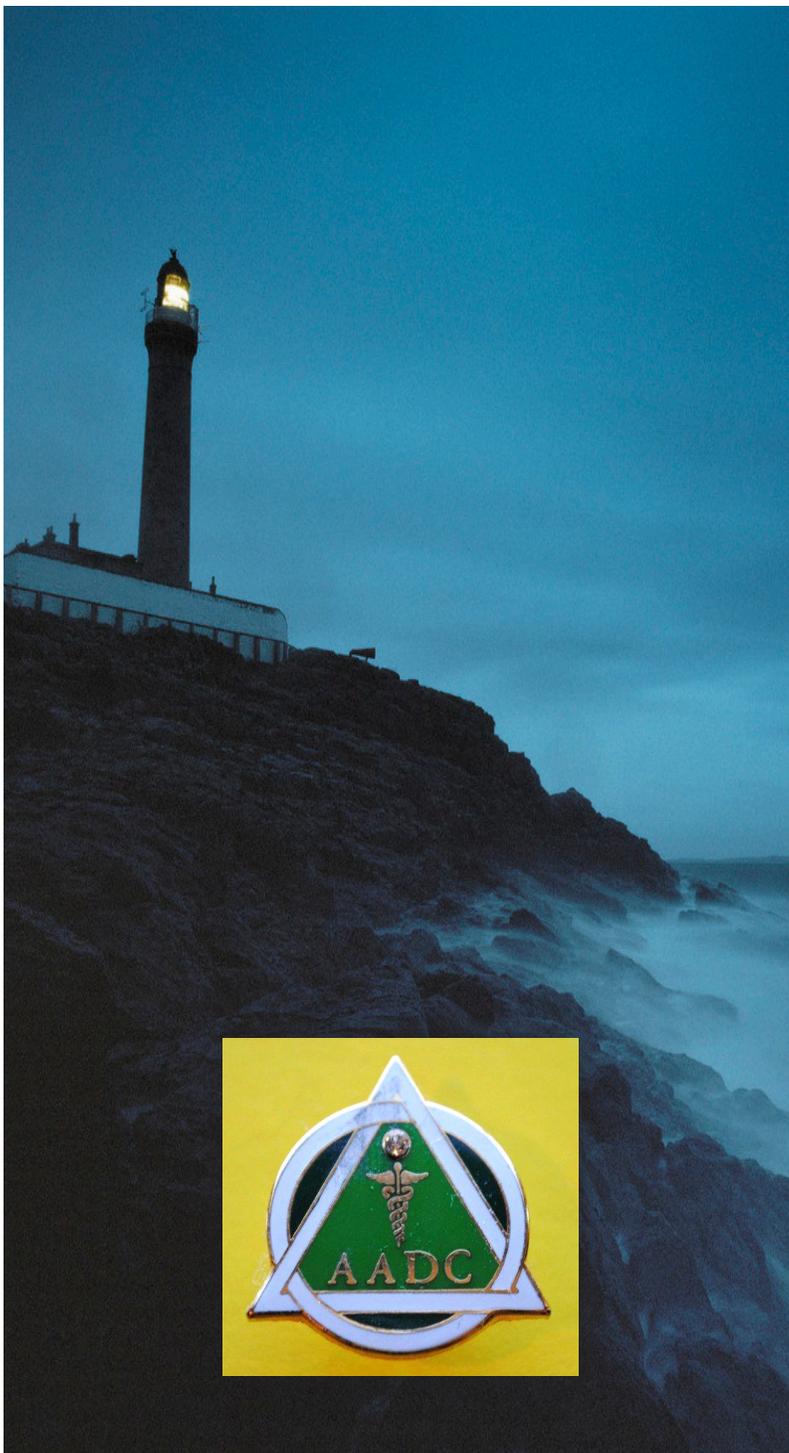


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YEARS

SPRING 2026

THE BEACON

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AMERICAN ASSOCIATION OF DENTAL CONSULTANTS

Updated May 2025
Terms expire annually in May

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President's Message

Dr. M. J. A. Thomas, CDC, FACD, FICD, FPFA
President, American Association of Dental Consultants

Elevate. Collaborate. Innovate. **Advancing the Future of Dental Consulting Together**

During my Incoming President's remarks, I shared three guiding principles that would shape our year together: Elevate, Collaborate, and Innovate. These principles were not simply aspirational words; they were intended to serve as the framework through which we would advance the mission and vision of the American Association of Dental Consultants.

With our mission as our North Star and our strategic plan as our GPS, the AADC has enjoyed an exceptional year marked by meaningful progress and purposeful action. Together, we have demonstrated what is possible when vision is matched with commitment.

Elevate

The concept of establishing an AADC Scholarship Program was introduced as a presidential legacy by Dr. Randi Tillman, reflecting her forward-thinking vision to invest in the future of the profession. During my presidential tenure, the AADC Scholarship Committee was formally established, and the development of the scholarship program is now actively underway.



This important initiative advances AADC's guiding principle to Elevate by expanding opportunity, fostering professional growth, and supporting the next generation of dental consultants.

Collaborate

This year we launched the AADC Vanguard Leadership Nexus—a dynamic intersection where leaders across organizations connect, share insights, and strengthen collaborative partnerships.

This initiative brings together AADC members who serve in leadership roles across professional organizations, creating opportunities to exchange ideas, align strategies, and amplify our collective impact across the dental profession.

Innovate

We also introduced the AADC Generations Collaborative, a cross-generational knowledge exchange designed to connect our members experience, insight, and innovation.

This initiative reimagines mentorship by creating a dynamic environment where members learn from one another, share lived expertise and cultivate leadership across generations assuring that the wisdom of experience and the energy of emerging leaders work together to strengthen the future of our profession.

In addition, the President's Roundtable was established to honor the invaluable legacy of our past presidents. This forum engages their collective wisdom to preserve institutional knowledge while providing insight and guidance to support the organization's continued growth.

A Year of Strength and Excellence

The AADC remains financially sound and membership strong as we continue to lead the way as the premier organization for dental insurance consultants. Under the expert leadership of our Committee Chairs and Co-Chairs, and through the dedicated work of our committees, this year's accomplishments reflect a continued commitment to excellence:

- Strong and engaged membership
- A stellar 2026 AADC Workshop
- A seamless CDC certification process
- An exemplary The Beacon publication
- A visionary strategic plan guiding our future
- Effective organizational governance and bylaws
- An extensive website serving as a valuable member resource

Gratitude and Reflection

AADC thrives because its success is built not by individuals alone, but by the collective contributions of dedicated members working together with purpose and passion.



I extend my deepest appreciation to our extraordinary Board of Directors, our exceptional Executive Director, our empowering Chairs, Co-Chairs, and committee members, and to our outstanding membership whose engagement and dedication continue to move this organization forward.

It has been a profound honor to serve as President of this illustrious organization as we continue to build

a legacy defined by excellence, integrity, elevation, collaboration, innovation and transformative impact.

Thank you for your trust, your service, and your steadfast commitment to the mission and values that make the American Association of Dental Consultants more than an organization, it makes us a force for progress and leadership within our profession.



AMERICAN ASSOCIATION OF DENTAL CONSULTANTS

DEDICATED TO SERVING PATIENTS, THE PUBLIC, PURCHASERS OF HEALTH BENEFITS, AND THE PROFESSION OF DENTISTRY.

THE MISSION of the American Association of Dental Consultants is to provide skills for competent and ethical decision making through quality education and networking opportunities which will serve the best interests of patients, purchasers of healthcare benefits, and the dental profession.





AADC President Honored with Distinguished Recognitions

At the 47th Western Area Conference of The Links, Incorporated, Dr. Madeline J. Anderson Thomas was celebrated for her remarkable 25 years of dedicated service. This milestone not only honors her steadfast commitment to friendship and service—the two core pillars of the organization—but also reflects the depth of her leadership and impact across communities. Throughout the conference, Dr. Thomas’s presence resonated as both a trusted voice in oral health and a respected advocate for oral health, underscoring her enduring influence within and beyond the dental profession.

During the conference, Dr. Thomas also served as a distinguished panelist during the *State of Black Women’s Health Lyceum*. This important forum convened thought leaders and advocates to address pressing health disparities affecting Black women and their families, underscoring the critical need for awareness, advocacy, and sustainable solutions. Dr. Thomas elevated the voice of oral health in this space, reinforcing the essential role of oral health in overall health.

In addition, she was awarded the prestigious *Western Area Emerald Vice Presidents Award*, an honor reserved for Chapter Vice Presidents who embody the values and mission of The Links, Incorporated and who demonstrated exceptional leadership and service within their local chapters.

Dr. Thomas's influence extended beyond The Links Conference. At the 112th *National Dental Association Convention*, she was deeply honored to deliver the message during the Ecumenical Service. As a long-time leader and Past Chairman of the NDA Board of Trustees, her words carried both spiritual depth and professional wisdom, inspiring colleagues and attendees alike.

Dr. Thomas's recent recognitions highlight a distinguished legacy of leadership, service, and excellence. Through her efforts to elevate the role of oral health on national platforms, inspire colleagues with both professional insight and spiritual depth, and champion community well-being, she exemplifies the highest standards of the dental profession. These honors not only acknowledge her past contributions but also affirm the continued impact of a leader whose work is anchored in purpose, advocacy, and excellence.

TO OUR MEMBERS

If you have received an award or special recognition related to dentistry or the dental benefit industry, we would be pleased to share such recognition with the membership in *The Beacon*.

Please forward to your editor at copdha@sunlink.net.

AADC Members are dedicated to serving patients, the public, purchasers of dental benefits, and the profession of dentistry. An experienced dental benefits consultant can provide valuable insight and input on:

Network issues

Dental claim policy and standards of care

Dental plan coverage and utilization management

Our goal is to connect dentists and others involved in dental benefits consulting and administration, to identify and promote best practices, and to advance education and promote a common base of knowledge for consistent, evidence-based plan and claims evaluations.



Botox: Newest Trend in Treating Bruxism

Angela M. Davis, DDS

Bruxism is not just the grinding of teeth. Teeth clenching and grinding are common involuntary reactions to anger, fear, or stress. In some people, this reaction plays out repeatedly throughout the day, even if they are not responding to an immediate stressor. Damage from bruxism can be minor or lead to irreversible damage of the hard and soft tissues of the oral cavity. No matter the age of the patient, treatment for bruxism can often include a multidisciplinary approach which includes hard and soft occlusal splints, counseling, and more recently providers have opted to treat bruxism with Botulism toxin A injections (commonly referred to as Botox).



©Dilich Hirschinger, DDS, Inc. Temporalis, Superficial and Deep Masseter Muscles

What is Bruxism?

Do you clench your teeth—biting down and holding your teeth together? Or perhaps you grind your teeth, rubbing them front to back or side to side.⁸ Putting this kind of pressure on your teeth is called bruxism. Bruxism can not only cause problems with your teeth, but it can also cause headaches or pain in your jaw joints or muscles.⁸

The term “la bruxomanie” was first introduced by Marie Pietkiewicz in 1907.¹¹ The term “bruxism” was adopted to describe gnashing and grinding of the teeth occurring without a functional purpose.¹¹ People who grind and clench their teeth usually do not do so intentionally.³ The Glossary of Prosthodontic Terms defines bruxism as parafunctional grinding of teeth or an oral habit consisting of involun-

tary rhythmic or spasmodic non-functional gnashing, grinding or clenching of teeth in other than chewing movements of the mandible which may lead to occlusal trauma.¹¹

Bruxism is a movement disorder.¹¹ The clenching is unconscious and is usually most severe during sleep.³ Even though they are asleep, people may clench down with a force of up to 250 pounds (1,700 kilopascals) because there is no active protective feedback mechanism.³ People may not be aware that they clench their teeth, but family members often notice.³ Tooth grinding is an activity particularly important to the dentist because of breakage of dental restorations, tooth damage, induction of temporal headache and temporomandibular disorders.¹¹ The pathophysiology of bruxism is related to the circadian phase.⁵ Teeth grinding can occur during sleep (sleep bruxism) and while awake (awake bruxism).³

Sleep Bruxism vs Awake Bruxism

Awake bruxism is often associated with stress and heightened alertness, which can lead to increased autonomic cardiac activity. Awake bruxism presents as masticatory muscle activity during wakefulness, where repetitive or sustained tooth contact is associated with mandibular bracing or thrusting. This activity is not considered a movement disorder in otherwise healthy patients.⁵ Awake bruxism is more common in adults.⁸ Awake bruxism affects 22.1% to 31% of the population.⁵

Sleep-related bruxism, associated with normal sleep arousals and various underlying medical conditions

such as obstructive sleep apnea, Down syndrome, and medication effects, can cause considerable damage to teeth and dental work, resulting in morning jaw pain or fatigue, temporal headaches, and restricted motion of the temporomandibular joint.⁵ Sleep apnea and anxiety are the most common risk factors associated with sleep bruxism.⁵ The damage is often worse in people who have gastroesophageal reflux disease (GERD) and/or obstructive sleep apnea.⁸ Teeth grinding eventually wears down and damages teeth. Sleep bruxism can develop as early as age 4 years, but it peaks at the ages of 10 through 14 years.⁸ Sleep bruxism is most common in children, affecting 15% to 40% of children and 8% to 10% of adults.⁵ Clinicians must utilize a comprehensive treatment approach encompassing counseling, lifestyle management, oral devices, and medication management to address bruxism.⁵

Cracked Tooth Syndrome

Cameron proposed “cracked tooth syndrome (CTS)” in 1964 and defined it as a critical posterior tooth incomplete fracture that includes the dentin extending to the pulp.¹ This definition was later modified by Ellis as “a fracture plane of unknown depth and direction passing through the tooth structure that, if not already involved, may progress to communicate with the pulp and/or periodontal ligament.”² Multiple factors such as bite force and thermal cycling can cause crack lines on the tooth or damage the tooth structure.⁶ The predisposing factors for CTS are factors that increase the force acting on the teeth or those that weaken the resistance of the teeth to



(a)



(b)

Pictured Above: Restoration of a fractured right mandibular second molar using a gold onlay. (a) A cracked tooth prepared for restoration via onlay bonded with resin; (b) 22 months after restoration via bonded type III gold alloy inlays with Panavia Ex cement.⁶

the chewing force.⁶ The symptoms of CTS include spontaneous pain, bite pain, and cold irritation pain; the bite pain gets worse when the bite force increases.⁶ Cracked tooth syndrome is associated with many complications ranging from pulp necrosis to catastrophic tooth fracture requiring extraction.⁴ The condition can be further complicated in patients with extensively restored dentition and parafunctional habits such as nail biting and nocturnal bruxism.⁴

Prevention plays an important role in halting the occurrence and development of CTS caused by medical, environmental, or genetic factors. Individuals should maintain good oral hygiene by adopting good oral hygiene practices, developing healthy chewing habits, and following a proper diet (such as avoiding clenching, extensive grinding, abrasion, bruxism, eating betel nut, and hard food). Additionally, increasing the frequency of oral examinations

can also be effective in preventing CTS, which is especially important for the elderly.⁶

Dental appliances such as hard acrylic and soft splints can prevent CTS by dividing the force throughout the masticatory system and decreasing the frequency, but not the intensity of bruxism.⁶ Appliances should be worn continuously because once the appliance is removed, the muscle activity may return to previous levels.⁶

Treating Bruxism with Botox

Botulism was first described by Kerner as a life-threatening disease. *Bacillus subtilis*, a gram-positive, rod-shaped, spore-forming anaerobe bacterium, and *Clostridium butyricum* and *Clostridium baratii*, which are commonly found on crops and also in soil, water, and animal fecal matter, produce botulinum toxin (BT).⁹ Botulinum toxin emerged in the 19th cen-



Figure 1. Safety limits for infiltration of the masseter: The upper limit is the commissure line to the earlobe (above the Stensen duct location). The anterior limit is the anterior edge of the masseter (the risorius muscle is in this area). The lower limit is the jaw's lower edge. The posterior boundary is the masseter's posterior border (the parotid gland).¹⁰

tury when the Belgian bacteriologist van Ermengem discovered it in 1895.¹⁰ This bacterium produces a protein that can produce the most powerful neurotoxic substance known.¹⁰ Botox is one of the deadliest toxic elements used in biological weapons.⁹

Botulinum toxin type A (BoNT-A) and hyaluronic acid (HA) dermal fillers have emerged as valuable adjuncts in various medical specialties, including dentistry, because of their diverse clinical applications and therapeutic benefits.¹⁰ All BoNTs share a sustained action (three to six months), which makes them unique pharmacotherapeutic agents.¹⁰ Muscle function is recovered after three to six months.¹⁰ Treatment with a BoNT appears beneficial in the case of bruxism, especially nocturnal bruxism, but several limiting factors, such as the high cost and need for repeated injections, prevent its widespread use.¹⁰

BoNT-A injections in the masseter muscle provide a non-invasive solution for bruxism and masseteric

hypertrophy.⁷ By selectively targeting the masseter muscle, BoNT-A can reduce muscle activity, alleviating symptoms such as teeth grinding and jaw clenching.⁷ Studies have demonstrated the efficacy of BoNT-A in managing bruxism-related symptoms and reducing masseteric hypertrophy, thus improving patient comfort and preventing dental complications.⁷

Injections of Botox (with a dosage ranging from 25 to 100 units on each side) into the masseter muscles on both sides have been proven to significantly diminish the severity of symptoms for 6 to 78 weeks (the mean is 17 to 19 weeks).⁹ The hypertrophy of temporalis and masseter muscles is generally associated with clenching or other parafunctional use of the jaws. The results of Botox use in cases with masseter and temporalis muscle hypertrophy are very encouraging and appear to be safe and effective in treating chronic facial pain associated with mas-

tatory hyperactivity.¹² For other healthy patients, injections with a concentration of 100 units seem to be dependable.⁹ Botox therapy is just as successful at treating bruxism as an oral splint. The use of Botox in children under the age of 18 should be limited, following FDA recommendations for its usage.⁹ Botox has no known lethal dose in humans, although injecting around 30 vials, estimated to cost around 3000 U.S. dollars, for dental applications totaling about 80-100 units, has the potential to be fatal.⁹ It offers a minimally invasive method for treating and controlling a limited number of appropriate cases, with the fewest possible problems.⁹ However, the practicing dentist must ensure that the treatment is within his/her scope of practice and has appropriate training not just to administer but also to deal with its potential adverse effects.¹² Continued interdisciplinary collaboration and evidence-based practice are crucial to fully realize the potential benefits of these treatments, meeting the evolving needs of patients and advancing dental care standards.⁷

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Dental Longevity



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Have you ever wondered how the “aging process” affects your oral health?

Changes in the oral cavity due to aging have three main drivers: physical, biochemical, and environmental. As a dentist, I educate my patients on these “aging drivers” and offer ways to help decrease their effects on the aging process.

Physical Changes

Teeth can drift and change position as we age. These positional changes can have ill effects on the teeth, periodontium, and even the airway. The first things noticed during an initial dental consultation are crowded teeth, gingival changes, worn cusps, and complaints of temperature sensitivity. If nothing is done to prevent things from progressing, then periodontal disease, broken teeth, or infection can worsen. This progression may lead to tooth loss and issues with chewing and nutrition.

Biochemical Changes

Our body’s biochemical changes are another reason oral health starts to fail. Our bodies go through hormonal and microbiome shifts, and the delicate pH of the mouth can change. Many people experience silent reflux, which causes a higher concentration of acid in the saliva and can lead to enamel erosion. Blood sugar changes affect the oral tissues and can make the gingival crevicular fluid sub-optimal so that inflammatory cells

start destroying the periodontium. Conditions such as Sjögren's Syndrome not only cause dry eyes but can also lead to a reduction in saliva, allowing more plaque bacteria to accumulate on the teeth and oral tissues. This may lead to caries and even oral yeast infections, causing a "burning mouth syndrome". Many of these patients can experience oral lesions, which make it more difficult to chew and process food. All of which can lead to behavioral changes, causing a reduction in proper home care, leading to additional dental problems.

Systemically, hormonal changes may lead to weight gain, which can lead to an obstructive airway. Obstructive airway disease is a disorder that causes many negative oral and systemic health effects. When people do not breathe while sleeping, they will also lack deep sleep. Lack of REM sleep can cause bruxism, leading to headaches, TMJ muscle pain, and worn-down teeth. The worn dentition causes failure of teeth, a collapse of the dimension of occlusion, and overall serious health issues.

Environmental Factors

The final category includes environmental factors, not just the processed and sugary foods we eat, but everything we consume, including prescription medications. Many patients take multiple medications per day to combat a variety of health and wellness conditions. I've seen patients who take medications that have side effects, including bruxism and dry mouth. Sometimes, the oral side effects of certain medications, such as Selective Serotonin Reuptake Inhibitors for depression or hot flashes, medications

for heart disease, and other disorders,; side effects of these medications can cause the mouth to be dry and lead to nighttime grinding. Other environmental factors include snoring, lack of sleep, bruxism, taking prescription drugs, and the habitual use of tobacco products and alcohol. All these factors combined create a stressed oral environment that accelerates breakdown and aging.

Solutions?

What can be done to reduce the effects of these factors on aging? Although currently, we cannot measure the biomarkers of the negative oral effects associated with aging, there are some physical and biological protective measures we can take to improve our "dental longevity".

First, it is best to re-establish a proper occlusion and realign the teeth. The alignment can be done with traditional orthodontics or clear aligners and is surprisingly fast. By doing this, the patient can prevent the breakdown due to poor tooth position, crowding, and traumatic occlusion. If orthodontics is not practical, then I may recommend a hard full arch occlusal guard or an obstructive airway device such as a "snore-guard", something to help alleviate the effects of grinding or an airway disorder.

For grinding caused by medications, a professional custom night guard works well for the protection of teeth and masticatory muscles. Botox injections into the masseter muscles can also depress muscle activity and help to prevent headaches and jaw pain caused by bruxism.

When it comes to dry mouth, the best thing we can do is drink plenty of water to hydrate the tissues. It is also best to stay away from foods and drinks that dehydrate the system, such as caffeine and alcohol. Eliminating sugar and utilizing the sugar replacement agent called Xylitol repeatedly throughout the day will also help prevent dry mouth. Xylitol is a sugar substitute, and the bacteria in our mouth, *Streptococcus mutans*, which consume sugar and excrete destructive acids onto the teeth, prefer Xylitol. The good news is that if the *Streptococcus mutans* "eats" the Xylitol, they will starve and ultimately die, leading to fewer decay-producing bacteria in the mouth. This lowers the caries rate, and people with dry mouth who are more susceptible to caries will have more protection against tooth decay. Fluoride applied to teeth, especially around existing dental work, can also help protect the enamel as it strengthens the structure and even reverses areas of early (incipient) caries.

Finally, proper diagnosis and treatment of periodontal disease is a well-established way to help prevent tooth loss. Whether the periodontal disease is caused by a physical, biochemical, or environmental process, the treatment of the disease that causes bone loss is critical, as without healthy bone, we will not have teeth. Having regular hygiene appoint-

ments, proper radiographs, and periodontal charting is necessary for the diagnosis of periodontal disease. This disease, which results in the loss of supporting bone to teeth, is typically painless and progressive. The disease is caused by invasive bacteria that infect the bone around the teeth. We help prevent this by scaling off the living environment of these anaerobic bacteria on the root surfaces of teeth. This way, the bacteria count is lowered, and we maintain this clean root surface professionally every three months to ensure the health of the tissues, decreased inflammation, and avoidance of recurrence. Sometimes lasers and chemical agents are used professionally to help clean deeper periodontal pockets, promote healing, and re-establish healthy periodontal tissues that support the teeth and gingiva. Proper home care, including ideal brushing technique using a soft toothbrush, flossing, and water irrigation, is the best way to keep the oral environment clean between professional appointments.

All in all, there is an obvious aging connection between our bodies and the oral cavity, and even though I do not have the means to tell the exact cause, the ill effects of this process can be greatly reduced with proper education, preventive treatment, and home care to increase the health and longevity of the mouth.



Silver Diamine Fluoride: An Effective Non-Invasive Approach to Restorative Dentistry

Marysia Lynn Taylor, DDS

International health organizations agree that one of the most common chronic oral diseases in children is dental caries. According to the Centers for Disease Control and Prevention, dental caries in children is one of the most prevalent chronic diseases in childhood¹. It is noticeably worse in low-income or underserved areas due to diet, hygiene, and lack of access to dental care. Traditionally caries lesions in children have been treated using invasive restorative methods. Caries removal and restoration with composite resins, amalgam, and stainless-steel crowns, often under general anesthesia or sedation, was considered standard of care. Such management of caries in children, while effective, is costly and traumatic. When considering treatment for young, apprehensive, uncooperative, or mentally challenged patients, practitioners should consider a noninvasive, less costly, method such as Silver Diamine Fluoride (SDF). The efficacy of SDF in controlling caries progression has been studied and is currently used in practices serving children and underserved adults. In the past, the material was applied biannually as a fluoride preventative agent. More recently, it is considered to be a cost-effective atraumatic choice of treatment for childhood caries.²



Current epidemiological data show that more than 500 million children around the world today have untreated dental caries.⁴ One in five children under the age of five have untreated caries lesions, and over half of the child population have at least one lesion by the age of eleven.⁴ There are multiple factors that contribute to the increase in dental caries lesions in children. For example, in communities with non-fluoridated water, you may find a population with a higher rate of rampant caries than people residing in communities with fluoridated public water supply. Fluoridated water helps prevent caries by strengthening the tooth structure and making it harder for bacteria to stick to enamel surfaces while making the enamel surface less susceptible to dissolution by bacterial acid. Another factor is the ratio of dental providers to residents. There may be a higher caries index in children in areas where the dentist population ratio is low, limiting access to care. Lack of access to professional dental care can lead to a higher rate of caries lesion progression. Fear is another factor that keeps these children from getting dental services. Often parents are reluctant to seek dental care for their children. They have concerns about the trauma, anxiety and fear associated with getting anesthetic injections, hearing the sound and feeling the vibrations of the drill. Other concerns may be the child's ability to remain still for the duration of the procedure. These same anxieties and fears are not uncommon for adult patients with disabilities or simply dental phobia, some of which may have been instilled as a child. Finally, consideration must be given to the positioning of decayed posterior teeth. The more common location of caries in children is in the primary molars.³ The ability

of some younger children to open their mouths adequately for proper access adds to the anxiety as well as the frustration for the dentist to place an acceptable restoration. These same operative difficulties exist with adult patients with disabilities. These are all valid concerns that can lead to neglect of the oral health for these patient populations. Providers should consider simpler methods to accomplish the arrest and prevention of caries. The atraumatic application of SDF is one such method.

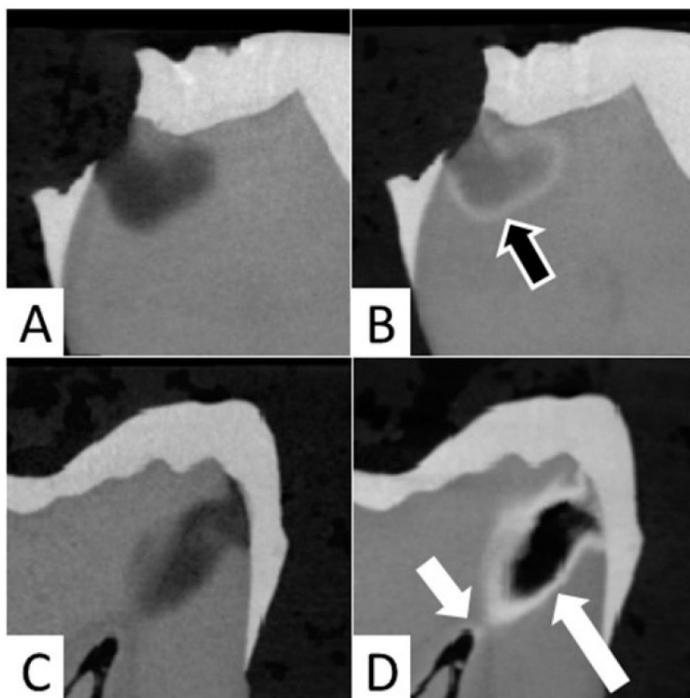
Tooth decay is related to the buildup of plaque, which consists of a biofilm in the mouth. Biofilm is the sticky, slimy layer of microorganisms that grows on teeth. The bacteria in the biofilm cause a change in pH, resulting in the formation of tooth decay.³ When addressed in the initial stages of tooth decay, diseased areas of the tooth can be removed by the traditional mechanical method, arrested, and then restored.

Highly concentrated fluoride is also a prominent component for the arrest of the progression of caries and its prevention. SDF in a clear or blue liquid form, applied to the area of decay arrests the further progression of tooth decay. It was initially approved by the FDA as a desensitizing agent and has been used in dentistry since the mid-1900s.⁴ It is considered cost-effective and a drill-less option to restore minor cavities. It is composed of four main components: silver, which helps kill bacteria; fluoride, which promotes remineralization; ammonia to help the solution stay concentrated in its most effective state; and water. It has a pH of 10, and for restorative purposes, it is used on the demineralized areas of a tooth.⁵

Since the agent is in liquid form, it may also be used in lieu of sealants in pits and fissures of posterior teeth by direct application without the use of the etching technique. In comparison to sealants, there is no need for light curing with the SDF method, thus lessening materials, tools, and time that would otherwise be needed. In addition, as a restorative measure, SDF is applied without the need of anesthetizing or prepping the tooth. A downside of SDF is that usage is not recommended if the lesion has exposed the pulp, as this can lead to an infection. SDF may also be used to reduce the bond strength of composite materials to dentin if such treatment is selected in the future, depending on the bonding system used.

There is another downside to the use of SDF. When applied, SDF oxidizes and leaves a black stain on the decayed portion of the tooth. The application prevents further spread of decay in the area applied.

It does not stain healthy tooth structure. However, if skin, tongue, gums, or cheeks come in contact with the agent, it will cause a stain on the soft tissue structures. The stain will not cause harm but may contribute to gum irritation. It may present as a temporary tattoo on soft tissue, but it will resolve in a few days. To minimize the possibility of staining surrounding structures, it is advisable to use barriers before beginning the procedures. Apply liquid with a micro brush to the decayed area for 60 seconds.⁷ After the application, remove any access with gauze and dry with a gentle air flow. Instruct the patient not to eat or drink for thirty minutes. Patients may complain about a metallic taste but assure them that this will be short-lived. SDF should not be used in patients allergic to silver. Providers may want to check the effectiveness to determine if further treatment is warranted. According to the American Academy of Pediatrics,⁸ the typical follow-up for the patient is six months with reapplication as needed.



(A,B) Micro-CT images showing precipitation of SDF at the junction of affected and infected dentin (outlined arrow). (A) Preoperative image and (B) after SDF application. (C,D) Micro-CT image showing aggregation of SDF (long white arrow) and penetration of the SDF to the pulp chamber (short white arrow) (C) Preoperative image and (D) after SDF application.(7)

How do practitioners code for payment of SDF treatment? Most insurances and Medicaid are reimbursing for SDF treatment, making it a more accessible option. As of 2024, the ADA utilizes the CDT code D1354.⁷ For use in the medical office, the AMA has approved its usage with the CPT code 0792T by a physician or qualified healthcare provider.⁹ Dental hygienists may also apply SFD in selected states. It is advisable to check with your practicing state for a hygienist application.

In conclusion, SDF provides a safe, inexpensive, and less time-consuming option for the arrest and prevention of caries. SDF not only prevents the spread of existing decay but also acts as an alternative preventive agent for pits, fissures, and grooves on molar teeth, using fewer steps than sealants. For teeth with current decay, the application is minimally invasive, painless, and time-conservative. There is no need for injections or drilling, and it can be easily applied by providers outside of the field of dentistry. It is cost-effective and covered by most insurances. With the pros outweighing the cons, it is the optimal choice for the arrest and dental treatment in children and patients with disabilities. This will promote less anxiety and more dental compliance and retention. Parents may now be able to put to rest the fears and take comfort in the ease of dental treatment for their children. Thus, SDF offers another option for patient care with optimum success rates for children and adults alike.

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SPOTLIGHT

JAMES DIMARINO, DMD, MSED, CDC, FACD



**James DiMarino, DMD, MSED,
CDC, FACD**

I want to thank Dr. Pesillo for asking me to write this Spotlight. When he suggested I share my path into dental benefits, I had to laugh a little, because my path was not exactly a straight line. I did not come up through public health or start out reviewing claims at a dental plan. Like many of you, I came from the chair. From an office with carpet in the operatories. From losing thousands of dollars on a capitated plan I did not understand. And from one phone call with a dental director who was kind enough to tell me something nobody at my study club ever mentioned.

I hope my story is useful to anyone reading this, especially those who are newer to the profession or wondering how they ended up in dental benefits when they started out holding a handpiece. For those of you who are seasoned AADC members, I hope you can relate to at least some of this, and if nothing else, I hope it gives you a good laugh. If my career has taught me anything, it is that the best plan is sometimes the one you never made. And if you pay attention, you will notice the God winks along the way, quietly pointing you toward the path that was meant for you all along.

A Detour on Broad Street

I never set out to be a dentist. After graduating from college, I enrolled in a medical program at Hahnemann Medical College in Philadelphia. Anatomy, histology, microbiology, all of it. On paper, everything looked right. But I was not comfortable. I wanted to help people and I was drawn to



medicine, but something about the fit was not quite there.

One afternoon, after a histology lab, I was driving home to New Jersey and had a thought that came out of nowhere: what about dentistry? I knew Temple University had a dental school somewhere up North Broad Street. There was no GPS back then, no Google Maps. So instead of driving home, I turned left down Broad Street.

I found Temple Dental and walked in. The first thing I noticed was a smell. I did not know what it was at the time, but it was IRM, that zinc oxide eugenol scent that every dentist reading this knows the moment it hits. Then I stumbled into the Temple Dental Museum, which traced centuries of dental history through artifacts and a recreated Victorian-era dental office. I could have spent hours there.

Walking the halls, I saw students carrying articulated models between classes, reviewing cases with their instructors. They were busy, but they seemed happy. I stopped one and asked how she liked dental school. She told me it was the hardest thing she had ever done, but she really liked it. And that was the moment something clicked and sparked my curiosity.

A few days later, I noticed a dental office with its lights still on around 4:30 PM. I pulled over, walked in, and told the office manager I was contemplating applying to dental school and asked if I could talk to the dentist. The dentist had just finished with his last patient and was kind enough to show me around. Turns out he was a Temple Dental grad, which felt like one of those moments you just cannot make up. When I asked what he loved most about being a dentist, he said something I have carried with me ever since. He told me that his handiwork leaves with every patient who walks out the door. And if that patient ever needs him again, they come back, because he earned their trust.

Something struck me there that has stayed with me my whole career. Dentistry was medicine combined with craftsmanship, with artistry. I then volunteered in several dental offices to be sure this was the right path, and what I kept seeing confirmed it: dentistry helps everyone. Adults can be terrified in the chair, while the smallest child sits there perfectly happy. But no matter who we treat, they all deserve the same thing: quality care and genuine compassion. And the one thing almost every patient had in common was gratitude.



Dental School and the Christmas Realization

Dental school was every bit as hard as everyone warned me it would be, but I loved it and felt grateful for the opportunity every single day. I enjoyed it so much, especially the teaching side of it, that I enrolled in a Master in Education program at the same time so I could eventually give back to the profession that was giving so much to me.

I remember sitting at my family's Christmas dinner during my first year of dental school and having this realization. The Christmas before, I had been in the medical program taking histology, microbiology, and anatomy, and I was uneasy. Now I was taking many of the same courses, and I was absolutely loving it. The only difference was that I was in dental school. That first semester we had already started working in the hygiene clinic and been introduced to preventive dentistry. I could see the runway ahead of me, and that made all the difference in the world.

The Brady Bunch Office

After graduating from dental school, I completed a General Practice Residency and started moonlighting in different offices. Then a dentist in

my hometown called needing someone to cover while he had surgery. I did not even know his office existed. It was a house set back off the main road, with the practice downstairs and an apartment upstairs. I had driven past it my entire life on my way to school and friends' houses and never once noticed it was a dental office.

I ended up buying the practice. Walking in as the new owner was like stepping onto the set of The Brady Bunch. Orange carpet. Orange vinyl sofas. Wood paneling. And yes, carpet in the operatories. My wife and I got to work. We "extracted" the carpet from the operatories, painted the walls, and started dragging the place into the modern era. I brought in Dentrax in 2001, digital radiography shortly after, and then I bought a CEREC 2 unit. This was not cutting edge at that point. It was the bleeding edge. But I loved the idea of designing and milling a restoration chairside while the patient was still in the chair. It pulled together everything I loved about dentistry: the clinical side, the technology, and the hands-on artistry of building something.

A Full-Circle Moment

There was one patient who brought it all together for me. He came in having a bad day. First thing he



said was, "I don't like being here, and I don't like dentists, but I broke a tooth." Fractured mesiobuccal cusp on #14. He wanted it pulled. I told him we could save it and restore it the same day. He was not buying it. We talked through the cost, the process, how long it would last. I even gave him a warranty. Don't laugh at me, but I gave warranties. I told him if it broke within a year, I would apply what he paid toward an extraction and bridge or partial.

He let me restore it. I put the CEREC to work and placed an MOB onlay. When the restoration was seated, he ran his tongue across the tooth, stood up, put his hands out and said: "I like you. I don't go to doctors because every time I go they find something wrong and they don't fix it. I only go to dentists if I can't take the tooth out myself. You're not like those other people. I came in here with a problem and you actually fixed it."

That hit me. I thought about the first dentist I had visited years earlier, the one who told me that a piece of his art walks out with the patient. Here I was, living that exact moment. That man became a friend and a regular patient, and I think about that exchange more than he will ever know.

A Rainy Night That Changed Everything

For all the clinical satisfaction, my understanding of how dentistry actually worked on the business and insurance side was, frankly, terrible. Early in my ownership, I had inherited a capitated insurance plan in the practice without knowing it. I completed thousands of dollars of dentistry for my patients, then called to find out where my reimbursement was. They told me I had not met the plan's threshold requirements. I got nothing. Zero. I opted out immediately. But the damage was done, and it got me thinking: what else am I getting wrong about dental insurance?

Around the same time, I started noticing a growing stack of papers on my office manager's desk. I finally asked her what they were. "Denied claims," she said. I asked why the stack kept getting bigger. "Because insurance companies keep denying your claims, and I'm too busy to call them and find out why." That was the moment it really sank in. We were doing a great job taking care of patients, but our inability to deal with insurance was negatively impacting my bottom line and family.

One rainy evening, I made myself go to a local study club dinner. My residency instructors had drilled into



me the importance of continuing education, even when you do not feel like going. A colleague stood up and announced: "I cracked the code; I figured out how to get paid by insurance companies!" I was all ears.

His approach was basically this: demand to speak to the dental director, insult the dental director, ask if they are even a licensed dentist, ask if they are licensed in your state, and challenge how they can dictate treatment when they have never seen the patient. He was convinced that if you put the dental director on their heels, you would get paid. Everyone in the room clapped. I wrote it all down.

A few weeks later, I had a bridge that paid out at the alternate benefit of a partial denture. I thought, this was my chance. I called the insurance company, asked for the dental director, and had my script ready. But first I tried my own approach, explaining the clinical rationale, the patient's gag reflex, why a bridge was more appropriate than a partial. The dental director listened patiently and said he could not change the determination. I remember how the dental director was very patient, polite and could not have been a nicer person.

Since I was not getting the results I needed, I decided to follow my script. I hesitantly asked: "Are you a licensed dentist?" Of course he was. "Are you licensed in my state?" He told me he did not have to be and suggested I look into how many states actually require that. Then I got to the big one: "How can you dictate treatment when you've never seen my patient?" He said, "You're right, I can't." Dead silence. I thought I had him, here comes the approval.

But NO, instead he asked me a question I did not expect. "Are you a recent graduate?" I told him I was. And he said something that made my head spin: "Let me give you a piece of advice that has served me well. I simply administer the benefits the employer purchased."

I looked down at my notes. The guy at the study club had never talked about any of this. I was completely off script. I honestly do not remember much of what the dental director said after that, because I was too busy processing what he had just told me. I am fairly sure he upheld the denial. But I walked away from that call with something worth more than any single reimbursement. In that moment I realized that dental insurance was not something happening



to me. It was something I had never bothered to understand. And if I did not change that, no amount of clinical experience was going to save my practice. Years later, I still cannot shake the feeling, and I am not one hundred percent sure, but I think Dr. Pesillo was that dental director. LOL, thank you Dr Pesillo!

Seeing Dentistry from the Other Side

That phone call planted a seed, but it took a few more years before I made the leap. In 2008, after a decade of owning Woodbury Dental, I accepted a position as Director of Clinical Affairs at Premier Dental Products. It was a completely different world. Instead of treating one patient at a time, I was working with key opinion leaders, developing products like Traxodent, Enamelon, 2PRO prophylaxis angles, zTech Two Stripper diamonds, and helping build continuing education programs that reached thousands of dentists. I got to see the profession from the manufacturing side, and it broadened my understanding of dentistry in ways private practice never could have.

From Premier, I moved to GlaxoSmithKline as Director of Medical Affairs for Oral Care, where I worked on global brands like Sensodyne and Pronamel, helped launch Parodontax, and

collaborated with research and development teams on scientific communications. What surprised me was how much the manufacturing side depends on dental codes. If a product does not have a clear reimbursement pathway, it does not matter how good the science is. Manufacturers need to understand coding just as well as the clinicians and payers do. Between Premier and GSK, I learned how the industry side of dentistry operates. And the whole time, that dental director's voice was still in the back of my head. I kept circling back to the question of how dental benefits actually work, and I knew that eventually I needed to be on that side of the table.

Finding the AADC

That realization eventually led me to connect with Dr. Marc Zweig, who responded to my inquiries with: "You've got to come to the American Association of Dental Consultants meeting." I attended my first AADC Spring Workshop in 2017, and I knew immediately that I had found my people. Everyone was friendly, thoughtful, and genuinely interested in helping each other. The sessions on claims review were outstanding, and the level of knowledge in the room was humbling. I went once and never looked back.



I earned my Certified Dental Consultant designation in 2018 and published my first Beacon article that same year, on acting on behalf of patients with congenital disorders. From there, the AADC gave me the confidence and the framework to make a real transition. I became a claims examiner, then Eastern Pennsylvania State Dental Director at Avesis (a Guardian company), and eventually National Dental Director at UNUM, where I was responsible for utilization management, credentialing, quality assurance, and fraud, waste, and abuse investigations across both PPO and DHMO products. I owe so much of that to the AADC and to Dr. Zweig for opening the door. In 2024, I was inducted as a Fellow of the American College of Dentists, which I consider a reflection of everything this organization helped me become.

Practice Booster and the Legacy of Dr. Charles Blair

I had admired Dr. Charles Blair for years. I had met him several times at various events, but it was at the AADC meetings that I really got to know him. I remember sitting in the back of the room thinking, boy, wouldn't it be something to work with him someday. And then I would catch myself: be realistic, Jim. This is Dr. Blair. You are you.

But as fate would have it, an opportunity came along to join him, and I did not hesitate. Dr. Blair's focus was always on helping dental offices maximize legitimate reimbursement. He loved working with dental payers, and his passion for educating dental professionals was contagious. It was a perfect fit. I was blessed to work alongside him for several years before we lost him in November 2023. His passing was a huge loss to our organization, to the AADC, and to everyone in this profession who learned from him. But we are carrying on his legacy, and we are honored and grateful to do so.

Today I serve as CEO of Practice Booster, Chief Clinical Officer of eAssist Dental Solutions (the nation's largest dental billing services provider, serving more than three thousand practices), and Chief Clinical Officer of UNITAS PPO Solutions. I also hold six U.S. patents for dental technologies and continue to speak and publish on coding, compliance, and reimbursement strategy. In all of it, Dr. Blair's vision remains the foundation.

Giving Back

Outside of the dental world, one of the things my family and I are most proud of is our work with The Seeing Eye in New Jersey. We have been volunteer



puppy raisers since 2007. It started as something we thought would be a great way to teach our children about volunteering and giving back, and it turned into one of the most rewarding things we have ever done. We receive each puppy at eight weeks old and raise them until they are about eighteen months, training them and socializing them before they go back to The Seeing Eye for formal guide dog training and placement with a blind person.

The hardest part is the goodbye. Once the dog goes back, we do not get to see them again. But the good news is that we receive a letter from their “forever person” telling us how grateful they are and how the dog has changed their life. That letter kept us going. It motivated us so much that we have raised seven Seeing Eye dogs: Todd, Prancer, Auburn, Carlos, Irina, Ranger, and Gavel. This experience has taught us as much about ourselves as it has about raising a puppy, and it has made our family better for it.

Looking Back, Looking Forward

When I think about how I got here, it all traces back to an impulsive left turn on Broad Street in 1991. I went from a student studying medicine who felt out of place, to a dental practice owner pulling orange

carpet out of operatories, to a guy fumbling through a phone call with a dental director who taught me more in five minutes than I had learned in years of practice. Every chapter prepared me for the next one.

To anyone in the AADC who is still figuring out their path, I would say this: your career does not have to look like anyone else’s. Mine sure didn’t. But if you stay curious, stay humble, and invest in understanding this complex and rewarding industry, the opportunities will find you. They found me.

Being a member of the AADC and working in the payer world has been one of the best things to ever happen to me. It is a gift that keeps giving back, and I mean that sincerely. I am grateful for this organization, for the friendships and mentorship it has provided, and for the chance to share my story. Thank you for reading.



MEET THE CANDIDATES

Candidate for President Elect

Kassie Kulb, DMD

I am excited about the opportunity to contribute to the positive influence AADC has on the dental industry. Should I be elected President-Elect, I will utilize my perspective to help continue the expansion and improvement of this organization and help members utilize the organization's benefits to enhance careers, as AADC has done for my career! I have been a member of AADC for 9 years, have served on the New Member Committee for 7 years, and most recently have contributed as a member of the Board of Directors. I am a graduate of the University of Kentucky College of Dentistry and maintained a private practice in Louisville, Kentucky. I began my consulting career in 2014 while in private practice and accepted a full-time role as Dental Director with Delta Dental of Kentucky in 2020. Through this role, as well as through the New Member Committee and Board of Directors, I communicate often with dentists who are seeking advice and information on entering the consulting industry. I often hear about the changing environment in dentistry and am equipped to help AADC with the ever-growing need of support for professionals in the dental industry. I thank you all for your consideration – and hopefully your support – in seeking the role of President-Elect.



Candidate for Secretary/ Treasurer

Lawrence (Larry) M. Hoffman, DMD, CDC

Dr. Lawrence M. Hoffman has been a Dental Consultant since 1983, having served several dental benefit plans in a wide range of positions, including Blue Cross and Blue Shield of Missouri-later Wellpoint and Anthem, and MetLife HealthCare Management Corporation. He developed dental provider networks for local HMOs and PPOs in the 1980s and 1990s and currently consults for Delta Dental of Missouri. He joined AADC in 1989 and received his CDC in 1991. He was elected to AADC's Board of Directors, then known as the Executive Committee, in 1999, and served as President in 2001-2002, rejoining the Board after his term. In 2006, he was elected to serve AADC as Secretary-Treasurer and was re-elected



to this position in all subsequent years. He also assembled and presented AADC's Spring Workshop claims review sessions for several years during the 1990s, and along with former President Dick Portune, served as a delegate to the American College of Dentists Ethics Summits I & II. Following these symposia, he, and Dr. Portune wrote and presented AADC's Code of Ethics.

Dr. Hoffman was honored with the Israel "Sonnie" Shulman Award for Meritorious Service to AADC in 2015.

Dr. Hoffman has maintained a private general dental practice in St. Louis, Missouri, since 1978, and retains an academic position in the Department of Otolaryngology at Washington University School of Medicine.

Dr. Hoffman is pleased to report that AADC remains on sound financial footing. Thanks to growing membership and sponsor participation, we can look forward to a successful Spring Workshop this year.

Candidates for Board of Directors

B. Hudson Graham, DDS, CDC

I am honored for the opportunity to be a candidate for the AADC board of directors. I earned my DDS from the University of the Pacific in 2004 and practiced clinical dentistry as both an associate and practice owner until 2016. Shortly after, I began my career in the dental benefits industry, working as a consultant in both the Medicaid and commercial spaces for Delta Dental of California and Avenir. In 2019 I became the dental director for California's Medi-Cal Dental managed care program. In that role, I not only served as the clinical and quality lead within the plan, but sat on external committees and workgroups, represented the plan in dental conventions, and lobbied in the state assembly to advocate for the continuation of state-funded dental care. Since 2023, I have worked as the California DHMO dental director for Guardian Life.

My affiliation with the AADC began in 2018 when I attended my first Spring Workshop. Being new to the industry, I was unsure about my future, but my apprehension quickly disappeared with the warm welcome I received at the new member reception. The people I met during that first workshop as well as the wealth of informative lectures reassured me that I had found the right career path and the right organization to support me. I have since continued to attend workshops and became a Certified Dental Consultant in 2023.

My vision for the AADC is to focus on membership. Membership is the lifeblood of the organization – injecting new ideas and viewpoints and increasing awareness of our profession through networking and word-of-mouth. Membership dues directly translate into increased resources and benefits for our members and advocacy in the industry. I would like to explore expanding membership and workshop attendance through increased



engagement of dental benefits carriers (for example, offering companies group rates for membership and the Spring Workshop for their consultants).

The AADC has been influential in my career, and I am excited for the opportunity to give back as a leader. If elected to the board, I will make every effort to ensure that this association continues to provide its members with the same experiences I've been privileged to have.

Jennifer Hinshaw, DMD

My background in continuing education, practice ownership, dental consulting, volunteering, and organized dentistry reflects a strong commitment to advancing excellence in dental consulting and would be an asset to the AADC Board of Directors.



My professional journey has been shaped by lifelong learning, leadership, and service to the profession, most recently earning my Mastership through the Academy of General Dentistry. Over my twenty-two-year career, I owned two dental practices that incorporated advanced digital and AI-enhanced technologies and later served as a dental director overseeing a large FQHC Medicaid-participating program. These experiences provided valuable insight into clinical practice, systems-based care, and the importance of sound policy and organizational oversight.

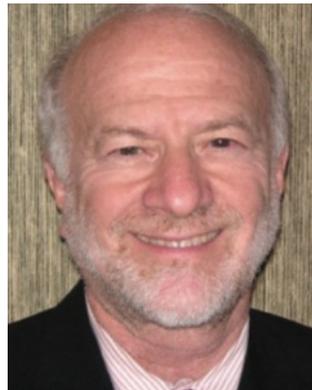
Three years ago, I sold my practice and now work in private practice while also serving as an independent dental consultant. I work with Blue Cross Blue Shield/HCSC/Dearborn Group under the direction of Dr. Randi Tillman, past president of the AADC. My consulting work includes claims review, participation on provider credentialing teams, and service on policy and utilization management committees. Through this work, I have developed a strong appreciation for the role dental consultants play in promoting fairness, consistency, and evidence-based decision-making across the profession.

This year, I was asked to serve as a member of the 2026 AADC Planning Committee and have greatly valued the opportunity to collaborate with colleagues who share a commitment to education, professionalism, and the continued advancement of dental consulting.

I am excited to seek a position on the AADC Board of Directors to further the organization's mission of supporting dental consultants through high-quality education, professional collaboration, and leadership development. As a board member, I would be dedicated to preserving the AADC's strong educational offerings and collegial culture while contributing strategic ideas to support membership engagement, organizational growth, and the evolving needs of dental consultants. I am honored to be a member of the AADC and would be grateful for your vote for a position on the Board of Directors.

Marc Zweig, DMD, CDC

- 1969: BS: University of Kentucky
- 1972: DMD: University of Louisville School of Dentistry
- 1974: Specialty Certificate in Periodontics: University of Maryland School of Dentistry
- 1974-1997: Specialty Periodontal Private Practice: Practice Limited to Periodontics
- 1997 to July 2013: Manager of Professional Review for Delta Dental of NJ
- 1997 to December 2013: Clinical Associate Professor in Dental Hygiene Department, Middlesex College, Edison, NJ
- November 2013 to Present: Dental and Periodontal Consultant for Cigna Healthcare.

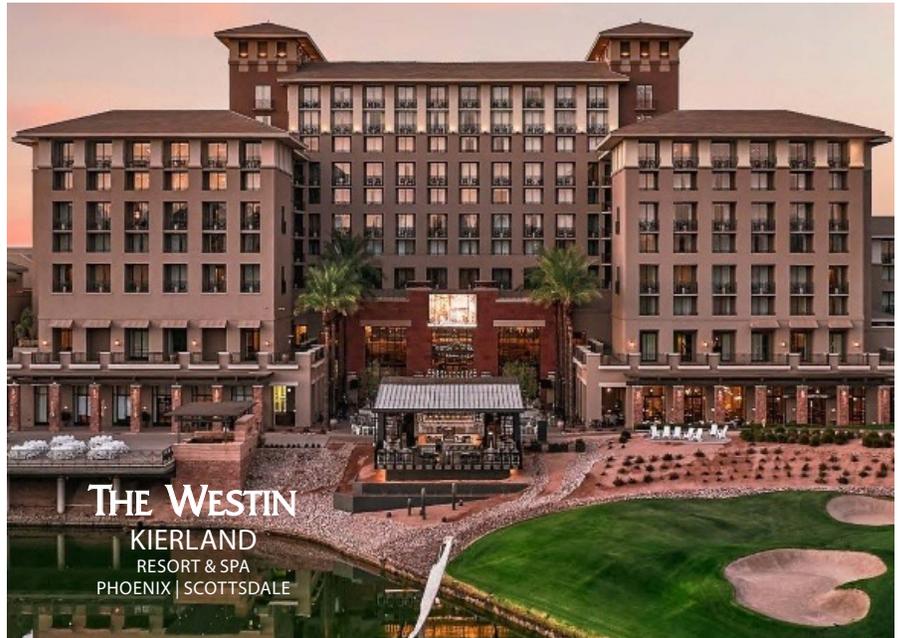


authority for information regarding dental consulting and third party administration relating to utilization review, dental plan design, provider networks, benefit determinations, appropriateness of treatment, and in short, "THE" source for all dental benefit information.

In addition to having been on the Board of Directors for the past 3 years, I have served as the President of AADC in 2016 and previously served on the Board of directors in the 6 years preceding my presidency. I have also been past co-chairman of the membership committee for AADC for many years, on the Web Committee and have been moderator/presenter for the Claims Review Sessions at the AADC Annual Seminar/Workshop in the past for approximately 8 annual workshops. I had been active with the Positions Committee since its onset and served on various other committees within AADC.

Anyone that is familiar with me knows that I am very passionate in relation to the AADC as an organization, and I would consider it an honor if the membership would allow me to continue to support and guide future direction within the AADC by electing me to serve an additional term on the Board of Directors.

I have been an active member of the AADC since 1998 and received AADC certification in 2004. I am a very strong proponent of the AADC as "THE" organization and



Randi S. Tillman, DMD, MBA, CDC
Chairperson Program Committee

The AADC Program Committee has spent the past several months thoughtfully crafting what promises to be an exceptional meeting in Scottsdale. This year's theme — **Elevate, Collaborate, Innovate** — reflects both the momentum of our profession and the spirit of our organization.

A word about our venue: **The Westin Kierland Resort & Spa** offers the perfect setting for our spring workshop. Located in North Scottsdale on a beautiful golf course and within walking distance of the shops and restaurants at Kierland Commons, it combines convenience with a true resort experience. We look forward to enjoying the Arizona sunshine and all that this outstanding property has to offer. We are hopeful it will be every bit as memorable as our recent gathering at the Hyatt Coconut Point in Bonita Springs.

Our 2026 program is designed to offer something for everyone. We are thrilled to welcome back our Thursday keynote speaker, Dr. Brian Novy, whose previous presentations earned enthusiastic reviews. His lectures are consistently engaging, insightful, and infused with both humor and unexpected moments that keep audiences thinking.

This year we are also pleased to introduce several new speakers, including Drs. Bryan Laskin, Sol Brotman, and Jim Comisi. Returning favorites — Drs. Jim DiMarino, Stewart Balikov, as well as Shaju Puthussery — will also be part of the program. Together, they will address topics that are timely and highly relevant to our profession, including fraud, waste, and abuse; the expanding role of AI in dental insurance; and the growing impor-

tance of medical-dental integration. And yes, for those who appreciate a bit of creativity, we even have a session devoted to the “Game of Crowns.”

As always, our popular claims review sessions will return this year featuring some new and some returning discussion leaders. Come ready to engage, contribute, and be challenged.

In addition, we are offering a series of unique and thought-provoking Lunch and Learn sessions. Topics include *Over the Teeth and Through the Gums: How Oral*

Health Impacts the Whole Body, The Changing Dental Landscape; The Hidden Cost of Coding Errors; and — for the first time — *Second Helpings*, which explores alternative career pathways within dentistry. These small-group sessions provide an excellent opportunity for deeper discussion and meaningful connection with colleagues.

I look forward to seeing you at the Spring Workshop. It is always a special time to reconnect with friends, gain fresh insights into our evolving field, and enjoy a well-deserved break from the everyday routine. See you in Scottsdale!



May 6-9, 2026

Westin
Kierland
Resort & Spa

Scottsdale, Arizona

ELEVATE — COLLABORATE — INNOVATE

AADC Spring Workshop is Worth Every Penny!

Three Day Early Registration
Fees Extended!

Your member workshop fees of \$995 include daily breakfasts, Thursday & Friday lunches, the President’s Welcome Reception, and access to all CE presentations and exhibits where you can earn up to **15 CEUs** for full attendance of lectures.

Book your hotel room at the beautiful **Westin Kierland Resort and Spa**, a four-star golf resort in Scottsdale, Arizona. The specially negotiated room rate of \$340/night plus taxes (includes reduced resort fee) offers AADC members reduced self-parking rates; 10% discount on prevailing golf rates and 10% discount on prevailing treatment Spa pricing. You can also enjoy a daily shuttle to neighboring Kierland Commons for shopping and restaurants, daily fitness classes, pickleball court use with rackets and balls, and wellness ritual experiences in the Spa. Please register your non-dental guests to take advantage of all the workshop benefits.

Don’t Delay—Register Now!

Workshop Registration and Hotel Reservation Deadline is
Friday, April 10, 2026

The American Association of Dental Consultants

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