BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	
Kenneth Jay Headen, M.D.,	)	CONSENT ORDER
	)	
Respondent.	)	

This matter is before the North Carolina Medical Board ("Board") regarding information provided to the Board concerning Kenneth Jay Headen, M.D., ("Dr. Headen"). Dr. Headen makes the following admissions and the Board makes the following findings and conclusions:

STATUTORY AUTHORITY

The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Article 1 of Chapter 90 of the North Carolina General Statutes and the rules and regulations promulgated thereto.

FINDINGS OF FACT

Dr. Headen was first issued a license to practice medicine and surgery by the Board on or about March 26, 1994, license number 9400266.

At all times relevant herein, Dr. Headen practiced psychiatry in Greensboro, North Carolina.

Beginning in 2011, Dr. Headen became a contract psychiatrist for Winford Brown-Ramseur and Associates ("Winford Brown"), a mental health provider for indigent individuals. As a contract provider, Dr. Headen provided psychiatric care to patients who received services from Winford Brown. Dr. Headen's duties included conducting psychiatric assessments, making appropriate diagnoses, formulating treatment plans, prescribing medication, and providing follow up care. Dr. Headen was also responsible for coordinating his care with the patients' primary care providers.

For the first two years of his association with Winford Brown, Dr. Headen worked one day a week every week. In 2013, Dr. Headen transitioned to working one day a week every other week.

Because of his bi-weekly schedule, Dr. Headen was continually overbooked with patients. At times, he would see as many as twenty to thirty patients per day.

To accommodate all the patients who needed assistance, Winford Brown cut corners, and thus, Dr. Headen's medical records suffered, and his medical services could have been better. Non-physician staff would develop Person-Centered Plans (PCP) and perform Comprehensive Clinical Assessments (CCA) without assistance from Dr. Headen.

Dr. Headen's medical records are insufficient for many patient visits. Diagnoses are made without documentation of proper assessments and justification. Medications are changed without documented medical justification. For many visits, office visit codes are not supported by the medical record. In addition to documentation issues, in many instances, pharmacovigilance is non-existent or poorly practiced, and medications are prescribed without baseline laboratory studies or continual monitoring of vital signs.

Patient A is a twenty-year old female patient who presented to Dr. Headen for medication management. Dr. Headen diagnosed Patient A with posttraumatic stress disorder (PTSD), attention deficit-hyperactive disorder (ADHD), bipolar 1 disorder, tobacco use disorder, and personality disorder not otherwise specified with borderline features. Dr. Headen prescribed Vyvanse® (lisdexamfetamine), Symbyax® (fluoxetine), and Klonopin® (clonazepam) without first obtaining baseline laboratory studies. The North Carolina Controlled Substance Registry System (NCCSRS) was not consulted. The session was coded using Current Procedural Terminology (CPT) code 99205 (high complexity new outpatient) with CPT code 90785 (interactive complexity).

With subsequent visits, pharmacotherapy was changed with the discontinuance of Vyvanse® and Symbyax®. Adderall®

(amphetamine), carbamazepine, and haloperidol were added. A visit on April 23, 2015 was coded 90833 -- psychotherapy of 30 minutes with evaluation and management services -- with total time spent noted as 16 to 37 minutes.

On July 16, 2015, Patient A reported she did not tolerate the carbamazepine and an extended-release version was substituted. Dr. Headen did not document any specifics regarding this intolerance. The session was coded 99214 and 90833 without any supporting documentation of any psychotherapy provided.

The standard of practice in North Carolina would be to document the review of the NCCSRS database prior to and during the prescription of controlled medications; perform and document surveillance for movement disorders and metabolic syndrome when prescribing antipsychotic medications; perform and document therapeutic drug monitoring and end organ functions when prescribing carbamazepine; and document sufficiently the signs and symptoms for the psychiatric diagnoses being provided and any medication intolerance or adverse reactions.

Regarding Patient A's diagnoses, Dr. Headen diagnosed bipolar 1 disorder, unspecified attention deficit-hyperactivity disorder, and personality disorder not otherwise specified with borderline features. These diagnoses were made without

documenting the specific signs and symptoms and temporal courses for those disturbances.

Regarding his treatment, Dr. Headen did not obtain baseline data before prescribing antipsychotic and anticonvulsant medications, and did not perform surveillance for movement disorders and metabolic disturbances related to antipsychotic medications. In addition, therapeutic drug monitoring for carbamazepine along with end organ functions was not done or requested from a primary care provider. Dr. Headen reports it is his custom and practice to encourage his patients to have lab work and physical examinations performed by their primary care providers, however, such encouragement is not documented in the records.

Documentation is at times inadequate to support the CPT codes that are used. Evaluation and management coding must indicate the total length of time for the service provided, a description of the counseling or coordination of care provided, and an indication that at least 50% of the time spent was for counseling or coordination of care. These elements are missing from Patient A's medical record.

Coding for Interactive Complexity (90785) is properly used when there is a need to involve others in the session due to the patient's maladaptive communication. This occurs when the patient possesses an emotional or behavioral condition which

impedes adherence to the treatment plan, there is a legal requirement of mandated reporting to authorities, or there exists a need to utilize play, special equipment or interpreters to communicate with the patient. None of these circumstances are documented in the treatment records.

When documenting a psychotherapy session or a psychotherapy element of a combined psychotherapy and evaluation and management visit, the standard of practice requires the provider to note the time he spent face-to-face with the patient in the psychotherapy, the type of therapeutic intervention provided, the target symptoms addressed, and the patient's progress towards achieving treatment goals. Not all elements are consistently present throughout Dr. Headen's record when psychotherapy services are coded.

Patient B is a twelve-year-old male. Dr. Headen diagnosed Patient B with ADHD, bipolar disorder manic, and oppositional defiant disorder. In August 2013, a diagnosis of PTSD was added. No acute problems or difficulties were documented and baseline vital signs, laboratory studies and movement disorder examinations are not documented in the medical record. The session was coded 99205 (high complexity new outpatient) and 90785 (interactive complexity). The elements justifying these codes, including presence and involvement of the mother during the session, are not documented.

On April 17, 2014, Patient B is seen by Dr. Headen and appears to be doing well; however, no interval history is recorded. Dr. Headen's office incorrectly states Patient B never had a trial of clonidine. Dr. Headen indicates this error was a result of a software issue. On May 8, 2014, Dr. Headen refers to requesting metabolic testing information from Patient B's primary care provider but the results are not found in the record, nor is any follow-up on the request documented.

A chart entry dated July 31, 2014 indicates Patient B is stable and has no acute needs. Patient B's current treatment is noted as effective and tolerated, the medications' risks and benefits are discussed, and no medication changes are made. The session is coded 99215 (extended outpatient evaluation and management service), 90833 (30 minutes psychotherapy) and 90785 (interactive complexity). The patient record should contain more documentation in support of the coding.

A session dated September 11, 2014 indicates Patient B is minimally communicative. Patient B convincingly denies suicidal or homicidal ideation and shows developmentally appropriate insight and judgment. The session is coded 99214, 90833, 90785, with total time of 16 to 37 minutes. Other sessions are similarly documented and coded. More substantial documentation should be included in support of the coding used.

The standard of practice in North Carolina would be to coordinate care with the pediatrician or primary care provider and document those communications; maintain an accurate medical history, especially regarding medication trials; perform and document movement disorder and metabolic syndrome surveillance for patients receiving antipsychotic medications; obtain serial vital signs and height/weight for children on stimulant therapy and clonidine; and document sufficiently in support of coding used.

Dr. Headen failed to meet these standards regarding Patient B.

Patient C is a 45-year-old divorced woman presenting to Dr. Headen for medication management. She complained of chronic pain, anxiety, and recurrent depressive episodes. Diagnoses at the time included major depressive disorder, recurrent, moderate severity, panic disorder, somatic symptom disorder, and dependent personality traits. Complex polypharmacy included an increase in Abilify® (aripiprazole), continuation of Viibryd® (vilazodone HCl), trazodone, Neurontin® (gabapentin), Lyrica® (pregabalin), doxepin, chlorpromazine, bupropion, and tramadol. The initial session was coded 99205 without documenting the required mental status examination, and as 90785 without specific documentation of what constituted interactive complexity.

Patient C returned for appointments on October 10, 2013, February 20, 2014, April 17, 2014, July 17, 2014, October 9, 2014, January 8, 2015, March 30, 2015, April 9, 2015, and July 2, 2015. The time element for most of the sessions is noted as 16 to 37 minutes. The interactive complexity modifier is added in four of the notes.

Medication management for Patient C included initiation of thyroid hormone without first obtaining baseline laboratory studies, prescribing Adderall® for presumptive attention problems based solely on Patient C's self-report, and providing phentermine at Patient C's insistence, presumably for weight loss. Collaborative communication with Patient C's pain clinic and primary care provider is not evident. There is no evidence Dr. Headen ever reviewed Patient C's NCCSRS report despite indications of prescription drug dependence and drug seeking behavior. Had Dr. Headen queried Patient C's NCCSRS record, he would have found an aberrant refill pattern as early as November 18, 2013, an unnecessary early refill on March 29, 2014, and an aberrant prescription pattern through June 28, 2015.

The standard of practice in North Carolina would be to coordinate care with the treating pain clinic and primary care provider and document those communications; monitor the patient's NCCSRS record when prescription medication abuse and drug seeking behavior is suspected; perform and document

movement disorder and metabolic syndrome surveillance for patients receiving antipsychotic medications; perform drug interaction reviews in the face of complex polypharmacy in order to minimize risk to the patient; perform baseline labs when initiating thyroid potentiation and an EKG to monitor for prolonged QTc; and adhere to accurate coding and billing requirements.

Dr. Headen did not comply with these requirements. For example, he accepted Patient C's self-report regarding attention deficit hyperactivity symptoms with known substance use concerns. He prescribed phentermine at Patient C's request without referring Patient C to her primary care provider for proper assessment and vital sign monitoring. He maintained Patient C on complex polypharmacy without documenting the justification of his medication choices or checking for potential drug interactions. He initiated thyroid potentiation without obtaining baseline laboratory studies. His psychotherapy documentation was at times too sparse while coding for psychotherapy services, as well as coding for interactive complexity.

Patient D is an 11-year-old male referred to Dr. Headen for behavioral and attention difficulties. Dr. Headen diagnosed ADHD, combined presentation. A history of asthma is not mentioned, though this is present in other parts of the record.

Patient D's stimulant medication was changed and the session was coded 99205 without a sufficiently comprehensive history or comprehensive psychiatric evaluation being evident from the records. Dr. Headen reports Patient D was always accompanied by a care provider to his visits, however, this is not documented, but the interactive complexity code of 90785 is present. Over 60 minutes was noted as the session length.

An incomplete PCP dated May 5, 2014 was signed by Dr. Headen. The boxes on the PCP form designating whether the patient had been seen by a physician were left blank. Dr. Headen's evaluation of Patient D occurred on May 8, 2014. This would indicate either a clerical error, or perhaps that Patient D's PCP was backdated to May 5, 2014.

Subsequent office visits are coded 99215 with psychotherapy (90833) though at times little treatment documentation for the psychotherapy is present. A note for January 8, 2015 mentions only that Dr. Headen provided a risk assessment and medication management services, yet a psychotherapy code was added. On May 7, 2015, it is noted that Patient D's mother was suspected of failing to fill his prescriptions but no specific treatment modification is documented. Prozac® (fluoxetine) was started at that appointment although the mother's consent is not explicitly noted in the record. The interactive complexity coded (90875) is added in four of the notes without supporting documentation.

Although Dr. Headen reports that it is his custom and practice to always ensure his minor patients are followed by a primary care provider, notes signifying collaboration with the pediatrician are not provided, and vital signs with weight and height throughout the course of Patient D's care are missing.

Patient D's NCCSRS shows obvious inconsistent adherence to therapy.

The standard of practice in North Carolina would be to coordinate care with the pediatrician or primary care provider and document those communications; obtain serial vital signs and height/weight for children on stimulant therapy and clonidine; document informed consent from the parent or guardian prior to instituting medication changes for a minor; and sufficiently document the services provided in support of coding used for billing purposes.

Dr. Headen failed to document that he obtained informed consent from Patient D's parent for medication changes; did not establish collaborative care with the pediatrician or primary care provider; and did not obtain vital signs and height and weight to monitor Patient D's tolerance to stimulant therapy.

On two occasions, May 5, 2014 and July 5, 2014, PCPs were incomplete.

Patient E is a 31-year-old single female presenting to Dr. Headen for medication management of hallucinations, panic

symptoms, and obsessive-compulsive symptoms. Her history was complicated by drug use, prostitution, and significant trauma including rape. Attention and concentration problems are also suspected. On a screening form, she indicated consuming 10 beers a week and active use of cannabis. Diagnoses included unspecified attention deficit-hyperactivity disorder, bipolar 1 disorder, depressed with psychotic features, PTSD, stimulant use disorder (cocaine, moderate, inactive). At her initial appointment three medications were discontinued, including Valium® (diazepam) being abruptly stopped at 30 mg daily (though a different benzodiazepine was substituted), ziprasidone 80 mg twice daily, and trazodone. Four medications were initiated including clonidine, clonazepam, Depakote® (divalproex sodium), and Latuda® (lurasidone HCl). Baseline laboratory studies were not obtained or requested. The NCCSRS record was not reviewed. The session is coded 99215 with 90785 and a session length of over 60 minutes noted.

On October 9, 2014, there is a diagnosis change to mania and Xanax® (alprazolam) 1 mg four times daily is substituted for clonazepam. Chantix® (varenicline) is added for smoking cessation. Notes for a December 14, 2014, visit note a "relapse" with the addition of Vyvanse®, though no treatment note shows the addition of this medication.

In January 9, 2015, the records reflect Patient E reported her dog ate all her prescriptions and her medications needed to be refilled, which was Dr. Headen's shorthand for an early refill request. On March 12, 2015, Cymbalta® (duloxetine) 60 mg a day is initiated for pain. The recommended induction dose for Cymbalta® is 30 mg daily for one week for all indications of the medication.

On April 16, 2015, the office staff noted aberrant Xanax® use and refill requests. The staff confirmed with a pharmacy that Patient E had picked up her prescription despite Patient E claiming she never received the prescription in the mail. On May 6, 2015, the staff document four missed therapy appointments and continued claims of Patient E running out of her medications early. In response, Dr. Headen noted that Patient E would be required to undergo substance abuse treatment and urinary drug screens to continue being a patient. On May 20, 2015, there is the one and only documentation of consultation with the NCCSRS for Patient E.

Sessions are coded 99214 or 99215 with 16 to 37 minutes of session time documented. Psychotherapy codes are added without defining the service beyond "emotional support." The use of the interactive complexity modifier is added without noting the reason.

The standard of practice in North Carolina would be to obtain vital signs or outside record review before initiating antihypertensive medication; monitor patients on antipsychotic medication for movement disorders and metabolic syndrome; obtain NCCSRS reports prior to and during the prescribing of controlled medications for patients at high risk; taper and discontinue Valium® and ziprasidone rather than stopping them abruptly; initiate Cymbalta® at the recommended levels; document signs and symptoms for psychiatric diagnoses and consider alternative diagnoses in the face of substance use; and accurately document services in support of codes used.

Dr. Headen ignored Patient E's admission of alcohol and cannabis use in the face of a self-report of hallucinations. He abruptly discontinued medications while inducing complex polypharmacy at Patient E's first appointment without obtaining baseline laboratory assessments. In addition, the induction of Cymbalta® was made at an excessively high dose. Monitoring for adverse effects from antipsychotic and stimulant agents were not documented. Collaborative communication with Patient E's pain management physician is not evident.

Regarding billing, there are instances in the records where the codes used, including the interactive complexity code need more documentation.

Patient F is a 53-year-old married female who consulted Dr. Headen for medication management for depression, anxiety, marital discord and attention deficit-hyperactivity disorder. The degree of illness was considered severe. Medical comorbidities included hypothyroidism, low back pain, and fibromyalgia. Diagnoses offered included major depressive disorder, single episode in partial remission, panic disorder, somatic symptom disorder, and unspecified attention deficit-hyperactivity disorder. Patient F's previously prescribed medications were continued which included Pristiq® (desvenlafaxine), alprazolam, and Adderall®. The session was coded 99205 with 38 to 52 minutes spent with the patient. Though there is documentation regarding patient history and psychotherapy, the required comprehensive psychiatric examination was not documented.

The standard of practice in North Carolina would be to obtain NCCSRS reports prior to and during the prescribing of controlled medications; initiate and document a collaborative communication with a primary care provider for a patient with significant chronic illness; obtain laboratory studies for a patient on high doses of stimulant therapy along with serial vital signs; and sufficiently document services rendered.

Overall, Dr. Headen's documentation is not always adequate. He did not document having paid sufficient attention to

substance use issues, and his documentation is not always sufficient for the codes.

Patient G is a 42-year-old female and colleague of Dr. Headen. Patient G requested treatment for attention and concentration difficulties related to personal and family stressors. No emergency or lack of alternative providers in the community were identified justifying Dr. Headen accepting Patient G as a patient. Diagnoses included unspecified attention deficit-hyperactivity disorder and adjustment disorder, unspecified. Adderall® was prescribed.

Additional sessions took place at two to four month intervals. Session length is noted to be 16 to 37 minutes each. The sessions are marked "non-billable."

The standard of practice in North Carolina would be to avoid boundary issues and dual relationship patterns outside of an emergency or lack of qualified resources in the community; bill for services actually rendered to maintain a proper therapeutic frame; and obtain and document vital signs when prescribing stimulants, or establish a collaborative communication with a primary care provider where such monitoring could be performed.

Regarding treatment, Dr. Headen took on Patient G for care thus establishing a dual relationship with potential hazards for both the patient and himself. By not billing for services

actually rendered, the therapeutic frame expected in a psychiatric practice becomes distorted.

Dr. Headen should have avoided boundary issues by not agreeing to treat Patient G absent some documented urgency.

CONCLUSIONS OF LAW

Dr. Headen acknowledges that the Board has evidence from which it could conclude that his conduct and care of Patients A through G, as described above, could be determined to constitute unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and grounds exist under this section of the North Carolina General Statutes for the Board to annul, suspend, revoke, condition or limit Dr. Headen's license to practice medicine or to deny any application he might make in the future.

PROCEDURAL STIPULATIONS

Dr. Headen acknowledges and agrees that the Board has jurisdiction over him and over the subject matter of this case.

Dr. Headen knowingly waives his right to any hearing and to any judicial review or appeal in this case.

Dr. Headen acknowledges that he has read and understands this Consent Order and enters into it voluntarily.

Dr. Headen desires to resolve this matter without the need for more formal proceedings.

The Board has determined that it is in the public interest to resolve this case as set forth below.

ORDER

NOW, THEREFORE, with Dr. Headen's consent, it is ORDERED that:

1. Dr. Headen's North Carolina license to practice medicine and surgery is hereby INDEFINITELY SUSPENDED, with that suspension being immediately STAYED, upon the following terms and conditions:

a. Within three months from the date of this Consent Order, Dr. Headen shall obtain an assessment by the Center for Personalized Education for Physicians ("CPEP") and follow all recommendations made by CPEP.

b. In the event that billing and coding are not addressed during the CPEP assessment, Dr. Headen shall obtain continuing medical education (CME) within six months from the date of this Consent Order in the areas of billing and coding. The CME shall be five hours of category 1 and the course(s) must be approved in advance by the Board's Office of Medical Director.

Dr. Headen shall provide a certificate of completion of the course(s) to the Board's Compliance Officer within thirty (30) days of completing the course(s).

c. Dr. Headen shall complete with a passing grade the ProBe Ethics and Boundaries course that is a part of CPEP.

d. Dr. Headen shall supervise nurse practitioners and physician assistants at the following two facilities only: Serenity Rehabilitation Services in Greensboro, and Residential Treatment Services of Alamance in Burlington. Dr. Headen shall not supervise nurse practitioners and physician assistants at any other location without first obtaining Board President approval, which the Board President is under no obligation to give.

2. Dr. Headen shall obey all laws. Likewise, he shall obey all rules and regulations involving the practice of medicine.

3. Dr. Headen shall notify the Board in writing of any change in his residence or practice addresses within ten (10) days of the change.

4. Dr. Headen shall meet with the Board or members of the Board for an investigative interview at such times as requested by the Board.

5. If Dr. Headen fails to comply with any of the terms of this Consent Order, that failure shall constitute unprofessional conduct within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and shall be grounds, after any required notice and hearing, for the Board to annul, suspend or revoke his license and to deny any application he might make in the future or then have pending for a license.

6. This Consent Order shall take effect immediately upon its execution by both Dr. Headen and the Board and it shall continue in effect until specifically ordered otherwise by the Board.

7. Dr. Headen hereby waives any requirement under any law or rule that this Consent Order be served on him.

8. Upon execution by Dr. Headen and the Board, this Consent Order shall become a public record within the meaning of Chapter 132 of the North Carolina General Statutes and shall be subject to public inspection and dissemination pursuant to the provisions thereof. Additionally, it will be reported to persons, entities, agencies and clearinghouses as required and permitted by law including, but not limited to, the Federation of State Medical Boards and the National Practitioner Data Bank.

By Order of the North Carolina Medical Board this the 9th day of June, 2017.

NORTH CAROLINA MEDICAL BOARD

By: Eleanor E. Greene, MD
Eleanor E. Greene, M.D.
President

Consented to this the 31 day of May, 2017.

Kenneth Jay Headen, M.D.

State of NC

County of Guilford

I, Ashley M. Coote, a Notary Public for the above named County and State, do hereby certify that Kenneth Jay Headen, M.D. personally appeared before me this day and acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal

this the 31 day of May, 2017.

Notary Public

(SEAL)

Ashley M. Coote
Notary Public
Guilford County
State of North Carolina

My Commission Expires: Sept. 18, 2017