

1                   **BEFORE THE ARIZONA STATE BOARD OF DENTAL EXAMINERS**

2  
3   IN THE MATTER OF:

Case No. 201200237

4   **Michael D. Margolis, D. D. S.**

**DISCIPLINARY  
CONSENT AGREEMENT  
AND ORDER**

5   Holder of License No. D 2957  
6   For the Practice of Dentistry  
7   In the State of Arizona.

8           In order to resolve this case quickly and judiciously, the Arizona State Board of  
9   Dental Examiners ("Board") and Michael D. Margolis, D.D.S. enter into this Disciplinary  
10   Consent Agreement and Order ("Consent Agreement") in lieu of further administrative  
11   and judicial proceedings. It is consistent with the public interest and the requirements  
12   and statutory authority of the Board, specifically, A.R.S. §§ 32-1263.01, -1263.02, and  
13   41- 1092.07(F) (5). This Consent Agreement shall resolve all issues the Board has  
14   reviewed and investigated regarding the allegations in this matter.

15           Therefore, in lieu of further proceedings, Michael D. Margolis, D.D.S. admits and  
16   understands that:

17           1.     Any record prepared in this matter, all investigative materials prepared and  
18   received by the Board concerning the allegations, and all related materials and exhibits  
19   may be retained in the Board's file pertaining to this matter.

20           2.     Dr. Margolis waives any right to a hearing or re-hearing of this matter and  
21   any right to judicial review of the attached Findings of Fact, Conclusions of Law, and  
22   Order.

23           3.     Dr. Margolis has the right to consult with an attorney prior to entering into  
24   this Consent Agreement.

25           4.     The findings contained in the Findings of Fact portion of the Consent  
26   Agreement are conclusive evidence of the stated facts. The Board may consider this  
Consent Agreement when and if future disciplinary proceedings arise.



1 and, extraction of tooth # 32. There is no corroborating clinical evidence in AM's  
2 treatment record other than the Cavitat, the radiographs, and her complaints of pain  
3 supporting the diagnosis.

4 3. There is no documentation of an informed consent process or discussion  
5 regarding proposed treatment in AM's treatment records.

6 4. The diagnosis of NICO (a clinical term used for facial pain generated by  
7 osteonecrosis of the jaw), is controversial and it is not recognized by the World Health  
8 Organization, American Dental Association, American Medical Association, American  
9 Association of Oral and Maxillofacial Surgeons, or the American Association of  
10 Endodontics.

11 5. Dr. Margolis treatment planned AM for the following procedures: the  
12 extraction of teeth #'s 2 and 3 and the removal of odontogenic cysts in those areas; the  
13 extraction of tooth # 32 (full bony impaction); radical resections of "NICO/cavitations" in  
14 the areas of teeth #'s 1, 16 and 17; and, bone grafting at teeth #'s 1, 2, 3, 16 and 17.

15 6. On April 10, 2012, AM presented to Dr. Margolis' office for surgery. Prior  
16 to the appointment, AM took .025 mg of Xanax, as prescribed by Dr. Margolis. AM  
17 signed a blanket, non-specific consent form and the treatment plan just prior to her  
18 surgery while under the influence of Xanax.

19 7. Dr. Margolis performed the following procedures on AM at the April 10,  
20 2012 appointment: extraction of teeth #'s 2, 3, and 32; intra-bony biopsy and dental  
21 DNA sample taken of tooth #1; biopsy of tooth #3 and dental DNA sample taken at area  
22 of tooth #3; and puross grafting at areas of teeth #'s 1, 2, and 3.

23 8. Dr. Margolis failed to document any referral of AM to an oral surgeon for  
24 the extraction of tooth #32 which was full bony impacted with close nerve proximity. Dr.  
25 Margolis experienced complications with the extraction of tooth #32. AM experienced  
26 pain during the extraction and requested Dr. Margolis to stop. Dr. Margolis stopped to

1 allow AM to rest but then continued with the extraction. He did not consider emergent  
2 referral to an oral surgeon.

3 9. After extracting teeth #'s 2, 3 and 32, Dr. Margolis "cleaned" the sockets  
4 with a #10 round bur. This was an atypical and improper surgical technique for tooth #32  
5 because it was a full, bony impacted tooth with extremely close proximity to the inferior  
6 alveolar nerve.

7 10. Dr. Margolis' treatment records for AM indicate that during the April 10,  
8 2012 appointment, he administered 810 mg of Mepivacaine over 3 hours, which exceeded  
9 the maximum recommended dose of 400mg.

10 11. Following the April 10, 2012 treatment, AM experienced significant and  
11 lasting right inferior alveolar nerve parasesthesia. AM returned to see Dr. Margolis on  
12 three occasions to address the parasesthesia. AM's treatment record indicates that Dr.  
13 Margolis treated the parasesthesia with Periolas, an off -label, non-FDA approved  
14 treatment, along with homeopathic remedies to attempt to rejuvenate the damaged nerve.  
15 Dr. Margolis failed to adequately address AM's paresthesia. There is no documentation  
16 in AM's treatment records of a discussion regarding micro-nerve exploration and  
17 possible repair and Dr. Margolis failed to document a referral to an oral surgeon to  
18 evaluate and treat the paresthesia.

## 19 20 **CONCLUSION OF LAW**

21 The conduct and circumstances described in the above Findings of Fact constitute  
22 unprofessional conduct as defined by A.R.S. § 32-1201 21(n). Such conduct is grounds  
23 for discipline under A.R.S. § 32-1263(A)(1).  
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25  
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1 A copy of the following mailed by CERTIFIED MAIL this 13<sup>th</sup> day of June 2013 to:

2 Michael D. Margolis, D.D.S.  
3 2045 S. Vineyard Rd., Suite 153  
4 Mesa, AZ 85210

5 A.M.

6 A copy mailed by US MAIL to:

7 Lori A. Curtis, Partner  
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