, 2016. Investigator Carter later inquired with the PMP administrator and received PMP use records that indicated that Defendant did not start running PMP reports until November 2016.

   b. J.R. began obtaining CDS prescriptions from Defendant in March 2016. Initially, Defendant prescribed opioids equivalent to over 500 MME, as well as Diazepam 10 mg #120, to be used over thirty (30) days. J.R.'s most recent prescription, at the time of this investigation, filled on October 3, 2016, show that he was prescribed 780 MME per day, while the Diazepam prescription remained consistent. However, Defendant added SOMA #120 to J.R.'s regimen.

   c. D.M. first filled a prescription from Defendant on July 8, 2016. The prescription was written for Oxycodone 30 mg IR #120. Defendant gradually added new drugs to D.M.'s treatment. Between September 29, 2016, and October 7, 2016, D.M. filled prescriptions for Alprazolam 1 mg #90, Adderall 15 mg #90, Fentanyl 100 mcg/hr patch #15, Oxycodone 15 mg #120, and Oxycodone 30 mg #120. If taken as directed, D.M. would consume opioids equivalent to 630 MME per day.

7. A summary of Defendant's PMP prescribing record shows that Defendant issued 3,357 CDS prescriptions between July 30, 2016 and January 30, 2017. The three highest classes of drugs Defendant prescribed were opiate agonists (78.3%), benzodiazepines (14.8%),

and muscle relaxants (4.3%). These prescriptions account for 97.4% of the total number of prescriptions Defendant prescribed.

III. INTERVIEW OF DEFENDANT

8. On July 17, 2017, Investigator Carter met with Defendant, Defendant's attorney, Robert Gifford, and Defendant's office manager, Maggie Bostwick.

9. Investigator Carter and Defendant discussed Defendant's knowledge and background in pain management. Defendant began to explain his surrender of his Oklahoma medical license in lieu of prosecution in Oklahoma in 2004. He stated that at the time he surrendered his license he did not realize that it would affect his licenses in other states and prevent him from being able to bill Medicare or Medicaid. He further stated that he came back to Oklahoma to straighten out the situation with his Oklahoma license and go back to work.

10. Defendant advised that he is not board certified, and described his medical practice since obtaining his license as a "general practice". Defendant has treated numerous patients, for all sorts of ailments, including pain. Defendant's first formal introduction to pain management was when he accepted a job with Alpha Pain in Oklahoma City. Defendant stated that he tried to stay up with medical information and trends in this field. He stated that he was aware that many doctors are now claiming that there is no benefit to long term use of opioids in the treatment of chronic pain, however, Defendant claimed that he had not seen any formal studies that support this change.

11. Investigator Carter discussed the three patients that stood out on the PMP report, S.V., J.R. and D.M.

    a. Defendant advised that S.V. was noncompliant with her treatment and was released from Defendant's practice several months before July 2017. Defendant stated that he used the PMP on each patient's visit to his clinic, and he was aware of the other physicians giving S.V. the CDS, but the doses were low. Defendant stated that he tried to work with S.V., but it became apparent to him that she would never follow his medical advice. Defendant felt it was inappropriate for him to continue her care.

    b. J.R. was still being treated by Defendant in July 2017. Investigator Carter pointed out that J.R. was taking unusually large doses of CDS, which included SOMA and Valium. J.R. also takes 600 mg of Morphine Sulfate ER per day, along with 120 mg of Oxycodone IR. Investigator Carter asked Defendant if the Oxycodone was used for "breakthrough pain". Defendant responded that he does not like to use that phrase because it does not satisfactorily describe the situation. Defendant said that the extended release medicines are used to try to establish a steady baseline of pain relief. The immediate release medication is used regularly throughout the day to help stabilize the patient so there are not significant deviations from that baseline. Defendant went on to say that many of his patients will cut their 30 mg Oxycodone

tablets in half and increase the number of times each day they take their pills to achieve better management of their pain.

c. Investigator Carter asked Defendant to focus on the Fentanyl prescriptions D.M. filled on August 16, 2016 (Fentanyl 100 mcg/hour patches #15) and September 8, 2016 (Fentanyl 100 mcg/hour patches #3). Both prescriptions had been written in August 16, 2016. Defendant said that he did not specifically remember these prescriptions. Defendant stated that on occasion in the past, he has anticipated a patient's need for more medication before they were scheduled to return to his office for a new prescription. Defendant said that may have been the case for these two prescriptions.

12. Defendant then went on to acknowledge that he is aware of the increasing scrutiny being brought in the field of pain management. Defendant also understands that current trends in medicine show a declining use of benzodiazepines and SOMA when prescribing high doses of opioids. Defendant stated that he does not treat every patient with the same mixture of drugs. Defendant stated that he tries to tailor a drug regimen to meet each patient's individual needs. Defendant stated that his goal was to achieve adequate pain relief so that his patients could function on a daily basis as close to normal as possible.

13. On August 10, 2017, Investigator Carter subpoenaed the charts of S.V., J.R., and D.M., which were subsequently delivered to Physicians' Health Care Consulting, Inc., for expert review by Dr. George J. Heymach, M.D., PhD, MBA, an Internist and Board Certified in Addiction Medicine, and Paul M. Doskey, M.D., a Pain Management Anesthesiologist.

14. On September 21, 2017, a new complaint was filed with OSBMLS by a patient B.O. B.O. stated:

a. That she was being treated by Defendant for pain management. Defendant treated her chronic pain by prescribing 180 tablets of 30 mg Oxycodone, as well as 120 tablets of 15 mg Oxycodone for the first couple of months.

b. B.O. returned to Defendant's clinic after being injured in a motor vehicle accident in which she sustained broken bones in her back and a cracked skull. Defendant then increased her prescription of oxycodone 30 mg to 240 tablets, added 30 tablets of 4 mg Dilaudid, and continued her on 90 tablets of Xanax 1 mg.

c. After B.O. had been taking the high doses of medication for 3-5 months, she visited Defendant for a follow-up appointment. At that time, Defendant cut her prescription back to 180 tablets of Oxycodone 30 mg and 45 tablets Xanax 1 mg.

d. When B.O. asked Defendant why her prescriptions were being reduced so suddenly, she was told that the District Attorney was starting to check on Defendant, and he was worried about getting in trouble for who and what he was prescribing.

e. B.O. stated that she went into withdrawal and saw another physician who gave her a prescription for Oxycodone 20 mg to help her wean off the higher doses of medication Defendant had abruptly stopped.

f. When B.O. returned to Defendant for a check-up, Defendant terminated her as a patient for being prescribed the oxycodone 20 mg from the other physician.

15. On October 26, 2017, Investigator Carter subpoenaed the chart of B.O., which was subsequently delivered to Physicians' Health Care Consulting, Inc., for expert review by Dr. George J. Heymach, M.D., PhD, MBA, and Paul M. Doskey, M.D.

16. On November 13, 2018, expert review was tendered to Investigator Carter from Dr. Heymach and Dr. Doskey.

17. Dr. Paul Doskey provided an overall summary of the four (4) patient records he reviewed as well as the evaluation of each patient's chart. The following is Dr. Doskey's summary of Defendant's practice:

a. Dr. Doskey reviewed the charts of four (4) patients treated by Defendant. This included progress notes, office communications, results of laboratory testing, including urine drug screens, radiology results when performed, and reports from consultants or lack thereof.

b. Based on his review of the records, much of defendant's patient management is simply restating the patient complaints into a diagnosis without any objective data such as physical exams or radiographic findings. Defendant's therapy is primarily narcotic prescription with occasional use of electrostimulation or ultrasound therapy. There is little or no use of consultation.

c. Based on the urine drug screens provided, it appears that several of the patients may have been hoarding or diverting medications. Patient drug screens were often missing prescribed medications, although there were no alteration in prescribing. Defendant continued to administer drugs, often at high dosages. Despite warning signs of addiction, abuse and diversion, Defendant did not alter or reduce his prescribing.

d. Defendant appears to practice by rapidly increasing patients to high doses of opiates. Defendant does not use objective data or consultants to influence his prescribing. Defendant was not deterred by CDC guidelines or insurance maximums from continuing to increase opiate dosages.

e. From the records reviewed, there is no indication that Defendant's practice was safe or that his prescribing was reasonable. Many of Defendant's practices have the likely outcome of addiction, dependence, abuse and possible overdose. Warning signs were often ignored or not recognized.

18. Evidence determined through Dr. Doskey's expert review, that the specific patient records included the following:

19. Patient S.V.:

a. The plan of care for this patient was not appropriate. Opiates were prescribed, but minimal other therapy. The plan of care did not meet necessity. The plan of care only included prescription of narcotics and no electrostimulation. The patient's response to the plan of care was not monitored and modified as needed. Prescriptions were modified pursuant to subjective complaint. There was no objective data. There were some random drug screens, but Defendant did not respond accurately to results. Patient had missing medications which were not addressed. The PMP was not documented as being checked on a frequent basis. The patient's controlled medication was never counted at any office visit. The patient's medical records from other treating physicians, hospitals or clinics were not attached to the medical chart. The patient's medical records only included the records for the initial referral. There were no other notes seen or referenced. The only diagnostic study performed was an outside X-ray. No MRI was ordered.

b. Defendant's practice of medicine was not considered safe. The medication regimen was not safe. The quantity of medication ordered was not safe. It was inconsistent and there were multiple prescribers. There was potential harm for addiction, abuse, diversion, and overdose.

c. Patient was initially referred to Defendant in April 2016 with complaints of right shoulder pain from a motor vehicle accident that occurred January 1, 2016. She had been seen with negative X-rays. Patient was scheduled for physical therapy. Patient attended one appointment, in which she was unable to participate, and then stopped attending. Patient was initially not seeking medication, but very early on was concerned about inadequate pain relief and requirements for complete disability.

d. Defendant ordered urine drug screens for patient, but they consistently showed no oxycodone or its metabolites. In August 2016, the urine drug screen showed metabolites of Hydrocodone, but no active Hydrocodone. Another urine drug screen did not check for Hydrocodone. State PMPs showed that patient consistently received opiates from other providers in violation of the narcotic's agreement. These were never addressed until her final dismissal from Defendant's clinic in July 2017.

e. Defendant either did not recognize or ignored the warning signs of addiction, dependence, or possible divergence. Patient's pain was out of proportion to the initial injury. Rather than improve with time, it required constant increasing doses of opiates without any objective improvement. Patient lost or had undocumented destruction of her medications on multiple occasions. Patient presented for early refills often and was belligerent and demanding about the refills. Patient frequently ran out of medications early because of increased use and never completed the proposed pill counts that were scheduled. Patient seemed to dictate medications which were met by Defendant.

f. Patient's initial complaint was a right shoulder injury. Her X-ray, which was never repeated, was completely normal. Despite this, Defendant diagnosed her with a torn rotator cuff. There was no MRI to confirm the diagnosis, and she was never referred to an orthopedic surgeon for evaluation and possible surgical repair. Most of patient's office visits were centered on subjective complaints with minimal or no physical exam.

g. Between the poor record keeping, the constant changing of medications and early refills, it is difficult to ascertain at any given time exactly what patient was supposed to be taking and what she had in her possession at any given time. The potential for addiction and abuse, as well as diversion, was very significant. Warning signs were ignored. Patient's primary conditions were never addressed, only symptomatic treatment offered. While patient's absolute drug doses were not extreme, they are out of proportion to the problem, and the long term plan (or lack thereof) would reach extreme doses of opiates.

20. Patient J.R.:

a. The plan of care for this patient was not appropriate. There was consistently high doses of narcotics. The plan of care did not meet medical necessity. Defendant increased opiates in response to patient complaints. The patient's response to the plan of care was not monitored and modified as needed. There was little monitoring. There was only subjective complaints. Defendant only increased opiates. The PMP was checked occasionally. The patient's controlled medication was not counted at any office visit. The patient's medical records from other treating physicians, hospitals or clinics were not attached to Defendant's medical chart. There were no diagnostic studies performed. The only alternative therapy ordered was electrostimulation. There were no consultations with medical specialists.

b. Defendant's practice of medicine was not considered safe. The medication regimen was not safe. The quantity of medication ordered was not safe. There was potential harm for addiction, dependence, and likely overdose. Defendant started patient at very high opiate doses and continued to escalate. The primary therapy was high dose narcotics with SOMA and Diazepam. Defendant escalated to 1 gram MME in less than a year, and patient showed no subjective or objective signs of improvement.

c. Patient began seeing Defendant in January 2017, for "failed back syndrome" and chronic pain. Patient was injured at work and had a subsequent decompression and fusion. The initial office notes state patient was already on Morphine ER 100 mg TID with instant release Morphine 30 mg before seeing Defendant, but no indication on state PMP of these medications. Patient was also on Diazepam 10 mg TID.

d. Defendant rapidly escalated patient's medications, going from the Morphine ER 100 TID to QID, then to 200 mg TID. Defendant also changed instant release

Morphine to instant release Oxycodone. The Oxycodone was increased. In August 2017, patient was receiving Oxycodone IR 30 mg six (6) times a day and Oxycodone 15 mg six (6) times a day. This put patient at over one (1) gram MME daily. With the recommendation of keeping these limits below 90 MMEs, and significant concern with doses over 200 MMEs, escalating over 1000 MMEs is rarely indicated. Defendant proceeded despite warning from insurance stating that doses over 400 MMEs would not be covered.

e. Throughout the course of patient's therapy, Defendant never ordered diagnostic testing (X-ray, MRI, CT, myelogram, EMG) or any consultation to assist with pain management. The only therapy, besides escalating narcotics, performed was electrostimulation therapy. There was little monitoring (urine drug screens or pill counts) despite the high doses of opiates. There was very little in terms of documentation of physical examinations with rare exceptions. There was also little or no documentation of improvement despite the continued increase of opiates. Pain was almost always rated 8/10. There was no demonstration of increased activity or productivity.

f. In addition to the opiates, Defendant also prescribed Diazepam 10 mg QID and SOMA. Combing central nervous system ("CNS") depressants with high dose opiates synergistically increases risks and toxicity for overdose. On screening surveys, patient is a high risk individual for abuse and addiction. Patient reported family history of both substance abuse of illegal and prescription medications.

g. Failed back syndrome is often difficult to manage and is often complicated. In a patient with high risk for substance abuse and addiction, escalation to high dose narcotics should be an absolute last resort, after all other options are exhausted. Other options were not even entertained, and other physicians were not consulted to assist. Surgical consultation for treatment and psychiatric consultation to monitor for abuse and addiction would be a minimum.

h. This patient survived this therapy, but detoxification and future treatment will be extremely complicated. This was only made worse by the rapid escalation to extreme doses of opiates. There doesn't appear to be multiple prescribers, but there was no need. Defendant was happy to accommodate patient's wants. If patient were to require surgery, pain management would be nearly impossible. This would make surgical evaluation even less likely in the future, as the risks and difficulty of management would be excessive.

i. The mismanagement of patient's pain will be difficult to correct. Before moving forward he would likely require extensive detoxification and rehabilitation. I do not believe it was Defendant's intention to harm patient, but the damage was clearly done.

21. Patient D.M.:

a. The plan of care for this patient was not appropriate. Defendant only added opiates and increased doses. Appropriate diagnoses were not made. Defendant diagnosed patient with Attention Deficit Disorder with no support. The plan of care did not meet medical necessity. There was no diagnostic testing and dangerous prescribing. Defendant monitored patient's response to the plan of care by noting, "no change", and notes occasional improvement. The response to the pain scale remains the same and there is no improved function. Defendant modifies the plan of care only by increasing opiates. Random urine drug screens were only performed twice and patient was never checked for Fentanyl. Defendant did not respond accurately to the results. The first drug screen did not have oxycodone and this was not addressed. The PMP was not documented as being checked on a frequent basis. The patient's controlled medication was not counted at any office visit. The patient's medical records from other treating physicians, hospitals or clinics were not attached nor referenced in the medical chart. No diagnostic studies were ever performed. Minimal alternate therapies were ordered. No consultations with medical specialist were conducted.

b. Defendant's practice of medicine is not considered safe. There was a dangerous escalation of opiates. The medication regimen was not safe. The quantity of medication ordered is not considered safe. There was potential harm of addiction, dependence, and a risk of overdose. The primary therapy was escalation of opiates. There was no consultation, diagnostic testing, and minimal other therapy. Defendant prescribed high dose opiates with benzodiazepines and amphetamines without alternatives or consultation. There is a high risk for dependence and addiction. Defendant's notes were poor to justify prescribing.

c. Patient started seeing Defendant in July 2017, for multiple injuries suffered in a motor vehicle accident. Among other injuries, patient suffered from a closed head injury with resultant cognitive deficits. This is mentioned because it makes polypharmacy and high dose opiates more risky. Also, the risk of addiction and dependence is increased. Defendant escalated and changed medications frequently.

d. The progress notes reviewed showed regular subjective complaints, but few actual physical exams. In the typed notes, physical examination is rarely repeated, just continued from previous exams. In a patient on high dose opiates, frequent examination and documentation of status is critical. Merely stating, "unchanged", or, "no change", as the majority of the notes is not satisfactory. This is particularly true when medications are changed or increased. Further, often the notes did not correlate with the actual prescriptions, but were carried over from the previous visit.

e. Initially, patient was on Fentanyl 75 mcg/hour patches and Oxycodone 15 mg QID. Defendant increased patient to Fentanyl 100 mcg/hour patches and increased to Oxycodone 30 mg QID. This brings patient over 400 MMEs. This does not appear to have made a significant difference. Pain scores still 6-7/10 and no documented increase in activity or function. Later the Oxycodone 15 mg QID was added to bring the dose to over 500 MMEs. Occasionally, Oxycodone was changed to six (6) times daily.

f. Adderall was used for treatment of Attention Deficit Disorder. There is no mention of testing or evaluation regarding either patient's diagnosis or response to therapy. As the prescribing physician, some documentation of the diagnosis or response to therapy would be expected. This is mentioned because Adderall is highly addictive and caution needs to be used when combining with sedatives and opiates.

g. In May 2017, Defendant changes Fentanyl patches to Methadone 20 mg BID. He did this due to difficulties with Fentanyl reimbursement and decreased efficacy of the patch. Methadone and amphetamines combined add increased cardiac risk factors. An initial ECG was done prior to starting the Methadone, but never repeated or rechecked.

h. Overall, Defendant's treatment of patient consisted of increasing opiate load with minimal documentation. The risks of addiction, tolerance, and dependence were not appreciated. No alternate therapies or consultations were provided. There is no long term viable plan.

22. Patient B.O.:

a. The plan of care for this patient was not appropriate. Appropriate diagnoses were not often made. Defendant merely restated subjective complaints. The plan of care did not meet medical necessity. The patient's response to the plan of care was not monitored or modified as needed. The care was directed by patient complaints without documentation or objective findings. There were two (2) random urine drug screens performed. Defendant did not respond accurately to them. The PMP was not documented as being checked on a frequent basis. The PMP was checked once. The patient's controlled medication was not counted at any office visit. The chart stated that the patient did not come in. The patient's medical records from other treating physicians, hospitals, or clinics were not attached to the medical chart. Diagnostic studies were not performed. Alternative therapies were not ordered. Consultation with medical specialists were not conducted.

b. Defendant's practice of medicine is not considered safe. The medication regimen was not safe. The quantity of medication ordered is not considered safe. There is significant potential harm for addiction and overdose. Patient started on significant doses of medications which were increased. Patient spent most of the time at greater than 300 MMEs. Patient did not comply with pill counts. Urine drug screens were inadequate and not responded to. There were no minimal objective findings. No alternative therapies or consultations were ordered. Patient's entire treatment consisted of increasing opiates and benzodiazepines. Patient is at a high risk for dependence, addiction, and possible overdose.

c. Patient initially saw Defendant on December 21, 2016, for multiple pain complaints. Patient's complaints included intestinal parasites, chronic back pain from childbirth, arthritic pain, and headaches. A minimal physical examination was performed, but nothing to support her diagnoses. Defendant did not order any of the appropriate diagnostic tests or consultations. Instead, Defendant simply

added opiates and benzodiazepines to meet patient's requests. Defendant did obtain a narcotic agreement on the first visit, prior to prescribing the medications.

d. Patient claimed, or Defendant documented, that patient was taking Oxycodone 30 mg four (4) times daily for two (2) years with additional opiates. The State PMP shows the patient had not received any opiates in the nine (9) months prior to seeing Defendant. In 2015 and early 2016, patient did appear to receive Oxycodone 30 mg approximately six (6) times daily. This is a very high dose of opiates, approximately 270 MMEs, without much supporting documentation. Defendant merely accepted this information and increased patient's medications at the patient's request.

e. Patient completed two (2) urine drug screens. The first was six (6) months into treatment and the second was the following month. On the first drug screen the patient showed narcotics, but not Oxycodone. The second drug screen showed Oxycodone. Otherwise the drug screens were concordant. These appeared to be field urine drug screen tests which were never sent for confirmation as indicated they would be. Further, there is no indication that the urine was checked for adulterants or dilution. These are incomplete at best.

f. There were no records from any other physician either in patient's initial presentation or throughout her course of therapy. There is no indication that any therapy, other than opiates and benzodiazepines, were offered or performed. There is no objective evidence, until the motor vehicle accident, demonstrating injury or cause of pain. There is nothing to support, or treat, a parasitic infection.

g. The high doses of opiates, particularly when combined with benzodiazepines, have a huge potential for dependence, addiction, and significant risk of overdose. Further, not addressing any sources of pain or trying to treat underlying conditions did not properly manage the patient. This would make proper management by other physicians difficult.

h. Defendant rapidly escalated this patient, who had been opiate naïve, no opiates for nine (9) months, to 270 MMEs, and then to 450 MMEs, while also increasing benzodiazepine use. There is more than reasonable concern that patient was diverting medications, as there appears to be no change or adverse effects, from any of the changes in patient's medications. Also, her initial urine drug screen did not show oxycodone. Not showing up for mandatory pill counts and request for early refills of medications are also causes of concern for possible diversion or misuse.

i. On September 21, 2017, Defendant did fire patient for receiving opiates from another pain management physician. This was appropriate, but overdue.

j. Overall, Defendant did a poor initial assessment, and immediately prescribed high doses of opiates which he combined with benzodiazepines. No attempts were made to diagnose, treat, or seek help for any underlying conditions. Opiates escalated

quickly and regulatory measures were ignored. Patient's pain was mismanaged with significant potential harm to the patient and signs of diversion were ignored.

23. Evidence determined through Dr. Heymach's expert review, that the specific patient records included the following:

24. Patient S.V.:

a. The plan of care for this patient was not appropriate. Appropriate examinations were not performed. An MRI was not done. No objective studies were done. Appropriate diagnoses were not made. The plan of care did not meet medical necessity. The patient's response to the plan of care was not monitored and modified as needed. The PMP appeared to be ignored. There was not actual harm, but patient will need to be detoxed from opiates.

b. Patient was twenty-nine (29) years old when she first encountered Defendant. Patient reported a motor vehicle accident on January 1, 2016, in which patient sustained injury to right shoulder. Defendant began ordering Percocet 10 mg TID, but by late March, increased the Percocet to QID.

c. It is germane to note that patient saw four (4) different physicians in the three (3) weeks after mid-February 2016, for opiates. Certainly the last three (3) could/should have known of the prior prescriptions. Patient went to physical therapy once on April 4, 2016. Patient had pain and refused to go back and requested to Defendant that she be "declared totally disabled" from the right shoulder injury. Patient stated she "wanted medications for pain".

d. On April 18, 2016, a urine drug screen showed no oxycodone. However, patient had received 168 Percocet from the VA on March 9, 2016. Diversion certainly should have been likely.

e. From July 2016, until patient left Defendant's practice, patient violated the drug agreement dated January 25, 2017, numerous times. Defendant knew or should have known and either have terminated the patient or documented his knowledge of patient drug seeking and given her a final warning.

f. The amount of medication prescribed was way out of proportion to what should have been patient's complaints. No MRI was obtained so we cannot establish if there was in fact a serious right shoulder injury.

g. In June 2017, just before Defendant stated he became aware of patient's "violation", patient was taking Oxycodone 30 QID, Tramadol 50 six (6) times daily, Lorazepam 1 mg BID, and SOMA 325 BID, totaling 210 MMEs, as well as Lorazepam 1 mg BID and SOMA.

h. The very substantial dosage of opiates for questionable indication is of concern as it potentiates dependence and addiction. This patient had many flags which should have been addressed earlier.

25. Patient J.R.:

a. The plan of care for this patient was not appropriate. The opiate usage was inappropriate. Appropriate examinations were not performed. Appropriate diagnoses were not made. Diagnoses reflected patient's complaints. The plan of care only addressed subjective pain. The patient did not appear to worsen from treatment, but it will be difficult to detox patient. The harm to this patient is related to development of dependence on drugs with high lethal potential.

b. Patient was fifty-eight (58) when he first encountered Defendant on March 22, 2016. The medical record is very incomplete until encounter report in November 2016. The record indicates that patient underwent a laminectomy and had, "failed back syndrome", with chronic pain. While the record suggests that patient was receiving Morphine ER 100 mg TID, Morphine Sulfate 30 mg every four (4) hours, 480 MMEs and Valium 10 mg TID, that is not shown in the Oklahoma PMP report.

c. The PMP documents that in March and April 2016, Diazepam 10 mg QID and MS-ER 100 mg QID was ordered. Immediate release MS 30 mg QID were added. However, the August 2016, progress notes state that patient was ordered MS Contin 200 mg TID, Oxycontin 30 mg QID to six (6) times daily and Norco 10 BID, totaling 1025 MMEs, with Diazepam 20 mg QID.

d. Failed back syndrome can be very difficult to address, and we note that Defendant also attempted electrostimulation. The dosages of opiates are enormous, and while pain needs to be addressed, the very high levels of opiates is very fraught with marked respiratory suppression. The very high and inappropriate dosage of Diazepam is unexplained and is the second component in the potentially lethal cocktail.

e. Opiates are necessary in many situations, but referral to pain medicine trained experts in anesthesia and physiatry are appropriate in situations like this after the patient is detoxed from these potentially lethal and dependency inducing opiates and benzodiazepines.

26. Patient D.M.:

a. The plan of care for this patient was not appropriate. The medication management is unclear. Appropriate examinations were performed occasionally. The diagnoses made resembled patient's complaints. The plan of care did not meet medical necessity. Excessive opiates were administered. The patient did not appear to worsen from treatment rendered. Patient was on huge doses of opiates and inappropriate amphetamines.

b. Patient was forty-five (45) when he first encountered Defendant, apparently on July 7, 2016. The history and physical examination are provided and monthly progress notes are documented.

c. When initially seen in mid-2016, patient was on Fentanyl patch 75 mcg/hour, Oxycodone 15 mg QID with Alprazolam 0.5 mg TID, totaling 270 MMEs.

d. Defendant doubled the oxycodone to 30 mg QID, increased the Fentanyl patch to 100 mcg/hour, added Lyrica 75 mg BID and increased the alprazolam to 0.5 mg QID, totaling 420 MMEs. This is a 55% increase in opiate equivalent.

e. It was hard to discern any significant benefit to the patient. Oxycodone 15 mg QID was added, and patient reported some improvement. At this point the patient was taking 510 MMEs.

f. In May 2017, Defendant added Methadone 20 mg BID to the Oxycodone 30 and 15 mg QID with planned termination of the Fentanyl patch, despite the patient filling an earlier script in June 2017 for the patch. This rendered for some time, the phenomenal 830 MMEs, which was decreased to 590 MMEs when the patch was finally stopped. Defendant's reason to switch to Methadone was, "discussed switch of long acting narcotics to methadone", which would be interesting except that the only, "long acting narcotic", was the Fentanyl patch which was inappropriately prescribed at twenty-four (24) hours and it was a seventy-two (72) hour patch. The Oxycodone was not long acting and potentially would have made more sense to use Oxycontin.

g. While the documentation appears better than a prior patient's chart, there is no clarity or appreciation for other modalities of treatment rather than increasing opiates, which at higher dosages often can produce hyperalgia. Further, these drugs at these dosages potentiate rapid dependence.

h. The quizzical use of Adderall, an amphetamine, because patient perhaps had Traumatic Brain Injury ("TBI") from a motor vehicle accident adds just another medication with abuse and dependence potential, with no proven value for TBI.

27. Patient B.O.:

a. The plan of care for this patient was not appropriate. The appropriate examinations were not performed. The diagnoses made were continued and reflected subjective complaints. The plan of care did not meet medical necessity. The patient appeared to divert and/or doctor shop for medications as a response to the plan of care. As far as harm to the patient, there was a delay in reducing the dosage of opiates. Patient's urine drug screens appear to have been ignored.

b. Patient was twenty-six (26) when she first encountered Defendant on December 21, 2016. The history and physical examination as presented at that time is woefully incomplete and certainly does not explain the resultant need, reasoning or objective diagnoses used, to order Oxycodone 30 mg six (6) times daily, totaling 270 MMEs, with Xanax 1 mg BID. The Oklahoma PMP, which Defendant should have reviewed would have revealed that patient had not been on Oxycodone for at least ten (10) months.

c. The enormous dose of Oxycodone Defendant ordered, and continued to order, while clearly inappropriate, additionally set patient up for dependency and addiction.

d. In January 2017, patient had stomach pain and Defendant's response was to add Oxycodone 15 mg QID as needed to the regimen.

e. Patient had a motor vehicle accident on March 31, 2017, and sustained multiple injuries. Patient stated she, "lost her 30 mg oxycodone", and on April 17, 2017, Defendant gave patient an early refill of the Oxycodone 30 mg six (6) times daily, which was added to the Oxycodone 15 mg QID as needed. Defendant then added Dilaudid 4 mg #30 to be used every eight (8) hours as needed. Patient, if she took the pills as prescribed, would have been on 408 MMEs plus the Xanax.

f. On June 2, 2017, the dose of Oxycodone was again increased to 60 mg QID, plus 15 mg QID, plus the benzodiazepine, totaling 450 MMEs, because of, "intractable pain".

g. The Oxycodone was not seen in the urine drug screens, but other opiates were. This should have been immediately addressed. There was obvious diversion taking place.

h. In late June, Defendant decreased patient's Oxycodone to 30 mg six (6) times daily and reduced the Xanax to 0.5 mg TID.

i. On September 21, 2017, Defendant noted that patient had sought additional medications from another physician, and he appropriately terminated patient.

j. Pill counts could never be done as Defendant could never reach patient.

k. The initial dosage of Oxycodone was inappropriate, and there was as a result of Defendant's management, the potential for development and/or continuation of dependence, and/ or addiction to both opiates and benzodiazepines.

IV. HISTORY AT THE BOARD

28. Case #03-08-2708, voluntary surrender of license in lieu of prosecution. Defendant was found guilty of the following unprofessional conduct:

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 OAC 435:10-7-4(41).

29. Surrender beginning September 23, 2004 and reinstated January 17, 2008.

30. Case #03-08-2708, term of indefinite probation beginning January 17, 2008, probation modified April 10, 2009, after Board staff, on behalf of Defendant, requested that the terms of Defendant's probation be modified to delete the requirements that he practice under the direct supervision of a physician licensed by the Board and that he submit quarterly reports from his supervising physician to the Board Secretary for his review. The modification was ordered.

31. Case #03-08-2708, probation terminated May 28, 2010, after Defendant requested his probation be terminated. The Board found that Defendant had complied in all respects with the terms of probation and the purpose of the probationary period had been accomplished.

V. VIOLATIONS

32. Based on the foregoing, Defendant is guilty of unprofessional conduct as follows:

a. Prescribing, dispensing or administering of controlled substances or narcotic drugs in excess of the amount considered good medical practice, or prescribing dispensing or administering controlled substances or narcotic drugs without medical need in accordance with published standards. 59 O.S. 2011, § 509 (16); Okla. Admin. Code § 435:10-7-4(2).

VI. CONCLUSION

Given the foregoing, the undersigned requests 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 the Defendant's professional license, including an assessment of costs and attorney's fees incurred in this action as provided by law.

Amy Stuart, OBA No. 31240
Assistant Attorney General
313 N.E. 21st Street
Oklahoma City, Oklahoma 73105
405/521.3921
405/522.4536 – Facsimile
FOR: OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

VERIFICATION

I, Larry Carter, under penalty of perjury, under the laws of the State of Oklahoma, state as follows:

1. I have read the above Complaint regarding the Defendant, Mark Reiheld, M.D.; and

2. The factual statements contained therein are true and correct to the best of my knowledge and belief.

Larry Carter, Investigator
OKLAHOMA STATE BOARD OF MEDICAL
LICENSURE AND SUPERVISION

Date: 29 May 2019

Oklahoma County
County, State of Execution