ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
600 West Broadway, Suite 1800
San Diego, CA 92101
Telephone: (619) 738-9515
Facsimile: (916) 732-7920
E-mail: Keith.Shaw@doj.ca.gov

Attorneys for Complainant

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

In the Matter of the Accusation Against: **HEIDI REGENASS, M.D.** **2549 Eastbluff Drive, #454** **Newport Beach, CA 92660-5519** **Physician's and Surgeon's Certificate No. C 165083,** Respondent.	Case No. 800-2023-095935 **A C C U S A T I O N**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 4, 2019, the Medical Board issued Physician's and Surgeon's Certificate No. C 165083 to Heidi Regenass, 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 September 30, 2027, unless renewed.

///

JURISDICTION

3. This Accusation is brought before the Medical Board of California, Department of Consumer Affairs, 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 states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

///

///

STATUTORY PROVISIONS

5. Section 2234 of the Code states:

"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:

". . .

"(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.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

". . ."

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 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

COST RECOVERY

8. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the

administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g)(1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

///

///

///

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

9. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that Respondent committed repeated negligent acts in her care and treatment of Patient A[1], as more particularly alleged herein.

PATIENT A

10. On or about January 21, 2022, Patient A, a then 49-year-old female, had a Zoom consultation with an unlicensed patient coordinator for Restore Medical Clinic (Restore), a medical spa and plastic surgery clinic, to discuss improving her body contours. Patient A discussed her interest in liposuction, skin tightening, and fat transfer to the buttocks. Patient A continued to communicate with the patient coordinator following the consultation, including sending photos of herself and agreeing to a price for the surgery. On or about January 24, 2022, the patient coordinator confirmed with Patient A that she had shown the photographs to the surgeon and had discussed their consultation.

11. Patient A scheduled cosmetic surgery with Restore to occur on or about July 11, 2022. Several days prior to surgery, Patient A notified Restore that she was using crutches and splints and was "moving very slowly." The patient coordinator informed Patient A that the surgeon did not believe that using crutches after arm liposuction would be an issue. However, there was no record as to why Patient A was using crutches and splints just prior to surgery, or whether it could be a contraindication to proceeding with surgery.

12. On or about July 5, 2022, Respondent had a telephonic pre-operative visit with Patient A since she was unable to come into the office. However, there was no record of this visit in the patient record. At no time until the day of her surgery did Patient A meet in person with a licensed health care provider at Restore.

13. Patient A first met Respondent in person on the day of her surgery on or about July 11, 2022. Respondent did not document a physical examination other than stating "cleared for

[1] The name of the patient is protected for her privacy. Respondent knows the name of the patient and can confirm her identity through discovery.

surgery," although photographs were taken, and surgical markings were made. Respondent performed liposuction of Patient A's arms, abdomen, flanks, and medial thighs, skin tightening to her abdomen and arms, and fat transfer into her buttocks. The surgery was performed using tumescent anesthesia (a localized anesthesia), oral medications for pain and anxiety, and nitrous oxide. Despite the liposuction procedure involving the removal of over 2000 cubic centimeters of aspirate, Patient A was not provided intravenous access or monitoring of vital signs as required.

14. Following surgery, Respondent did not document an Operative Report, and the Patient Encounter Note provided minimal information. Additionally, Respondent did not record the amount of tumescent anesthesia infiltrated (although 6 liters of tumescent solution was formulated). Further, Respondent did not record the amount of lipoaspirate extracted, the amount of fat compared to supranatant fluid extracted, the amount of fat transferred into each buttock, or where the fat was placed.

15. In the ensuing days after surgery, Patient A informed Restore that the procedure resulted in lax skin to her abdomen, unusual texture on her arms, the presence of a lump of unsightly fat in her left arm, as well as undesirable contouring of her buttocks. Patient A returned to Restore for two post-surgical visits, as well as several procedures and injections with Respondent in an attempt to address her post-surgical concerns.

16. Respondent committed repeated negligent acts in her care and treatment of Patient A which included, but was not limited to, the following:

(a) Respondent failed to document an appropriate physical examination prior to surgery;

(b) Respondent failed to document the pre-operative phone visit;

(c) Respondent failed to appropriately document the liposuction procedure;

(d) Respondent failed to provide intravenous access and intraoperative monitoring; and

(e) Respondent failed to document the amount of fat transferred into the buttocks, and where the fat was placed.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

17. Respondent is further subject 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 her care and treatment of Patient A, as more particularly alleged in paragraphs 9 through 16, 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. C 165083, issued to Respondent Heidi Regenass, M.D.;

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

3. Ordering Respondent Heidi Regenass, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: FEB 09 2026

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SD2025803798
Accusation - Medical Board.docx