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9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

12 In the Matter of the Second Amended
13 Accusation Against:

14 **RICHARD PAUL HEIDENFELDER, M.D.**
15 **826 Orange Avenue #605**
Coronado, CA 92118

16 **Physician's and Surgeon's Certificate**
17 **No. A 79836,**

18 Respondent.

Case No. 800-2016-024443

OAH No. 201910661

SECOND AMENDED ACCUSATION

19
20 **PARTIES**

21 1. Christine J. Lally (Complainant) brings this Second Amended Accusation solely in
22 her official capacity as the Interim Executive Director of the Medical Board of California,
23 Department of Consumer Affairs (Board).

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

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JURISDICTION

1
2 3. This Second Amended Accusation, which supersedes the First Amended Accusation
3 filed on September 25, 2019, is brought before the Board, under the authority of the following
4 laws. All section references are to the Business and Professions Code (Code) unless otherwise
5 indicated.

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

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

11 The board shall take action against any licensee who is charged with
12 unprofessional conduct. In addition to other provisions of this article, unprofessional
13 conduct includes, but is not limited to, the following:

13 ...

14 (b) Gross negligence.

15 (c) Repeated negligent acts. To be repeated, there must be two or more
16 negligent acts or omissions. An initial negligent act or omission followed by a
17 separate and distinct departure from the applicable standard of care shall constitute
18 repeated negligent acts.

18 ...

19 (e) The commission of any act involving dishonesty or corruption which is
20 substantially related to the qualifications, functions, or duties of a physician and
21 surgeon.

21 ...

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

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

26 (a) For purposes of this division, the following definitions shall apply:

27 ...

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1 (2) "Distant site" means a site where a health care provider who provides
health care services is located while providing these services via a
2 telecommunications system.

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

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

5 ...

6 (6) "Telehealth" means the mode of delivering health care services and public
health via information and communication technologies to facilitate the diagnosis,
7 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
8 provider is at a distant site. Telehealth facilitates patient self-management and
caregiver support for patients and includes synchronous interactions and
9 asynchronous store and forward transfers.

10 (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
11 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
12 shall be documented.

13 (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
14 after agreeing to receive services via telehealth.

15 (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.

16 (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
17 a manner, not otherwise authorized by law.

18 (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.

19 ...
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21 8. Section 2228.1 of the Code states, in pertinent part:

22 (a) On and after July 1, 2019, except as otherwise provided in subdivision (c),
23 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
24 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
25 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
26 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,
27 2019, in any of the following circumstances:

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

4 ...

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

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

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

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

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

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

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

28 (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

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.

1 chronic insomnia. This initial in-person visit did not include a physical examination or review of
2 systems. At the conclusion of this visit, Respondent diagnosed Patient A with post traumatic
3 stress disorder (PTSD), anxiety disorder, and prescribed her Klonopin² and Propranolol.³ The
4 chart note for this visit does not contain a return appointment date.

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

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

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

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

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

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25 _____
26 ² Klonopin, brand name for Clonazepam, is a Schedule IV controlled substance pursuant to Health
27 and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and
28 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.

1 15. On or about July 12, 2016, Respondent did not contact Patient A for her telemedicine
2 appointment until approximately 8:00 p.m., at which time he left her a voicemail. Respondent
3 subsequently exchanged multiple emails with Patient A that evening via his non-secure email
4 account, and Respondent called in medication refills for her. Respondent did not speak with or
5 see Patient A on or about July 12, 2016, but he prepared a progress note for treatment provided to
6 Patient A on that date that included a mental status exam. The chart note does not indicate that
7 the treatment was by email. Respondent submitted a superbill to Patient A's insurance company
8 for this interaction with CPT Code 99214, for a moderately complex office visit.

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

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

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

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

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

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

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

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

3 24. On or about December 23, 2016, Respondent's employee replied to Patient A via
4 Respondent's non-secure email account, and informed Patient A that she had called in her refills.
5 Respondent did not speak with or see Patient A on or about December 23, 2016, but he prepared a
6 progress note for treatment provided to Patient A on that date that included a mental status exam.
7 The chart note does not indicate that the treatment was by email. Respondent submitted a
8 superbill to Patient A's insurance company for this interaction with CPT Code 99213, for a 15-
9 minute office visit.

10 **PATIENT B**

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

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

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

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

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

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

27 ⁵ Oxycontin (brand name for Oxycodone), is a Schedule II controlled substance pursuant to Health
28 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.

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

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

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

9 33. Between in or around 2012, and in or around 2015, Respondent’s treatment of Patient
10 B included monthly prescriptions of methylphenidate⁶ and alprazolam.⁷ Throughout that time,
11 Patient B received regular prescriptions of opioid medication from other providers, displayed
12 poor medication compliance and treatment response, and regularly corresponded with Respondent
13 about her treatment via his non-secure email account.

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

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

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

23 37. On or about December 11, 2014, Patient B reported to Respondent a recent
24 “accidental overdose,” that caused her to be hospitalized for two (2) days after she “accidentally

25 ⁶ Methylphenidate (brand name Ritalin / Concerta), is a Schedule II controlled substance pursuant
26 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.

27 ⁷ Alprazolam (brand name Xanax), is a Schedule IV controlled substance pursuant to Health and
28 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.

1 took 20 Xanax.” Patient B denied suicidal ideation. Respondent discussed coping skills and
2 safety planning at that visit, but did not obtain a copy of Patient B’s hospitalization records on
3 that date or any date thereafter.

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

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

13 **PATIENT C**

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

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

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

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

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

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

1 46. On or about August 25, 2016, at approximately 10:01 a.m., Respondent's employee
2 sent an email to Patient C via Respondent's non-secure email account, informing her that
3 Respondent would need to reschedule her appointment for the following day. Patient C did not
4 receive this message until approximately 11:02 a.m., when she was on her way to the
5 appointment.

6 47. On or about August 26, 2016, Patient C presented to Respondent for an initial
7 evaluation with complaints of depression and anxiety. After completing a physical examination
8 and review of systems, Respondent diagnosed Patient C with dysthymia (persistent depressive
9 disorder) and generalized anxiety disorder (GAD). At the conclusion of the visit, Respondent
10 advised the patient to taper and discontinue her Zoloft for two weeks, and prescribed her an
11 unknown amount of Wellbutrin⁸ 75 mg and Klonopin 0.25 mg. The chart note for this visit does
12 not contain a copy of the prescription.

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

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

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

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

24 52. On or about October 1, 2016, Patient C exchanged multiple emails with Respondent
25 via his non-secure email account, informing him that the pharmacy was still refusing to fill her

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28 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.

1 Klonopin as written, and needed clarification in the prescription. On that same date, Respondent
2 called the pharmacy and changed Patient C's prescription to #30 Klonopin 0.5mg.

3 **PATIENT D**

4 53. On or about May 7, 2010, Patient D, a then thirty-three year old female, presented to
5 Respondent for psychiatric treatment. Patient D's past psychiatric history included a nervous
6 breakdown at age 18, self-injurious behaviors, suicide attempt, hospitalization for danger-to-self
7 in January 2010, episodes of extreme mania, and anxiety. The patient denied any recent suicidal
8 ideation, and denied drug use, but admitted to using marijuana for IBS and Percocet⁹ for pain.
9 Respondent diagnosed the patient with bipolar disorder, major depressive disorder, and
10 generalized anxiety disorder. At the conclusion of the visit, Respondent prescribed Patient D
11 medications that included, but were not limited to, Valium¹⁰ 5mg, and Depakote¹¹ 500mg.

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

16 55. On or about July 21, 2010, Patient D reported to Respondent that she was
17 experiencing a lot of anxiety and claimed the Valium was not working. At the conclusion of this
18 visit, Respondent increased Patient D's Valium to 10mg, and added Restoril¹² 15mg.

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

24 ¹⁰ Valium (brand name for Diazepam) is a Schedule IV controlled substance pursuant to Health
25 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.

26 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.

27 ¹² Restoril (brand name for Temazepam) is a Schedule IV controlled substance pursuant to Health
28 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.

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

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

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

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

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

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

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1 62. On or about August 27, 2012, Patient D informed Respondent that she had
2 discontinued Valium because it had not been helping her. At the conclusion of this visit,
3 Respondent prescribed the patient, among other things, Oxazepam¹³ 10mg.

4 63. On or about October 11, 2012, Patient D informed Respondent that she had been
5 taking Vicodin¹⁴ every 4 to 6 hours for pain. Respondent advised Patient D of the risks of mixing
6 sleep medications and pain medications at night, but made no changes to her medication regimen
7 at that time.

8 64. On or about December 6, 2012, Patient D presented to Respondent with complaints
9 that Oxazepam was not working. At the conclusion of this visit, Respondent discontinued the
10 Oxazepam and prescribed her Klonopin¹⁵ 1mg to be taken at bedtime.

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

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

19 67. On or about May 6, 2013, Patient D informed Respondent that she had restarted
20 herself on Ritalin due to her feeling low energy, low motivation, and depression. At the
21

22 ¹³ Oxazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section
23 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It
24 is a benzodiazepine medication used to treat anxiety and depression.

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

28 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.

1 conclusion of the visit, Respondent maintained Patient D on her medication regimen that
2 included, among other things, Klonopin and Depakote.

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

6 **PATIENT E**

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

10 70. On or about February 19, 2014, Respondent prescribed Patient E Adderall¹⁷ 20mg
11 five times daily and Vyvanse¹⁸ 40mg every morning.

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

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

21 73. On or about May 5, 2016, Patient E emailed Respondent informing him that her
22 therapist noted that she was "clinically depressed," and recommended she speak with Respondent

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25 ¹⁷ Adderall (brand name for dextroamphetamine and amphetamine) is a Schedule II controlled
26 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.

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

1 about her medications. Respondent replied to this email the next day via his non-secure email
2 account and asked the patient to schedule an appointment to be seen.

3 74. On or about April 28, 2017, Patient E emailed Respondent via his non-secure email
4 account, informing him that she has been crying for a week, wants to be in bed all day, and feels
5 like she cannot take care of her children. Respondent replied to this email via his non-secure
6 email account on or about May 10, 2017, inquired if she was feeling better, and encouraged her to
7 schedule an appointment to be seen.

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

12 76. On or about November 7, 2017, Patient E presented to Respondent and informed him
13 that she had less episodes of depression, but still required current stimulant dosing combined with
14 Adderall to control her severe depression and ADD symptoms. At the conclusion of this visit,
15 Respondent maintained the patient on her medication regimen that included Adderall 20mg five
16 times daily and Vyvanse 50mg every morning. The chart notes for this visit do not indicate that
17 this was a telemedicine appointment and contain the exact same notes as the visit from October
18 12, 2017.

19 77. On or about March 28, 2018, Patient E presented to Respondent and informed him
20 that she still needed her Adderall and Vyvanse to control her severe depression and ADD. The
21 patient further informed Respondent that she had tried to decrease her dose but had depression
22 immediately with decreased dosing. At the conclusion of this visit, Respondent maintained the
23 patient on her medication regimen that included Adderall 20mg five times daily and Vyvanse
24 50mg every morning. The chart notes for this visit do not indicate that this was a telemedicine
25 appointment.

26 **PATIENT F**

27 78. On or about June 19, 2015, Patient F, a then fifty-six year old female, presented to
28 Respondent for psychiatric treatment for PTSD, anxiety, and insomnia. Patient F's past medical

1 history included thyroid removal and cancer diagnosis in 2013, and a history of substance abuse
2 that involved daily use of methamphetamine and alcohol. Patient F reported current medications
3 that included Oxycodone¹⁹ 10mg for chronic pain and Restoril 30mg. The patient denied any
4 suicidal ideation, but reported feelings of hopelessness, low energy, decreased interest, insomnia,
5 and daily anxiety. Respondent ran the patient's CURES report that day, but did not refer the
6 patient for any labs, did not review any prior treatment records, and did not discuss the patient's
7 care with any of her prior treatment providers. At the conclusion of the visit, Respondent
8 diagnosed the patient with depression, anxiety, and insomnia, and prescribed her medications that
9 included, but were not limited to, Valium 10mg and Restoril 30mg.

10 79. On or about July 15, 2015, Patient F presented to Respondent with complaints of
11 persistent depression, anxiety, and insomnia. At the conclusion of this visit, Respondent
12 discontinued the patient on Valium and Restoril, and prescribed Lexapro²⁰ 20mg, Halcion²¹
13 0.25mg, and Klonopin 1mg.

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

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

21 ///

22 ///

23 ¹⁹ Oxycodone is a Schedule II controlled substance pursuant to Health and Safety Code section
24 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.

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

27 ²¹ Halcion (brand name for Triazolam) is a Schedule IV controlled substance pursuant to Health
28 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.

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

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

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

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

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

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

22 88. On or about September 27, 2016, Patient F presented to Respondent with complaints
23 of worsening anxiety and chronic pain. At the conclusion of this visit, Respondent added Valium
24 10mg back into her medication regimen.

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

28 ///

1 90. On or about March 16, 2017, Patient F presented to Respondent with complaints of
2 persistent moderate depression and anxiety. The patient informed Respondent that she had
3 discontinued Xanax and denied any significant use of pain medications. Respondent discussed
4 the risks of mixing pain medications with benzodiazepines. At the conclusion of this visit,
5 Respondent discontinued the patient on Xanax and prescribed Vyvanse 30mg, Concerta 36mg,
6 Requip²² 0.25mg, and Valium 10mg.

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

9 92. On or about November 7, 2017, Patient F informed Respondent that she had tapered
10 herself off Xanax, but had begun taking Suboxone²³ for chronic pain. At the conclusion of the
11 visit, Respondent increased the patient's Vyvanse dose, but made no other changes to her
12 medication regimen at that time. The patient's chart does not show any documented coordination
13 of care with the patient's pain management doctor on that date or any date thereafter.

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

16 **PATIENT G**

17 94. On or about May 4, 2015, Patient G, a then forty-three year old male, presented to
18 Respondent with complaints of PTSD, depression, and psychotic features. This initial in-person
19 visit did not include a physical examination or review of systems. At the conclusion of this visit,
20 Respondent diagnosed Patient G with PTSD and major depressive disorder, and prescribed him
21 Lexapro and Restoril. The chart note for this visit does not contain a return appointment date.

22 95. Between on or about May 4, 2015, through on or about January 5, 2017, Respondent
23 provided psychiatric treatment to Patient G that included medication refills.

24 _____
25 ²² Requip (brand name for Ropinirole) is a dangerous drug pursuant to Business and Professions
26 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.

27 ²³ Suboxone (brand name for Buprenorphine and Naloxone) is a Schedule III controlled substance
28 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.

1 96. On or about March 17, 2016, Patient G presented to Respondent for a follow-up
2 appointment. Respondent did not see the patient twice that day, but Respondent inexplicably
3 prepared two different progress notes for that same date in the patient's chart. One entry indicates
4 that the presenting problem was, "Pt reports persistent intermittent worsening of depn, anxiety,
5 insomnia, etoh abuse related to depn / anxiety sx's." The second entry indicates the presenting
6 problem was, "pt reports more stable moods / anxiety – denies recent etoh abuse."

7 97. On or about May 31, 2016, Respondent prepared an email to Patient G via his non-
8 secure email account stating that he was "checking in making sure everything is going ok."

9 98. On or about January 5, 2017, Patient G presented to Respondent for a follow-up
10 appointment. At the conclusion of the visit, Respondent discontinued the patient on Restoril and
11 prescribed the patient Halcion and Lexapro with two refills. The chart notes for this visit indicate
12 a plan to continue the current treatment plans, and for the patient to return in one to two months.

13 99. On or about March 17, 2017, Patient G presented to Respondent's office for a
14 prescheduled follow-up appointment. Upon his arrival, the door was locked. Patient G did not
15 receive prior notification that his appointment had been cancelled. The patient emailed
16 Respondent that same day via Respondent's non-secure email account, informing him of the
17 missed appointment and requesting a medication refill. Five days later, on or about March 22,
18 2017, Respondent's employee replied to Patient G via Respondent's non-secure email account,
19 informing him that she called in his refills.

20 100. On or about June 20, 2017, Respondent wrote a prescription for Patient G for Halcion
21 and Lexapro, with two refills. Respondent had not seen the patient since January 5, 2017, and
22 there is no entry in the patient's chart indicating why this medication was prescribed on that date.

23 101. Between in or around June 2017, and in or around August 2017, Patient G repeatedly
24 attempted to contact Respondent for medication refills, and to obtain copies of his medical
25 records. Patient G went to Respondent's office multiple times during that time period, but found
26 it empty and locked. Prior to that time, Patient G did not receive any notification from
27 Respondent notifying him of his permanent office closure, or providing him with updated contact
28 information, or a referral for continued medical care.

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

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

- 7 A. Paragraphs 9 through 24, and paragraphs 40 through 52, above, are hereby
8 realleged and incorporated by this reference as if fully set forth herein;
- 9 B. Failing to maintain appointments with Patient A without prior notification;
- 10 C. Failing to examine Patient A when documenting a patient visit and providing
11 ongoing treatment; and
- 12 D. Failing to maintain appointments with Patient C without prior notification
13 within a reasonable period of time.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Repeated Negligent Acts)**

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

- 20 A. Paragraphs 9 through 102, above, are hereby realleged and incorporated by this
21 reference as if fully set forth herein;
- 22 B. Failing to use HIPAA compliant means of communication of protected
23 information with Patient A;
- 24 C. Failing to prevent long-term use of benzodiazepines in Patient B;
- 25 D. Failing to regularly perform and/or document thorough suicide risk screening in
26 Patient B;
- 27 E. Failing to use HIPAA compliant means of communication of protected
28 information with Patient B;

- 1 F. Failing to timely respond to questions from the pharmacy regarding a
2 prescription for Patient C;
- 3 G. Failing to use HIPAA compliant means of communication of protected
4 information with Patient C;
- 5 H. Failing to prevent long-term use of benzodiazepines with Patient D;
- 6 I. Failing to regularly perform and/or document thorough suicide risk screening in
7 Patient D;
- 8 J. Failing to use HIPAA compliant means of communication of protected
9 information with Patient D;
- 10 K. Prescribing multiple concomitant psychostimulants at excessive dosages to
11 Patient E;
- 12 L. Failing to use HIPAA compliant means of communication of protected
13 information with Patient E;
- 14 M. Failing to consider alternative etiologies to Patient F's problems before
15 prescribing controlled substances;
- 16 N. Failing to prevent long-term use of benzodiazepines with Patient F;
- 17 O. Failing to mitigate risk of medication overdose with CNS depressants combined
18 with opioids in Patient F;
- 19 P. Failing to use HIPAA compliant means of communication of protected
20 information with Patient F;
- 21 Q. Failing to provide Patient G with reasonable notice of his practice closure,
22 updated contact information, or referral to an adequate medical attendant; and
- 23 R. Failing to use HIPAA compliant means of communication of protected
24 information with Patient G.

25 **THIRD CAUSE FOR DISCIPLINE**

26 **(Dishonesty or Corruption)**

27 104. Respondent has further subjected his Physician's and Surgeon's Certificate No.
28 A 79836 to disciplinary action under sections 2227 and 2234, as defined by section 2234,

1 subdivision (e), of the Code, in that he has committed an act or acts of dishonesty or corruption,
2 as more particularly alleged in paragraphs 9 through 101, above, which are hereby incorporated
3 by reference and realleged as if fully set forth herein.

4 **FOURTH CAUSE FOR DISCIPLINE**

5 **(Failure to Maintain Adequate and Accurate Records)**

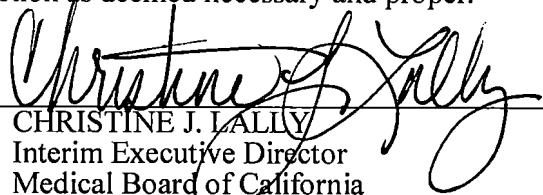
6 105. Respondent has further subjected his Physician's and Surgeon's Certificate No.
7 A 79836 to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the
8 Code, in that Respondent failed to maintain adequate and accurate records regarding his care and
9 treatment of Patients A, B, C, D, E, and G, as more particularly alleged in paragraphs 9 through
10 101, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

11 **PRAYER**

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

- 14 1. Revoking or suspending Physician's and Surgeon's Certificate No. A 79836, issued
15 to Respondent, Richard Paul Heidenfelder, M.D.;
- 16 2. Revoking, suspending or denying approval of Respondent, Richard Paul
17 Heidenfelder, M.D.'s authority to supervise physician assistants and advanced practice nurses;
- 18 3. Ordering Respondent, Richard Paul Heidenfelder, M.D., if placed on probation, to
19 pay the Board the costs of probation monitoring;
- 20 4. Ordering Respondent, Richard Paul Heidenfelder, M.D., if placed on probation, to
21 disclose the disciplinary order to patients pursuant to section 2228.1 of the Code; and
- 22 5. Taking such other and further action as deemed necessary and proper.

23 DATED: December 6, 2019

24 
25 CHRISTINE J. LALLY
26 Interim Executive Director
27 Medical Board of California
28 Department of Consumer Affairs
State of California
Complainant

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