BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **JOHN PELLERITO, M.D.** License No. 14864 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-10-1255A **FINDINGS OF FACT, CONCLUSIONS OF LA W AND ORDER** (Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on June 8, 2011. John Pellerito, M.D. ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of license number 14864 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-10-1255A after receiving a complaint from the patient's mother regarding Respondent's care and treatment of a 27 year-old female patient ("SM") alleging inappropriate prescribing.

4. Respondent began to see SM as a patient in March 2007 for severe chronic pain of bilateral TMJ that she had experienced since the age of six. SM had co-morbidities with neck pain, upper back pain, headaches and insomnia.

5. According to the Board's medical consultant, Respondent did not obtain consultations for the work up of SM's complaints regarding neck pain, upper back pain, insomnia or headaches. The medical consultant also stated that he failed to refer her for

physical therapy, neurology, psychiatry, anesthesiology, or other specialties to manage her pain. According to Respondent's testimony at the formal, hearing however, the patient did see a TMJ specialist

6. SM had a history of opioid abuse and treatment at a drug detox center, yet Respondent prescribed her methadone and other opioids even after she failed to see a pain specialist or return to the drug detox center. Finally, Respondent received an x-ray of SM performed on March 11, 2010 with a diagnosis of "overdose," but failed to document any discussion of this result with the patient.

7. Respondent did not monitor SM for aberrant behavior and side effects of the medication prescribed. He administered a urine drug screen on only one occasion even though a pharmacy informed him that she had submitted prescriptions from other providers for Oxycodone and Percocet.

8. In February 2010, a pharmacy questioned the prescription for Restoril to be given with Methadone. In June 2010, the pharmacy called to change the prescription of Ciproflaxin and it was changed to Bactrim due to moderate interaction of Ciproflaxin with Methadone.

9. Respondent failed to do X-rays, MRI, EMG/NCS or sleep studies on SM and did not execute a pain contract with her until February 2009. He also failed to document a detailed history and physical and establish medical diagnoses during the course of the treatment.

10. At the Formal Interview, Respondent testified that the patient came to him in pain and appeared to have nowhere else to go. He believed that his job was to try to help her. He acknowledged that he did not do some of "the objective things" he should have been doing, but noted that the patient had started to see a psychiatrist and had been improving.

11. During deliberations, Board members expressed concern that Respondent had previously received an Advisory Letter for inappropriate prescribing practices and that the potential for serious harm to the patient in this case was substantial..

12. The standard of care for prescribing opioids for chronic pain requires a physician to establish the diagnosis and treatment plan prior to prescribing opioids.

13. Respondent deviated from the standard of care by failing to establish the diagnosis and treatment plan prior to prescribing opioids.

14. The standard of care for prescribing opioids for chronic pain requires a physician to obtain appropriate consults from other physicians in pain medicine, neurology, psychiatry and/or psychology and physical therapy.

15. Respondent deviated from the standard of care by failing to obtain appropriate consults from other physicians.

16. The standard of care for prescribing opioids for chronic pain requires a physician to adjust medication doses to control the pain and non-pharmacological treatments such as injections and physical therapy are to be included in the overall management of the patient.

17. Respondent deviated from the standard of care by failing to adjust medication doses to control the pain and include non-pharmacological treatments such as injections and physical therapy in the overall management of the patient.

18. The standard of care for prescribing opioids requires a physician to perform random urine drug testing and pill counts to determine medication compliance.

19. Respondent deviated from the standard of care by failing to perform random urine drug screens and pill counts to determine SM's medication compliance.

20. SM is at risk for unnecessary and incorrect treatment as a result of the inappropriate prescribing practices.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

3. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient.")

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.

2. Respondent is placed on probation for ONE year with the following terms and conditions:

Respondent shall within six months of the effective date of this Order complete the PACE prescribing course. Upon completion of the CME, Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical license. The probation shall terminate upon successful completion of the CME.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after

date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 11TH day of AUGUST, 2011.

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(SEAL)

ARIZONA MEDICAL BOARD

By _____
Lisa S. Wynn
Executive Director

EXECUTED COPY of the foregoing mailed this 17th day of August, 2011 to:

John Pellerito, MD
Address of Record

ORIGINAL of the foregoing filed this 17th day of August, 2011 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

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Arizona Medical Board Staff