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

In the Matter of the Accusation Against: **RICHARD PAUL HEIDENFELDER, M.D.** **1020 Arroyo Ave.** **South Pasadena, CA 91030** **Physician's and Surgeon's Certificate No. A 79836,** Respondent.	Case No. 800-2016-024443 **A C C U S A T I O N**

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this 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 Accusation 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:

"...

"(b) Gross negligence.

"(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.

"...

"(e) The commission of any act of dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"..."

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."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. 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 Patient A,[1] as more particularly alleged hereinafter:

PATIENT A

8. On or about September 15, 2015, Patient A, a then twenty-eight year old female patient, 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 stress disorder (PTSD), anxiety disorder, and prescribed her Klonopin[2] and Propranolol.[3] The chart for this visit does not contain a return appointment date.

9. 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. 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.

10. 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.

11. 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

[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.

[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.

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.

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

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

14. 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 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.

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

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

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

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

19. 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.

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

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

22. 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.

23. 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 face visit.

24. Respondent committed gross negligence in his care and treatment of Patient A, which included, but was not limited to, the following:

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

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

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. 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 and B, as more particularly alleged hereinafter:

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PATIENT B

26. In or around 2004, Respondent began providing psychiatric treatment to Patient B, a then thirty-six (36) year old female patient he diagnosed with bipolar disorder, generalized anxiety disorder, and attention deficit hyperactivity disorder (ADHD).

27. 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.

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

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

30. 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.

31. 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.

32. 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.

33. 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.

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[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.

34. 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.

35. 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.

36. 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.

37. 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.

38. 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.

39. 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.

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[6] Methylphenidate, brand name Ritalin, 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.

40. On or about December 10, 2015, Patient B was found unresponsive on the floor next to her bed. 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. Her admitting toxicology screen was positive for opiates and benzodiazepines. Patient B died in the hospital approximately ten (10) days later.

41. Respondent committed repeated negligent acts in his care and treatment of Patients A and B, which included but was not limited to, the following:

A. Paragraphs 7 through 40, above, are hereby realleged and incorporated by this reference as if fully set forth herein;

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

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

D. Failing to use HIPAA compliant means of communication of protected information with Patients A and B.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty or Corruption)

42. 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 7 through 41, 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)

43. 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 and B, as more particularly alleged in paragraphs 7 through 41, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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; and

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

DATED: July 9, 2019

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

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