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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: **RICHARD PAUL HEIDENFELDER, M.D.** **826 Orange Avenue #605** **Coronado, CA 92118-2619** **Physician's and Surgeon's Certificate No. A 79836,** Respondent.	Case No. 800-2016-024443 **FIRST AMENDED ACCUSATION**

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 17, 2002, the Medical Board issued Physician's and Surgeon's Certificate No. A 79836 to Richard Paul Heidenfelder, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on March 31, 2020, unless renewed.

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JURISDICTION

3. This First Amended Accusation, which supersedes the Accusation filed on July 9, 2019, is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states in pertinent part:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> ...
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> (b) Gross negligence.
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> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
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> ...
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> (e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
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> ...

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

7. Section 2290.5 of the Code states, in pertinent part:

> (a) For purposes of this division, the following definitions shall apply:
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> ...
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> (2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means either of the following:

(A) A person who is licensed under this division.

...

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

...

8. Section 2228.1 of the Code states, in pertinent part:

(a) On and after July 1, 2019, except as otherwise provided in subdivision (c), the board shall require a licensee to provide a separate disclosure that includes the licensee's probation status, the length of the probation, the probation end date, all practice restrictions placed on the licensee by the board, the board's telephone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information Internet Web site, to a patient or the patient's guardian or health care surrogate before the patient's first visit following the probationary order while the licensee is on probation pursuant to a probationary order made on and after July 1, 2019, in any of the following circumstances:

(1) A final adjudication by the board following an administrative hearing or admitted findings or prima facie showing in a stipulated settlement establishing any of the following:

...

(D) Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

(2) An accusation or statement of issues alleged that the licensee committed any of the acts described in subparagraphs (A) to (D), inclusive, of paragraph (1), and a stipulated settlement based upon a nolo contendere or other similar compromise that does not include any prima facie showing or admission of guilt or fact but does include an express acknowledgment that the disclosure requirements of this section would serve to protect the public interest.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(d) On and after July 1, 2019, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information Internet Web site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

FACTUAL ALLEGATIONS

PATIENT A

9. On or about September 15, 2015, Patient A,[1] a then twenty-eight year old female, presented to Respondent with complaints of low-level depression, persistent daily anxiety, and chronic insomnia. This initial in-person visit did not include a physical examination or review of systems. At the conclusion of this visit, Respondent diagnosed Patient A with post traumatic

[1] To protect the privacy of the patients involved, patient names have not been included in this pleading. Respondent is aware of the identity of the patients referred to herein.

stress disorder (PTSD), anxiety disorder, and prescribed her Klonopin[2] and Propranolol.[3] The chart note for this visit does not contain a return appointment date.

10. Sometime after September 15, 2015, Patient A presented to Respondent's office for a prescheduled follow-up appointment. Upon her arrival, Patient A saw approximately twenty (20) other patients waiting outside. Respondent's office was locked and he was unable to be reached. Patient A did not receive prior notification that her appointment had been cancelled.

11. On or about September 28, 2015, Respondent prepared a progress note for treatment provided to Patient A, that included medication refills. Respondent did not see the patient in-person that day, and did not perform a physical examination or review of systems. The chart note does not indicate whether this appointment was by video, email, or phone. Respondent submitted a superbill to Patient A's insurance company for this visit with CPT Code 99215, for a complex office visit.

12. On or about October 29, 2015, Respondent prepared a progress note for treatment provided to Patient A. Respondent did not see the patient in-person that day, and did not perform a physical examination or review of systems. The chart note does not indicate whether this appointment was by video, email, or phone. Respondent submitted a superbill to Patient A's insurance company for this visit with CPT Code 99214, for a moderately complex office visit.

13. On or about November 10, 2015, Respondent emailed Patient A through his non-secure email account, apologizing for "some glitches" with her appointments.

14. On or about July 8, 2016, Patient A scheduled a telemedicine appointment with Respondent for July 12, 2016, at 5:50 p.m.

15. On or about July 12, 2016, Respondent did not contact Patient A for her telemedicine appointment until approximately 8:00 p.m., at which time he left her a voicemail. Respondent subsequently exchanged multiple emails with Patient A that evening via his non-secure email

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[2] Klonopin, brand name for Clonazepam, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an anti-anxiety medication in the benzodiazepine family.

[3] Propranolol is a beta blocker medication used to treat high blood pressure. It is a dangerous drug pursuant to Business and Professions Code section 4022.

account, and Respondent called in medication refills for her. Respondent did not speak with or see Patient A on or about July 12, 2016, but he prepared a progress note for treatment provided to Patient A on that date that included a mental status exam. The chart note does not indicate that the treatment was by email. Respondent submitted a superbill to Patient A's insurance company for this interaction with CPT Code 99214, for a moderately complex office visit.

16. On or about July 12, 2016, Patient A scheduled a telemedicine appointment with Respondent for August 30, 2016, at 8:00 p.m.

17. On or about August 30, 2016, Respondent did not contact Patient A for her telemedicine appointment.

18. On or about August 31, 2016, Respondent exchanged multiple emails with Patient A via his non-secure email account, apologizing for missing her appointment.

19. On or about September 15, 2016, Patient A emailed Respondent via his non-secure email account asking for a refill on her medication.

20. On or about September 16, 2016, Respondent replied to Patient A via his non-secure email account, and informed her that he called in her refills. Respondent did not speak with or see Patient A on or about September 16, 2016, but he prepared a progress note for treatment provided to Patient A on that date that included a mental status exam. The chart note for this date does not indicate that the treatment was by email. Respondent submitted a superbill to Patient A's insurance company for this interaction with Patient A with CPT Code 99213, for a 15-minute office visit.

21. On or about September 20, 2016, Patient A scheduled a telemedicine appointment with Respondent for November 9, 2016, at 6:00 p.m.

22. On or about November 9, 2016, Respondent did not contact Patient A for her telemedicine appointment.

23. On or about December 22, 2016, Patient A emailed Respondent informing him that he missed her last phone appointment and asked for a medication refill.

24. On or about December 23, 2016, Respondent's employee replied to Patient A via Respondent's non-secure email account, and informed Patient A that she had called in her refills.

Respondent did not speak with or see Patient A on or about December 23, 2016, but he prepared a progress note for treatment provided to Patient A on that date that included a mental status exam. The chart note does not indicate that the treatment was by email. Respondent submitted a superbill to Patient A's insurance company for this interaction with CPT Code 99213, for a 15-minute office visit.

PATIENT B

25. In or around 2004, Respondent began providing psychiatric treatment to Patient B, a then thirty-six year old female he diagnosed with bipolar disorder, generalized anxiety disorder, and attention deficit hyperactivity disorder (ADHD).

26. On or about May 15, 2007,[4] Patient B reported to Respondent that she had been recently hospitalized for a medication overdose attempt when she was feeling increased stress. Respondent did not obtain a copy of Patient B's hospitalization records for this hospitalization on that date or any date thereafter.

27. On or about April 7, 2008, Patient B reported to Respondent an increase in depression and suicidal ideation.

28. On or about June 2, 2008, Patient B reported to Respondent a recent suicide by her brother and an increase in depression.

29. On or about November 4, 2008, Patient B reported to Respondent her arrest for driving under the influence of OxyContin,[5] involvement by Child Protective Services, and an increase in depression and suicidal ideation.

30. On or about November 8, 2008, Patient B reported to Respondent an increase in depression and suicidal ideation, but denied active suicidal ideation that day.

31. On or about September 25, 2009, Patient B reported to Respondent that she was "EXTREMELY depressed for the last month," having gone several days without bathing.

[4] Conduct occurring more than seven years before the filing of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action. (Bus. & Prof. Code, § 2230.5.)

[5] Oxycontin (brand name for Oxycodone), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication used to treat pain.

32. On or about November 1, 2011, Patient B reported to Respondent a recent hospitalization for suicidal ideation. Patient B denied suicidal intent. Respondent discussed coping skills and safety planning at that visit, but did not obtain a copy of Patient B's hospitalization records.

33. Between in or around 2012, and in or around 2015, Respondent's treatment of Patient B included monthly prescriptions of methylphenidate[6] and alprazolam.[7] Throughout that time, Patient B received regular prescriptions of opioid medication from other providers, displayed poor medication compliance and treatment response, and regularly corresponded with Respondent about her treatment via his non-secure email account.

34. On or about November 30, 2012, Patient B sent an email to Respondent via his non-secure email account requesting a medication change due to regular suicidal ideations.

35. On or about December 1, 2012, Respondent responded to Patient B via his non-secure email account informing her that he did not want to switch her medications. Respondent's response to Patient B did not address her suicidal ideations in any way.

36. On or about July 24, 2014, Patient B sent an email to Respondent via his non-secure email account informing him that she had not received a disability check because she forgot to complete a form, and that this had caused her to have suicidal thoughts. Respondent's response to Patient B did not address the suicidal thoughts in any way.

37. On or about December 11, 2014, Patient B reported to Respondent a recent "accidental overdose," that caused her to be hospitalized for two (2) days after she "accidentally took 20 Xanax." Patient B denied suicidal ideation. Respondent discussed coping skills and safety planning at that visit, but did not obtain a copy of Patient B's hospitalization records on that date or any date thereafter.

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[6] Methylphenidate (brand name Ritalin / Concerta), is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a stimulant medication used to treat ADHD and narcolepsy.

[7] Alprazolam (brand name Xanax), is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety and panic disorder.

38. Between on or about January 19, 2015, and on or about December 8, 2015, Respondent provided treatment to Patient B on approximately ten (10) occasions. Throughout that time, Respondent did not perform and/or document a thorough suicide risk assessment of the patient.

39. On or about December 10, 2015, Patient B was found unresponsive on the floor next to her bed at home. A handwritten suicide note was found near the patient. Patient B was transported to the emergency room and was admitted for an apparent overdose on prescription medications. Patient B's admitting toxicology screen was positive for opiates and benzodiazepines. Patient B died in the hospital approximately ten (10) days later.

PATIENT C

40. On or about July 21, 2016, Patient C, a then forty year old female, scheduled an initial evaluation telemedicine appointment with Respondent on July 25, 2016, at 6:15 p.m.

41. On or about July 22, 2016, Respondent's employee sent an appointment confirmation email to Patient C via Respondent's non-secure email account.

42. On or about July 25, 2016, Respondent did not contact Patient C at 6:15 p.m. for her telemedicine appointment. Later that evening, Patient C sent multiple emails to Respondent advising him of the missed appointment, informing him that she was leaving town in three (3) days, and requested an urgent appointment for a medication refill.

43. Between on or about July 25, 2016, through on or about August 23, 2016, Patient C's medical chart does not show any attempted contact with the patient regarding the missed appointment.

44. On or about August 23, 2016, Patient C scheduled another initial evaluation telemedicine appointment with Respondent on August 25, 2016, at 12:00 p.m.

45. On or about August 24, 2016, Respondent's employee sent an email to Patient C via Respondent's non-secure email account, confirming the appointment would be an in-person visit.

46. On or about August 25, 2016, at approximately 10:01 a.m., Respondent's employee sent an email to Patient C via Respondent's non-secure email account, informing her that Respondent would need to reschedule her appointment for the following day. Patient C did not

receive this message until approximately 11:02 a.m., when she was on her way to the appointment.

47. On or about August 26, 2016, Patient C presented to Respondent for an initial evaluation with complaints of depression and anxiety. After completing a physical examination and review of systems, Respondent diagnosed Patient C with dysthymia (persistent depressive disorder) and generalized anxiety disorder (GAD). At the conclusion of the visit, Respondent advised the patient to taper and discontinue her Zoloft for two weeks, and prescribed her an unknown amount of Wellbutrin[8] 75 mg and Klonopin 0.25 mg. The chart note for this visit does not contain a copy of the prescription.

48. On or about August 30, 2016, Patient C emailed Respondent informing him that the pharmacy had been unable to reach him and needed clarification regarding whether he intended her Klonopin prescription to be sublingual.

49. Between on or about August 30, 2016, through on or about September 9, 2016, Patient C's medical chart does not show any attempted contact with the patient or the pharmacy regarding the patient's Klonopin prescription.

50. On or about September 10, 2016, Respondent faxed Patient C's prescription for #60 Klonopin 0.25mg to the pharmacy.

51. On or about September 28, 2016, Respondent exchanged multiple emails with Patient C via his non-secure email account, apologizing for rescheduling her appointments, and informing her that he faxed the pharmacy the information needed.

52. On or about October 1, 2016, Patient C exchanged multiple emails with Respondent via his non-secure email account, informing him that the pharmacy was still refusing to fill her Klonopin as written, and needed clarification in the prescription. On that same date, Respondent called the pharmacy and changed Patient C's prescription to #30 Klonopin 0.5mg.

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[8] Wellbutrin is an antidepressant medication used to treat major depressive disorder and seasonal affective disorder, and is a dangerous drug pursuant to Business and Professions Code section 4022.

PATIENT D

53. On or about May 7, 2010, Patient D, a then thirty-three year old female, presented to Respondent for psychiatric treatment. Patient D's past psychiatric history included a nervous breakdown at age 18, self-injurious behaviors, suicide attempt, hospitalization for danger-to-self in January 2010, episodes of extreme mania, and anxiety. The patient denied any recent suicidal ideation, and denied drug use, but admitted to using marijuana for IBS and Percocet[9] for pain. Respondent diagnosed the patient with bipolar disorder, major depressive disorder, and generalized anxiety disorder. At the conclusion of the visit, Respondent prescribed Patient D medications that included, but were not limited to, Valium[10] 5mg, and Depakote[11] 500mg.

54. Between on or about May 7, 2010, through on or about May 6, 2013, Respondent provided psychiatric treatment to Patient D. Throughout that time, the patient's chart does not contain reference to a thorough screening for suicidal ideation, risk factors, or a full mental status exam.

55. On or about July 21, 2010, Patient D reported to Respondent that she was experiencing a lot of anxiety and claimed the Valium was not working. At the conclusion of this visit, Respondent increased Patient D's Valium to 10mg, and added Restoril[12] 15mg.

56. On or about November 29, 2010, Patient D presented to Respondent with complaints of increased depression over the holidays. At that time, Respondent maintained Patient D on a medication regimen that included Valium, Restoril, and Depakote.

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[9] Percocet (brand name for oxycodone and acetaminophen), a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022.

[10] Valium (brand name for Diazepam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety.

[11] Depakote (brand name for Valproic acid) is a medication used to treat bipolar disorder, and is a dangerous drug pursuant to Business and Professions Code section 4022.

[12] Restoril (brand name for Temazepam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat insomnia.

57. On or about January 3, 2011, Patient D presented to Respondent and reported that she had not engaged in self-harm in four (4) weeks. At that time, Respondent maintained Patient D on a medication regimen that included Valium, Restoril, and Depakote.

58. On or about March 3, 2011, Patient D informed Respondent that she had been recently hospitalized for two days due to depression. The patient's chart does not indicate any further inquiry regarding the hospitalization or any attempt by Respondent to obtain the hospital records on that date or any date thereafter.

59. On or about March 30, 2011, Patient D presented to Respondent with complaints of increased depression. She further admitted to recent cutting and burning herself, and having passive suicidal ideation, but denied intent. At that time, Respondent maintained Patient D on a medication regimen that included Valium, Restoril, and Depakote.

60. On or about October 8, 2011, Patient D emailed Respondent informing him that she had been treated by her primary care physician with Percocet for severe abdominal pain. Over the next few days, Respondent exchanged emails with Patient D via his non-secure email account, and advised her not to take Percocet with Valium or Restoril at bedtime due to the dangers of mixing these types of medications.

61. On or about October 14, 2011, Patient D presented to Respondent with complaints of a depressed mood and informed him that she was taking pain medications related to her abdominal adhesions. Respondent advised Patient D that she was at risk of overdose if she was taking other sedating medications, but maintained her on her medication regimen that included Valium.

62. On or about August 27, 2012, Patient D informed Respondent that she had discontinued Valium because it had not been helping her. At the conclusion of this visit, Respondent prescribed the patient, among other things, Oxazepam[13] 10mg.

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[13] Oxazepam Is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety and depression.

63. On or about October 11, 2012, Patient D informed Respondent that she had been taking Vicodin[14] every 4 to 6 hours for pain. Respondent advised Patient D of the risks of mixing sleep medications and pain medications at night, but made no changes to her medication regimen at that time.

64. On or about December 6, 2012, Patient D presented to Respondent with complaints that Oxazepam was not working. At the conclusion of this visit, Respondent discontinued the Oxazepam and prescribed her Klonopin[15] 1mg to be taken at bedtime.

65. On or about February 5, 2013, Patient D informed Respondent that she had been taking Klonopin twice daily and was still using Oxazepam intermittently. Respondent discussed the importance of medication compliance with the patient, and increased her prescription of Klonopin 1mg to twice daily.

66. On or about March 1, 2013, Patient D emailed Respondent via his non-secure email account asking about Elavil,[16] and reported she was very depressed, had not showered for two weeks, and was unable to do anything for both physical and mental reasons. Respondent replied to this email four days later, and informed the patient that they could try Elavil.

67. On or about May 6, 2013, Patient D informed Respondent that she had restarted herself on Ritalin due to her feeling low energy, low motivation, and depression. At the conclusion of the visit, Respondent maintained Patient D on her medication regimen that included, among other things, Klonopin and Depakote.

68. On or about June 9, 2013, Patient D was found dead in her home as a result of a combined excess of medications, which included but was not limited to, oxycodone, clonazepam, and valproic acid.

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[14] Vicodin (brand name for acetaminophen and hydrocodone bitartrate) is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

[15] Klonopin (brand name for Clonazepam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat anxiety.

[16] Elavil (brand name for Amitriptyline) is an antidepressant medication and a dangerous drug pursuant to Business and Professions Code section 4022.

PATIENT E

69. In or around 2013, Respondent began providing psychiatric treatment to Patient E, a then thirty-six year old female he diagnosed with severe depression, anxiety, and attention deficit disorder (ADD).

70. On or about February 19, 2014, Respondent prescribed Patient E Adderall[17] 20mg five times daily and Vyvanse[18] 40mg every morning.

71. On or about August 27, 2014, Respondent increased Patient E's Vyvanse prescription to 50mg every morning.

72. On or about January 21, 2016, Patient E presented to Respondent with complaints of ongoing marital issues and fear of returning to previous severe depression. Patient E further reported needing to take both Adderall and Vyvanse because she had been working extra 12 hour shifts at work. The chart notes for this visit do not include any discussion with the patient regarding her use of stimulants to work additional hours. At the conclusion of the visit, Respondent maintained Patient E on her medication regimen that included Adderall 20mg five times daily and Vyvanse 50mg every morning.

73. On or about May 5, 2016, Patient E emailed Respondent informing him that her therapist noted that she was "clinically depressed," and recommended she speak with Respondent about her medications. Respondent replied to this email the next day via his non-secure email account and asked the patient to schedule an appointment to be seen.

74. On or about April 28, 2017, Patient E emailed Respondent via his non-secure email account, informing him that she has been crying for a week, wants to be in bed all day, and feels like she cannot take care of her children. Respondent replied to this email via his non-secure

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[17] Adderall (brand name for dextroamphetamine and amphetamine) is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is psychostimulant medication used for attention-deficit hyperactivity disorder (ADHD) and narcolepsy.

[18] Vyvanse (brand name for Lisdexamfetamine) is a dangerous drug pursuant to Business and Professions Code section 4022. It is psychostimulant medication used to treat ADHD and binge eating disorders.

email account on or about May 10, 2017, inquired if she was feeling better, and encouraged her to schedule an appointment to be seen.

75. On or about August 15, 2017, Patient E exchanged emails with Respondent via his non-secure email account regarding her medication refills. In that email exchange, Respondent informed the patient that his physical office was closed and that he would only be available for phone and video appointments.

76. On or about November 7, 2017, Patient E presented to Respondent and informed him that she had less episodes of depression, but still required current stimulant dosing combined with Adderall to control her severe depression and ADD symptoms. At the conclusion of this visit, Respondent maintained the patient on her medication regimen that included Adderall 20mg five times daily and Vyvanse 50mg every morning. The chart notes for this visit do not indicate that this was a telemedicine appointment and contain the exact same notes as the visit from October 12, 2017.

77. On or about March 28, 2018, Patient E presented to Respondent and informed him that she still needed her Adderall and Vyvanse to control her severe depression and ADD. The patient further informed Respondent that she had tried to decrease her dose but had depression immediately with decreased dosing. At the conclusion of this visit, Respondent maintained the patient on her medication regimen that included Adderall 20mg five times daily and Vyvanse 50mg every morning. The chart notes for this visit do not indicate that this was a telemedicine appointment.

PATIENT F

78. On or about June 19, 2015, Patient F, a then fifty-six year old female, presented to Respondent for psychiatric treatment for PTSD, anxiety, and insomnia. Patient F's past medical history included thyroid removal and cancer diagnosis in 2013, and a history of substance abuse that involved daily use of methamphetamine and alcohol. Patient F reported current medications that included Oxycodone[19] 10mg for chronic pain and Restoril 30mg. The patient denied any

[19] Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It

suicidal ideation, but reported feelings of hopelessness, low energy, decreased interest, insomnia, and daily anxiety. Respondent ran the patient's CURES report that day, but did not refer the patient for any labs, did not review any prior treatment records, and did not discuss the patient's care with any of her prior treatment providers. At the conclusion of the visit, Respondent diagnosed the patient with depression, anxiety, and insomnia, and prescribed her medications that included, but were not limited to, Valium 10mg and Restoril 30mg.

79. On or about July 15, 2015, Patient F presented to Respondent with complaints of persistent depression, anxiety, and insomnia. At the conclusion of this visit, Respondent discontinued the patient on Valium and Restoril, and prescribed Lexapro[20] 20mg, Halcion[21] 0.25mg, and Klonopin 1mg.

80. On or about August 5, 2015, Patient F presented to Respondent with complaints of persistent depression, anxiety, low motivation, and a poor response to Klonopin. At the conclusion of this visit, Respondent discontinued the patient on Klonopin and Lexapro, and prescribed Xanax 1mg, Wellbutrin XL 1mg, and Halcion 0.25mg.

81. On or about September 9, 2015, Patient F presented to Respondent with complaints of persistent anxiety with Xanax. At the conclusion of the visit, Respondent discontinued the patient on Xanax, and prescribed Valium 10mg.

82. On or about September 17, 2015, Patient F emailed Respondent concerns that she was getting "zaps" from her Wellbutrin. On or about September 23, 2015, Respondent replied to Patient F via his non-secure email account.

83. On or about November 4, 2015, Patient F presented to Respondent with complaints of breakthrough anxiety and panic, and reported using Xanax in addition to Valium. At the conclusion of the visit, Respondent added Xanax 1mg to Patient F's medication regimen.

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is an opioid medication used to treat severe pain.

[20] Lexapro (brand name for Escitalopram) is a dangerous drug pursuant to Business and Professions Code section 4022. It is a selective serotonin reuptake inhibitor medication used to treat depression and generalized anxiety disorder.

[21] Halcion (brand name for Triazolam) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a benzodiazepine medication used to treat insomnia.

84. On or about March 31, 2016, Respondent emailed Patient F via his non-secure email account and informed the patient that she should not need to take Xanax if she was taking Valium, and cautioned the patient that both medications were too much benzodiazepines.

85. On or about June 7, 2016, Patient F presented to Respondent for a follow-up appointment. At this visit, Patient F informed Respondent that she had been using Valium four times daily with Xanax. At the conclusion of this visit, Respondent discontinued the patient on Valium, but continued her on Xanax.

86. On or about June 22, 2016, Patient F presented to Respondent with complaints of severe insomnia, restless legs, and muscle spasms since her Valium was discontinued. The patient requested to restart Lexapro. Respondent discussed her prior overuse of Valium and the risks of mixing pain medications with benzodiazepines. At the conclusion of the visit, Respondent prescribed the patient Xanax 1mg, Lexapro 20mg, and Valium 10mg.

87. On or about September 7, 2016, Patient F presented to Respondent with complaints of decreasing effect from Valium. At the conclusion of this visit, Respondent discontinued the patient on Valium and prescribed Restoril 30mg and Xanax 1mg.

88. On or about September 27, 2016, Patient F presented to Respondent with complaints of worsening anxiety and chronic pain. At the conclusion of this visit, Respondent added Valium 10mg back into her medication regimen.

89. On or about November 2, 2016, Respondent noted Patient F had intermittent compliance issues with not taking her medications on schedule, but no changes to her medication regimen were made at that time.

90. On or about March 16, 2017, Patient F presented to Respondent with complaints of persistent moderate depression and anxiety. The patient informed Respondent that she had discontinued Xanax and denied any significant use of pain medications. Respondent discussed the risks of mixing pain medications with benzodiazepines. At the conclusion of this visit,

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Respondent discontinued the patient on Xanax and prescribed Vyvanse 30mg, Concerta 36mg, Requip[22] 0.25mg, and Valium 10mg.

91. On or about May 15, 2017, during a follow-up appointment, Respondent discussed with the patient his intention to taper and potentially discontinue benzodiazepines.

92. On or about November 7, 2017, Patient F informed Respondent that she had tapered herself off Xanax, but had begun taking Suboxone[23] for chronic pain. At the conclusion of the visit, Respondent increased the patient's Vyvanse dose, but made no other changes to her medication regimen at that time. The patient's chart does not show any documented coordination of care with the patient's pain management doctor on that date or any date thereafter.

93. On or about April 25, 2018, Respondent ran Patient F's CURES report for the second time during his course of treatment.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

94. Respondent has subjected his Physician's and Surgeon's Certificate No. A 79836 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he was grossly negligent in his care and treatment of Patients A and C, as more particularly alleged hereinafter:

A. Paragraphs 9 through 24, and paragraphs 40 through 52, above, are hereby realleged and incorporated by this reference as if fully set forth herein;

B. Failing to maintain appointments with Patient A without prior notification;

C. Failing to examine Patient A when documenting a patient visit and providing ongoing treatment; and

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[22] Requip (brand name for Ropinirole) is a dangerous drug pursuant to Business and Professions Code section 4022. It is a dopaminergic agent used to treat symptoms of Parkinson's disease, including stiffness, tremors, muscle spasms, and poor muscle control.

[23] Suboxone (brand name for Buprenorphine and Naloxone) is a Schedule III controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. It is an opioid medication used to treat severe pain and opiate dependence.

D. Failing to maintain appointments with Patient C without prior notification within a reasonable period of time.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

95. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 79836 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of Patients A, B, C, D, E, and F, as more particularly alleged hereinafter:

A. Paragraphs 9 through 94, above, are hereby realleged and incorporated by this reference as if fully set forth herein;

B. Failing to use HIPAA compliant means of communication of protected information with Patient A;

C. Failing to prevent long-term use of benzodiazepines in Patient B;

D. Failing to regularly perform and/or document thorough suicide risk screening in Patient B;

E. Failing to use HIPAA compliant means of communication of protected information with Patient B;

F. Failing to timely respond to questions from the pharmacy regarding a prescription for Patient C;

G. Failing to use HIPAA compliant means of communication of protected information with Patient C;

H. Failing to prevent long-term use of benzodiazepines with Patient D;

I. Failing to regularly perform and/or document thorough suicide risk screening in Patient D;

J. Failing to use HIPAA compliant means of communication of protected information with Patient D;

K. Prescribing multiple concomitant psychostimulants at excessive dosages to Patient E;

L. Failing to use HIPAA compliant means of communication of protected information with Patient E;

M. Failing to consider alternative etiologies to Patient F's problems before prescribing controlled substances;

N. Failing to prevent long-term use of benzodiazepines with Patient F;

O. Failing to mitigate risk of medication overdose with CNS depressants combined with opioids in Patient F; and

P. Failing to use HIPAA compliant means of communication of protected information with Patient F.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty or Corruption)

96. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 79836 to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of the Code, in that he has committed an act or acts of dishonesty or corruption, as more particularly alleged in paragraphs 9 through 95, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

97. Respondent has further subjected his Physician's and Surgeon's Certificate No. A 79836 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients A, B, C, D, and E as more particularly alleged in paragraphs 9 through 95, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 79836, issued to Respondent, Richard Paul Heidenfelder, M.D.;

2. Revoking, suspending or denying approval of Respondent, Richard Paul Heidenfelder, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent, Richard Paul Heidenfelder, M.D., if placed on probation, to pay the Board the costs of probation monitoring;

4. Ordering Respondent, Richard Paul Heidenfelder, M.D., if placed on probation, to disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and

5. Taking such other and further action as deemed necessary and proper.

DATED: September 25, 2019

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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