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

In the Matter of the Second Amended Accusation Against **Richard Paul Heidenfelder, M.D.** **Physician's and Surgeons License No. A 79836** **Respondent.**	**Case No. 800-2016-024443**

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on October 2, 2020.

IT IS SO ORDERED: September 3, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **RICHARD PAUL HEIDENFELDER, M.D.** **826 Orange Ave. #605** **Coronado, CA 92118** **Physician's and Surgeon's Certificate No. A 79836** Respondent.	Case No. 800-2016-024443 OAH No. 2019100661 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka[1] (Complainant) is the Executive Director of the Medical Board of California (Board). Christine J. Lally brought this action solely in her official capacity as the Interim Executive Director of the Board. They have been represented in this matter by Xavier

[1] On October 28, 2019, Christine J. Lally became the Interim Executive Director of the Medical Board when former Executive Director, Kimberly Kirchmeyer, became the Director of the Department of Consumer Affairs. On June 15, 2020, William Prasifka became the Executive Director of the Medical Board.

Becerra, Attorney General of the State of California, by Karolyn M. Westfall, Deputy Attorney General.

2. Respondent Richard Paul Heidenfelder, M.D. (Respondent) is represented in this proceeding by attorney Robert W. Frank, Esq., whose address is: Neil, Dymott, Frank, McFall & Trexler, McCabe & Hudson, APLC, 110 West A Street, Suite 1200, San Diego, CA 92101.

3. On or about July 17, 2002, the 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 in Second Amended Accusation No. 800-2016-024443, and will expire on March 31, 2022, unless renewed.

JURISDICTION

4. Second Amended Accusation No. 800-2016-024443, which superseded the First Amended Accusation filed on September 25, 2019, was filed before the Board, and is currently pending against Respondent. The Second Amended Accusation and all other statutorily required documents were properly served on Respondent on December 6, 2019. Respondent timely filed his Notice of Defense.

5. A copy of Second Amended Accusation No. 800-2016-024443 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Second Amended Accusation No. 800-2016-024443. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Second Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision;

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and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent admits that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Second Amended Accusation No. 800-2016-024443, and agrees that he has thereby subjected his Physician's and Surgeon's Certificate No. A 79836 to disciplinary action.

10. Respondent further agrees that if he ever petitions for modification or early termination of probation, or if an accusation and/or petition to revoke probation is filed against him before the Medical Board of California, all of the charges and allegations contained in Second Amended Accusation No. 800-2016-024443 shall be deemed true, correct, and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

12. With Respondent's early acknowledgment that cause exists for the Board's action, Complainant hereby agrees to not further pursue a subpoena enforcement action to obtain medical records of Respondent's family members A.H., L.H., R.H., W.H., and K.R., for five Investigational Subpoena Duces Tecums to Produce Papers and Documents served upon Respondent through his counsel on October 28, 2019.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the

stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 79836 issued to Respondent, Richard Paul Heidenfelder, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years from the effective date of the Decision and Order on the following terms and conditions.

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

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2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING – PRACTICE / BILLING. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice and billing monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American

Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice and billing shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine or billing, or both, and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its

designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. PROHIBITED PRACTICE. During probation, Respondent is prohibited from prescribing controlled substances to himself or family members.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

8. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

11. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards' Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve

Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

14. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of

California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Robert W. Frank, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 6-29-20

RICHARD PAUL HEIDENFELDER, M.D.
Respondent

I have read and fully discussed with Respondent, Richard Paul Heidenfelder, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6-29-20

ROBERT W. FRANK, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 6/29/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

KAROLYN M. WESTFALL
Deputy Attorney General
Attorneys for Complainant

Exhibit A

Second Amended Accusation No. 800-2016-024443

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Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: **RICHARD PAUL HEIDENFELDER, M.D.** **826 Orange Avenue #605** **Coronado, CA 92118** **Physician's and Surgeon's Certificate No. A 79836,** Respondent.	Case No. 800-2016-024443 OAH No. 201910661 **SECOND AMENDED ACCUSATION**

PARTIES

1. Christine J. Lally (Complainant) brings this Second Amended Accusation solely in her official capacity as the Interim 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 Second Amended Accusation, which supersedes the First Amended Accusation filed on September 25, 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:
>
> ...
>
> (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 involving dishonesty or corruption which 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.

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:

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(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

[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.

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 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.

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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.

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 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.

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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.

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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.

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.

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

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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.

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.

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

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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.

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.

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.

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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.

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.

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.

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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.

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

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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.

[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.

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.

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

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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.

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 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 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.

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[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 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.

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.

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.

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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, 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.

PATIENT G

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

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

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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.

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

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

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

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

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

102. 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

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

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

103. 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, F, and G, as more particularly alleged hereinafter:

A. Paragraphs 9 through 102, 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;

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

Q. Failing to provide Patient G with reasonable notice of his practice closure, updated contact information, or referral to an adequate medical attendant; and

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

THIRD CAUSE FOR DISCIPLINE

(Dishonesty or Corruption)

104. 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 101, 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)

105. 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, E, and G, as more particularly alleged in paragraphs 9 through 101, 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;

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: December 6, 2019

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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