Pediatric Dental Checklist
Mandated Coverage

DIAGNOSTIC SERVICES:

- □ ***Exams:***
  - □ For children (under age 19):
    - □ Exams (billed as D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations:
      - □ D0150: once every 12 months when performed by the same practitioner;
      - □ D0150: twice every 12 months only when performed by different practitioners;
      - □ D0180: once every 12 months;

      Code D0160 only once every 12 months when performed by the same practitioner;
  - □ For each emergent episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams;
  - □ Covers oral exams by medical practitioners when the medical practitioner is an oral surgeon.

- □ ***Radiographs:***
  - □ Routine radiographs once every 12 months;
  - □ Bitewing radiographs for routine screening once every 12 months;
  - □ A maximum of six radiographs for any one emergency;
  - □ For insureds under age six, radiographs may be billed separately every 12 months as follows:
    - □ D0220 — once;
    - □ D0230 — a maximum of five times;
  - □ D0270 — a maximum of twice, or D0272 once; for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period;
  - □ Insureds must be a minimum of six years old for billing intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are:
    - □ For insureds age six through 11- a minimum of 10 periapicals and two bitewings for a total of 12 films;
    - □ For insureds ages 12 and older - a minimum of 10 periapicals and four bitewings for a total of 14 films;
  - □ If fees for multiple single radiographs exceed the allowable reimbursement for a full mouth complete series (D0210), reimburse for the complete series;
  - □ Additional films may be covered if dentally or medically appropriate, e.g., fractures (Refer to OAR 410-123-1060 and 410-120-0000);
  - □ If it is determines the number of radiographs to be excessive, payment for some or all radiographs of the same tooth or area may be denied;
  - □ The exception to these limitations is if the insured is new to the office or clinic and the office or clinic was unsuccessful in obtaining radiographs from the previous dental office or clinic. Supporting documentation outlining the provider's attempts to receive previous records must be included in the insured's records;
  - □ Digital radiographs, if printed, should be on photo paper to assure sufficient quality of images.

PREVENTIVE SERVICES:

- □ ***Prophylaxis:***
  - □ For children (under age 19) – Limited to twice per 12 months;
  - □ Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care;
  - □ Are coded using the appropriate Current Dental Terminology (CDT) coding:
    - □ D1110 (Prophylaxis – Adult) – Use for insureds 14 years of age and older; and
    - □ D1120 (Prophylaxis – Child) – Use for insureds under 14 years of age;

- □ ***Topical fluoride treatment:***
  - □ For children (under age 19) – Limited to twice every 12 months;
  - □ For children under 7 years of age who have limited access to a dental practitioner, topical fluoride varnish may be applied by a medical practitioner during a medical visit:
    - □ Bill using a professional claim format with the appropriate CDT code (D1206 – Topical Fluoride Varnish);
    - □ An oral screening by a medical practitioner is not a separate billable service and is included in the office visit;
  - □ Additional topical fluoride treatments may be available, up to a total of 4 treatments per insured within a 12-month period, when high-risk conditions or oral health factors are clearly documented in chart notes for the following insureds who:

- □ Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries;
- □ Are pregnant;
- □ Have physical disabilities and cannot perform adequate, daily oral health care;
- □ Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or
- □ Are under seven year old with high-risk oral health factors, such as poor oral hygiene, deep pits and fissures (grooves) in teeth, severely crowded teeth, poor diet, etc;

□ ***Sealants (D1351):***
- □ Are covered only for children under 16 years of age;
- □ Limits coverage to:
  - □ Permanent molars; and
  - □ Only one sealant treatment per molar every five years, except for visible evidence of clinical failure;

□ ***Space management:***
- □ Covers fixed and removable space maintainers (D1510, D1515, D1520, and D1525) only for insureds under age 19;
- □ No reimbursement for replacement of lost or damaged removable space maintainers.

RESTORATIVE SERVICES:

□ ***Restorations — amalgam and composite:***
- □ Covers resin-based composite restorations only for anterior teeth;
- □ Resin-based composite crowns on anterior teeth (D2390) are only covered for insureds under 19;
- □ No reimbursement of resin-based composite restorations for posterior teeth (D2391-D2394);
- □ Limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth. Refer to the American Dental Association (ADA) CDT codebook for definitions of restorative procedures;
- □ Providers must combine and bill multiple surface restorations as one line per tooth using the appropriate code. Providers may not bill multiple surface restorations performed on a single tooth on the same day on separate lines. For example, if tooth #30 has a buccal amalgam and a mesial-occlusal-distal (MOD) amalgam, then bill MOD, B, using code D2161 (four or more surfaces);
- □ No reimbursement for an amalgam or composite restoration and a crown on the same tooth;
- □ Surface once in each treatment episode regardless of the number or combination of restorations;
- □ The restoration fee includes payment for occlusal adjustment and polishing of the restoration;

□ ***Crowns and related services:***
- □ General payment policies:
  - □ The fee for the crown includes payment for preparation of the gingival tissue;
  - □ Covers crowns only when:
    - □ There is significant loss of clinical crown and no other restoration will restore function; and
    - □ The crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;
  - □ Covers core buildup (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure from caries or a fracture and only when done in conjunction with a crown. Less than 50% of the tooth structure must be remaining for coverage of the core buildup. No coverage of core buildup if the crown is not covered under the insured's benefit package;
  - □ Retention pins (D2951) is per tooth, not per pin;
- □ No coverage of the following services:
  - □ Endodontic therapy alone (with or without a post);
  - □ Aesthetics (cosmetics);
  - □ Crowns in cases of advanced periodontal disease or when a poor crown/root ratio exists for any reason;
- □ Covers acrylic heat or light cured crowns (D2970 temporary crown, fractured tooth) — allowed only for anterior permanent teeth;
- □ Covers the following only for insureds under age 19:
  - □ Provisional crowns (D2799) – allowed as an interim restoration of at least six months during restorative treatment to allow adequate healing or completion of other procedures. This is not to be used as a temporary crown for a routine prosthetic restoration;
  - □ Prefabricated plastic crowns (D2932) — allowed only for anterior teeth, permanent or primary;

- □ Stainless steel crowns (D2930/D2931) -– allowed only for anterior primary teeth and posterior permanent or primary teeth;
- □ Prefabricated stainless steel crowns with resin window (D2933) – allowed only for anterior teeth, permanent or primary;
- □ Prefabricated post and core in addition to crowns (D2954/D2957);
- □ Permanent crowns (resin-based composite - D2710 and D2712, and porcelain fused to metal (PFM) - D2751 and D2752) as follows:
    - □ Limited to teeth numbers 6-11, 22 and 27 only, if dentally appropriate;
    - □ Limited to four (4) in a seven-year period. This limitation includes any replacement crowns allowed according to (E)(i) of this rule;
    - □ Only for insureds at least 16 years of age; and
    - □ Rampant caries are arrested and the insureds demonstrates a period of oral hygiene before prosthetics are proposed;
- □ PFM crowns (D2751 and D2752) must also meet the following additional criteria:
    - □ The dental practitioner has attempted all other dentally appropriate restoration options, and documented failure of those options;
    - □ Written documentation in the insured's chart indicates that PFM is the only restoration option that will restore function;
    - □ The insured has documented stable periodontal status with pocket depths within 1 – 3 millimeters. If PFM crowns are placed with pocket depths of 4 millimeter and over, documentation must be maintained in the insured's chart of the dentist's findings supporting stability and why the increased pocket depths will not adversely affect expected long term prognosis;
    - □ The crown has a favorable long-term prognosis; and
    - □ If tooth to be crowned is clasp/abutment tooth in partial denture, both prognosis for crown itself and tooth's contribution to partial denture must have favorable expected long-term prognosis;
- □ Crown replacement:
    - □ Permanent crown replacement limited to once every seven years;
    - □ All other crown replacement limited to once every five years; and
    - □ Possible exceptions to crown replacement limitations due to acute trauma, based on the following factors:
        - □ Extent of crown damage;
        - □ Extent of damage to other teeth or crowns;
        - □ Extent of impaired mastication;
        - □ Tooth is restorable without other surgical procedures; and
        - □ If loss of tooth would result in coverage of removable prosthetic;
- □ Crown repair, by report (D2980) is limited to only anterior teeth.

ENDODONTIC SERVICES:

- □ ***Pulp capping:***
    - □ Includes direct and indirect pulp caps in the restoration fee; no additional payment shall be made for insureds;
    - □ Covers direct pulp caps as a separate service for insuredsbecause restorations are not a covered benefit under this benefit package;

- □ ***Endodontic therapy:***
    - □ Pulpal therapy on primary teeth (D3230 and D3240) is covered only for insureds under age 19;
    - □ For permanent teeth:
        - □ Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all insureds; and
        - □ Molar endodontic therapy (D3330):
            - □ For insureds through age 19, is covered only for first and second molars; and
    - □ Covers endodontics only if the crown-to-root ratio is 50:50 or better and the tooth is restorable without other surgical procedures;

- □ ***Endodontic retreatment and apicoectomy/periradicular surgery:***
    - □ Does not cover retreatment of a previous root canal or apicoectomy/periradicular surgery for bicuspid or molars;
    - □ Limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when:
        - □ Crown-to-root ratio is 50:50 or better;
        - □ The tooth is restorable without other surgical procedures; or
        - □ If loss of tooth would result in the need for removable prosthodontics;

- □ Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth;

□ ***Does not allow separate reimbursement for open-and-drain as a palliative procedure when the root canal is completed on the same date of service, or if the same practitioner or dental practitioner in the same group practice completed the procedure;***

□ ***Covers endodontics if the tooth is restorable within the benefit coverage package;***

□ ***Apexification/recalcification and pulpal regeneration procedures:***
- □ Limits payment for apexification to a maximum of five treatments on permanent teeth only;
- □ Apexification/recalcification and pulpal regeneration procedures are covered only for insureds under 19 years of age.

PERIODONTIC SERVICES:

□ ***Surgical periodontal services:***
- □ Gingivectomy/Gingivoplasty (D4210 and D4211) – limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and
- □ Includes six months routine postoperative care;

□ ***Non-surgical periodontal services:***
- □ Periodontal scaling and root planing (D4341 and D4342):
  - □ For insureds through age 19, allowed once every two years;
  - □ A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;
  - □ Quadrants are not limited to physical area, but are further defined by the number of teeth with pockets 5 mm or greater:
    - □ D4341 is allowed for quadrants with at least four or more teeth with pockets 5 mm or greater;
    - □ D4342 is allowed for quadrants with at least two teeth with pocket depths of 5 mm or greater;
  - □ Prior authorization for more frequent scaling and root planing may be requested when:
    - □ Medically/dentally necessary due to periodontal disease as defined above is found during pregnancy; and
    - □ Insured's medical record is submitted that supports the need for increased scaling and root planing;
- □ Full mouth debridement (D4355):
  - □ For insureds through age 19, allowed only once every 2 years;

□ ***Periodontal maintenance (D4910):***
- □ For insureds through age 19, allowed once every six months;
  - □ Limited to following periodontal therapy (surgical or non-surgical) that is documented to have occurred within the past three years;
  - □ Allowed once every twelve months;
  - □ Prior authorization for more frequent periodontal maintenance may be requested when:
    - □ Medically/dentally necessary, such as due to presence of periodontal disease during pregnancy; and
    - □ Insured's medical record is submitted that supports the need for increase periodontal maintenance (chart notes, pocket depths and radiographs);

□ ***Records must clearly document the clinical indications for all periodontal procedures, including current pocket depth charting and/or radiographs;***

□ ***May not reimburse for procedures identified by the following codes if performed on the same date of service:***
- □ D1110 (Prophylaxis – adult);
- □ D1120 (Prophylaxis – child);
- □ D4210 (Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant);
- □ D4211 (Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant);
- □ D4341 (Periodontal scaling and root planning – four or more teeth per quadrant);
- □ D4342 (Periodontal scaling and root planning – one to three teeth per quadrant);
- □ D4355 (Full mouth debridement to enable comprehensive evaluation and diagnosis); and
- □ D4910 (Periodontal maintenance).

REMOVABLE PROSTHODONTIC SERVICES:

- □ ***Insureds age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140);***

- □ ***The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to insureds;***

- □ ***Resin partial dentures (D5211-D5212):***
  - □ May not approve resin partial dentures if stainless steel crowns are used as abutments;
  - □ For insureds through age 19, the insured must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth;
  - □ The dental practitioner must note the teeth to be replaced and teeth to be clasped when requesting prior authorization;

- □ ***Replacement of removable partial or full dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following:***
  - □ For insureds at least 16 years and under 19 years of age - shall replace full or partial dentures once every ten years, only if dentally appropriate. This does not imply that replacement of dentures or partials must be done once every ten years, but only when dentally appropriate;
  - □ The ten year limitations apply to the insured regardless of the insured's enrollment status at the time insured's last denture or partial was received. Replacement of partial dentures with full dentures is payable ten years after the partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement;

- □ ***Replacement of all teeth and acrylic on cast metal framework (D5670-D5671):***
  - □ Is covered for insureds age 16 and older a maximum of once every 10 years, per arch;
  - □ Ten years or more must have passed since the original partial denture was delivered;
  - □ Is considered replacement of the partial so a new partial denture may not be reimburseable for another 10 years; and
  - □ Requires prior authorization as it is considered a replacement partial denture;

- □ ***Denture rebase procedures:***
  - □ Covers rebases only if a reline may not adequately solve the problem;
  - □ For insureds through age 19, limits payment for rebase to once every three years;
  - □ May make exceptions to this limitation in cases of acute trauma or catastrophic illness that directly or indirectly affects the oral condition and results in additional tooth loss. This pertains to, but is not limited to, cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing;
    - □ Denture reline procedures:
  - □ For insureds through age 19, limits payment for reline of complete or partial dentures to once every three years;
  - □ May make exceptions to this limitation under the same conditions warranting replacement;
  - □ Laboratory relines:
    - □ Are not payable prior to six months after placement of an immediate denture; and
    - □ For insureds through age 19, are limited to once every three years;

- □ ***Interim partial dentures (D5820-D5821, also referred to as "flippers"):***
  - □ Are allowed if the insured has one or more anterior teeth missing; and
  - □ Reimburse for replacement of interim partial dentures once every 5 years, but only when dentally appropriate;

Tissue conditioning:

- □ Is allowed once per denture unit in conjunction with immediate dentures; and
- □ Is allowed once prior to new prosthetic placement.

MAXILLOFACIAL PROSTHETIC SERVICES:

- □ ***Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The dental practitioner must document failure of those options prior to use of the fluoride gel carrier;***

- □ ***All other maxillofacial prosthetics (D5900-D5999) are medical services. Refer to the "Covered and Non-Covered Dental Services" document and OAR 410-123-1220.***

- □ ***Fixed Prosthodontics:***

- □ ***Limits coverage of post and core (D6970, D6972 and D6977) only to insureds under 19;***

- □ ***Shall cover core buildup for retainer (D6973) only when necessary to retain a cast restoration due to extensive loss of tooth structure and only when done in conjunction with a crown. Less than 50% of the tooth structure must be remaining for coverage of the core buildup. Shall not cover core buildup if the crown is not covered under the insured's benefit package.***

ORAL SURGERY SERVICES:

- □ ***Bill the following procedures in an accepted dental claim format using CDT codes:***
  - □ Procedures that are directly related to the teeth and supporting structures that are not due to a medical, including such procedures performed in an ambulatory surgical center (ASC) or an inpatient or outpatient hospital setting;
  - □ Services performed in a dental office setting (including an oral surgeon's office):
    - □ Such services include, but are not limited to, all dental procedures, local anesthesia, surgical postoperative care, radiographs and follow-up visits;
    - □ Refer to OAR 410-123-1160 for any prior authorization requirements for specific procedures;

- □ ***Bill the following procedures using the professional claim format and the appropriate American Medical Association (AMA) CPT procedure and ICD-9 diagnosis codes:***
  - □ Procedures that are a result of a medical condition (i.e., fractures, cancer);
  - □ Services requiring hospital dentistry that are the result of a medical condition/diagnosis (i.e., fracture, cancer);

- □ ***Refer to the "Covered and Non-Covered Dental Services" document to see a list of CDT procedure codes on the HSC Prioritized List that may also have CPT medical codes. See OAR 410-123-1220. The procedures listed as "medical" on the table may be covered as medical procedures, and the table may not be all-inclusive of every dental code that has a corresponding medical code;***

- □ ***Oral surgical services performed in an ASC or an inpatient or outpatient hospital setting require prior authorization;***

- □ ***All codes listed as "by report" require an operative report;***

- □ ***Covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success;***

- □ ***Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service;***

- □ ***Does not cover surgical excisions of soft tissue lesions (D7410 – D7415);***

- □ ***Extractions — Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service;***

□ ***Surgical extractions:***
- □ Include local anesthesia and routine post-operative care;
- □ Limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums;
- □ Does not cover alveoloplasty in conjunction with extractions (D7310 and D7311) separately from the extraction;
- □ Covers alveoplasty not in conjunction with extractions (D7320-D7321) only for insureds under age 19;

□ ***Frenulectomy/frenulotomy (D7960) and frenuloplasty (D7963):***
- □ Covers either frenulectomy or frenuloplasty once per lifetime per arch only for insureds under age 19;
- □ Covers maxillary labial frenulectomy only for insureds age 12 through 19;
- □ Covers frenulectomy/frenuloplasty in the following situations:
  - □ When the insured has ankyloglossia;
  - □ When the condition is deemed to cause gingival recession; or
  - □ When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension;

□ ***Covers excision of pericoronal gingival (D7971) only for insureds under age 19.***

ORTHODONTIA SERVICES:

□ ***Limits orthodontia services and extractions to eligible insureds:***
- □ With the ICD-9-CM diagnosis of:
  - □ Cleft palate; or
  - □ Cleft palate with cleft lip; and
- □ Whose orthodontia treatment began prior to age 19; or
- □ Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 19;

□ ***Prior authorization is required for orthodontia exams and records. A referral letter from a physician or dentist indicating diagnosis of cleft palate/cleft lip must be included in the insured's record and a copy sent with the prior authorization request;***

□ ***Documentation in the insured's record must include diagnosis, length and type of treatment;***

□ ***Payment for appliance therapy includes the appliance and all follow-up visits;***

□ ***Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). Reimburse each phase individually (separately);***

□ ***Shall pay for orthodontia in one lump sum at the beginning of each phase of treatment. Payment for each phase is for all orthodontia-related services. If the insured transfers to another orthodontist during treatment, or treatment is terminated for any reason, the orthodontist must refund any unused amount of payment, after applying the following formula: Total payment minus $300.00 (for banding) multiplied by the percentage of treatment remaining;***

□ ***Use the length of the treatment plan from the original request for authorization to determine the number of treatment months remaining;***

□ ***As long as the orthodontist continues treatment, may not require a refund even though the insured may become ineligible for medical assistance sometime during the treatment period;***

□ ***Code:***
- □ D8660 — Prior authorization required (reimbursement for required orthodontia records is included);
- □ Codes D8010-D8690 — Prior authorization required.

ADJUNCTIVE GENERAL AND OTHER SERVICES:

- □ ***Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment;***

- □ ***Anesthesia:***
  - □ Only use general anesthesia or IV sedation for those insureds with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242);
  - □ Reimburses providers for general anesthesia or IV sedation as follows:
    - □ D9220 or D9241: For the first 30 minutes;
    - □ D9221 or D9242: For each additional 15-minute period, up to three hours on the same day of service. Each 15-minute period represents a quantity of one. Enter this number in the quantity column;
  - □ Reimburses administration of Nitrous Oxide (D9230) per date of service, not by time;
  - □ Oral pre-medication anesthesia for conscious sedation (D9248):
    - □ Limited to insureds under 13 years of age;
    - □ Limited to four times per year;
    - □ Includes payment for monitoring and Nitrous Oxide; and
    - □ Requires use of multiple agents to receive payment;
  - □ Upon request, providers must submit a copy of their permit to administer anesthesia, analgesia and/or sedation to the Division;
  - □ For the purpose of Title XIX and Title XXI, limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication;

- □ ***Limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits that occur outside of a dental office. This code is not reimbursable for provision of preventive services or for services provided outside of the office for the provider or facilities' convenience;***

- □ ***Oral devices/appliances (E0485, E0486):***
  - □ These may be placed or fabricated by a dentist or oral surgeon, but are considered a medical service.

Stat. Auth.: ORS 413.042, 414.065 & 414.707
Stats. Implemented: ORS 414.065 & 414.707
Hist.: HR 3-1994, f. & cert. ef. 2-1-94; HR 20-1995, f. 9-29-95, cert. ef. 10-1-95; OMAP 13-1998(Temp), f. & cert. ef. 5-1-98 thru 9-1-98; OMAP 28-1998, f. & cert. ef. 9-1-98; OMAP 23-1999, f. & cert. ef. 4-30-99; OMAP 8-2000, f. 3-31-00, cert. ef. 4-1-00; OMAP 17-2000, f. 9-28-00, cert. ef. 10-1-00; OMAP 48-2002, f. & cert. ef. 10-1-02; OMAP 3-2003, f. 1-31-03, cert. ef. 2-1-03; OMAP 65-2003, f. 9-10-03 cert. ef. 10-1-03; OMAP 55-2004, f. 9-10-04, cert. ef. 10-1-04; OMAP 12-2005, f. 3-11-05, cert. ef. 4-1-05; DMAP 25-2007, f. 12-11-07, cert, ef. 1-1-08; DMAP 18-2008, f. 6-13-08, cert. ef. 7-1-08;DMAP 38-2008, f. 12-11-08, cert. ef. 1-1-09; DMAP 16-2009 f. 6-12-09, cert. ef. 7-1-09; DMAP 41-2009, f. 12-15-09, cert. ef. 1-1-10; DMAP 14-2010, f. 6-10-10, cert. ef. 7-1-10; DMAP 31-2010, f. 12-15-10, cert. ef. 1-1-11; DMAP 17-2011, f. & cert. ef. 7-12-11; DMAP 41-2011, f. 12-21-11, cert. ef. 1-1-12; DMAP 46-2011, f. 12-23-11, cert. ef. 1-1-12