AOPA In Advance SmartBrief
Breaking News
November 19, 2020

AOPA Headlines:

Medicare to Allow Nurse Practitioners and Physician Assistants to Certify the Medical Need for Diabetic Shoes in Limited Circumstances

AOPA, in collaboration with other healthcare organizations, has actively supported the inclusion of nurse practitioners (NPs) and physician assistants (PAs) to serve as certifying practitioners under the Medicare diabetic shoe benefit. The Social Security Act states that the certifying physician must be the MD or DO that is managing the patient's systemic diabetic condition. This has led to significant access issues as the delivery of healthcare has evolved and non-physician practitioners have become more prevalent as primary care providers.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) recently announced two separate pathways that expand the ability of NPs and PAs to certify the medical need for diabetic shoes provided to Medicare beneficiaries.

The first pathway only applies to NPs and is being coordinated by the Center for Medicare and Medicaid Innovation through the Primary Care First (PCF) demonstration project. The PCF demonstration project will be implemented on January 1, 2021 and will run through December 31, 2025. NPs that are participating in the PCF demonstration project in one of the 26 states/regions that it will be implemented in may serve as the certifying practitioner for diabetic shoes covered by Medicare. The PCF model does not require the NP to operate under the direct supervision of a physician, but it does not apply to physician assistants. The announcement of the expansion of the role of NPs under the PCF demonstration project may be viewed HERE.

The second pathway is effective immediately and applies to both NPs and PAs that are providing healthcare services under the direct supervision of an MD or DO through "incident to" provisions. The DME MACs have indicated that CMS has offered guidance that allows NPs and PAs to certify the medical need for diabetic shoes when **ALL** the following conditions are met:

1. The supervising physician has documented in the medical record that the patient is diabetic and has been, and continues to provide, the patient follow-up under a comprehensive management program of that condition; and,
2. The NP or PA certifies that the provision of the therapeutic shoes is part of the comprehensive treatment plan being provided to the patient; and,
3. The supervising physician must review and verify (sign and date) all of the NP or PA notes in the medical record pertaining to the provision of the therapeutic shoes and inserts, acknowledging their agreement with the actions of the NP or PA.

It is important to note that this pathway does not apply to NPs that are practicing independently (billing under their own NPI). They must be practicing under the direct supervision of an MD or DO. The announcement of the "incident to" clarification may be viewed HERE.

AOPA is encouraged by the announcements above and is pleased that CMS has acknowledged the expanding role of NPs and PAs in the delivery of primary healthcare. We will provide additional details on these policy changes as they become available.

Questions regarding this issue may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

Thank YOU Supplier Plus Partners

Prior Authorization Reminder

Prior authorization for six lower limb prostheses codes (L5856, L5857, L5858, L5973, L5980 and L5987) will be mandatory for all states and territories for claims with a date of service on or after December 1, 2020. In anticipation of the December 1 date, and to allow for processing time, the DME MACs will begin to accept prior authorization requests on November 17, 2020.

In addition, don't forget that for claims with a date of service on or after January 1, 2021 items billed using L5856, L5857, L5858, L5973, L5980 and L5987 must be PDAC verified and on the Product Classification List.

Questions? Contact Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@AOPAnet.org .

Revised OSHA Rule for COVID-19 Reporting Obligations

OSHA has recently revised its reporting obligations for employers for COVID-19 cases. The revised rule represents a significant change and an improvement over the prior rule. Key changes have been made for employers to the Hospitalization Reporting Rule, Fatality Reporting Rule and Detailed Recording Obligations. With the current reporting requirements already so confusing and difficult to follow, employers need to be more

cautious and stay in-tune with these changes on how to investigate and record COVID-19 cases amongst your workforce. Employers also have to be made aware of the latest information regarding completion of OSHA logs and the electronic posting of injury information to OSHA's electronic record keeping website for 2021. You should also be aware of the latest OSHA regulatory changes in effect to stay complaint and away from red flags. With so much confusion around these practices, failure to comply has resulted in employers taking financial losses as penalties and fines. Participants will also receive an update regarding OSHA, its priorities, and its regulatory agenda updates for 2021.

This webinar titled "**Revised OSHA Rule For COVID-19 Reporting Obligations & 300 Log Electronic Recordkeeping/Reporting Compliance Mandates For 2021**" is scheduled on **Thursday, December 03, 2020** at **10am EST.**

Please use this **REGISTRATION LINK** to register yourself to participate in this webinar.

The following agenda will be discussed in detail during this session :

- Revised OSHA Rules for recording & reporting Covid-19 cases
- OSHA's Covid-19 updates and changes made to Hospitalization Reporting Rule, Fatality Reporting Rule and Recording Obligations
- Managing suspected or confirmed COVID-19 cases in the workplace
- Maintenance and preparation of the OSHA 300 log & summary in 2021
- Latest guidelines for Employers to maintain OSHA logs and report electronically
- What is a recordable injury or illness ?
- Electronic posting of injury information to OSHA's electronic recordkeeping website
- Detailed assessment of OSHA's requirements for reporting certain injuries and fatalities in 2021
- Understanding OSHA's specific anti-discriminatory and prohibited activities in 2021
- Utilization of OSHA logs to calculate incident rate benchmarks
- Latest state of affairs at OSHA & Insights into OSHA's regulatory agenda
- Case studies & Examples

Ask your questions & receive expert advice directly from the speaker during the informative Q/A session at the end of the webinar session.

CMS Introduces Single Payment Amounts for Medicare Competitive Bidding of OTS Knee and OTS Spinal Orthoses

On October 27, 2020, the Centers for Medicare and Medicaid Services (CMS) announced the Single Payment Amounts (SPAs) for select Off-the-Shelf (OTS) knee and OTS spinal orthosis codes included in the Medicare DMEPOS competitive bidding program scheduled for implementation on January 1, 2021.

AOPA has continually expressed a need for CMS to delay implementation of Round 2021of the Medicare DMEPOS competitive bidding program due to the COVID-19 Public Health Emergency (PHE). These efforts include but are not limited to multiple communications with high ranking CMS officials, coordination of advocacy efforts with AOPA partner organizations both within and outside of O&P, vocal support of congressional efforts, including a letter to CMS signed by more than 100 members of Congress requesting consideration of a program delay, and comprehensive discussions with key legislators on the importance of ensuring Medicare beneficiaries have access to high quality, clinically appropriate care, delivered by properly credentialed and accredited providers.

AOPA will continue to provide feedback to CMS through these and other channels. In addition, AOPA is still working to secure co-sponsors and congressional support for the Medicare O&P Patient Centered Care Act which includes a provision that, if enacted, would preserve patient access to OTS orthoses from certified and/or licensed orthotists and prosthetists by creating an exemption from the requirement to have a competitive bidding contract, similarly to physicians and other healthcare professionals. To support this legislative effort visit AOPAvotes.org.

While CMS removed several product categories from inclusion in Round 2021, it elected to move forward with competitive bidding for OTS knee and OTS spinal orthoses. The product categories removed from inclusion in competitive bidding by CMS represented product categories that have been part of the Medicare DMEPOS competitive bidding program in the past. Due to their inclusion in previous rounds of competitive bidding, SPAs were established nationally that resulted in significant savings to the Medicare program. New bids that were submitted as part of the Round 2021 competition for these product categories did not result in significant additional savings for the Medicare program. Because OTS knee and OTS spinal orthoses were not previously part of Medicare competitive bidding, the competition resulted in significant savings to the Medicare program over the three-year initial program length and the subsequent expansion of the SPAs into non-competitive bid areas.

In its announcement, CMS indicated that in a limited number of CBAs where competitive bidding did not result in significant savings to the Medicare program and therefore, competitive bidding for OTS orthoses will not be implemented. AOPA will be providing more information about these CBAs shortly.

If you elected to participate in the competitive bidding program for OTS knee orthoses, OTS spinal orthoses, or both, you will either be offered a contract effective for claims with a date of service on or after January 1, 2021 or you will receive a disqualification notice indicating that you will not be offered a contract. If you are offered a contract, you must accept or decline the contract offer by November 10, 2020. It is important to remember that if your previously submitted bid was found to be at or below the median composite bid rate and you decline a contract offer, you will forfeit your $50,000 bid surety bond. Your contract offer(s) will indicate whether your submitted bid was at or below the median composite bid rate. If you receive a disqualification notice and believe that you were disqualified incorrectly, you may submit a bidder inquiry through the DMEPOS competitive bidding website portal.

The SPAs for each competitive bidding area (CBAs) and detailed information regarding next steps may be found on the Medicare DMEPOS competitive bidding website here. The complete CMS announcement may be viewed here.

Questions regarding the Medicare DMEPOS Competitive Bidding Program can be directed to Devon Bernard at dbernard@AOPAnet.org or Joe McTernan at jmcternan@AOPAnet.org.

University of Washington Study

The University of Washington research team is conducting a survey study to better understand the clinical resources (e.g., time, space, equipment) that impact use of outcome measures in clinical practices across the United States. This study is open to all ABC Certified Prosthetists (CP), Prosthetist-Orthotists (CPO), and Prosthetic Assistants (CPA or CPOA). If you haven't yet taken our survey, we really want to hear from you, whether or not you use outcome measures in your practice.

Participation in the study involves completing a short (~15 min) online survey. The survey asks questions about use of outcome measures in clinic, your opinions about outcome measures, and general questions about your experience and training. We really want to capture the opinions of as many people in the profession as possible, so please take a few minutes to take the survey.

If you participate and complete the survey, you will be entered into a raffle for a $50 Amazon gift card. We will add one Amazon gift card for every 20 completed surveys, so you will have about a 5% chance of winning a gift card. As an added bonus, we will do one final drawing for a $250 Amazon gift card from among all those who completed the survey when we close the survey next month.

To complete the survey, or to find out more information about the study, please visit: https://uwstudy.org/.

2021 Medicare O&P Fee Schedule Update

The Centers for Medicare and Medicaid Services (CMS) has published an update on the economic factors that are used to calculate the Medicare O&P fee schedule. The annual Medicare fee schedule increase for O&P services is based on a combination of change in the Consumer Pricing Index for Urban Areas (CPI-U) from June to June of the previous year combined with the annual Multi-Factor Productivity Adjustment (MFP).

CMS recently announced that the CPI-U for June 2019 through June 2020 is 0.6% and the annual MFP adjustment is -0.4% for a net increase of 0.2%. While CMS has not officially announced the 2021 update to the Medicare O&P fee schedule, the announcement of the CPI-U and MFP adjustment lead to relative confidence in the 2021 increase of 0.2%.

The 0.2% increase in the O&P Medicare fee schedule for 2021 is slightly lower than the 2020 increase of 0.9%. While the Medicare 2% sequestration-based reduction to all Medicare payments has been suspended through dates of service through December 31, 2020 as a result of the CARES Act, continued suspension of sequestration-based fee

reduction will require additional legislative action. AOPA is following this issue closely and supports the continued suspension of sequestration-based fee reductions.

Questions regarding the 2021 Medicare fee schedule may be directed to Joe McTernan at jmcternan@aopanet.org or Devon Bernard at dbernard@aopanet.org.

CGS Announces New Audits for AFOs

CGS, the DME MAC for Jurisdictions B&C, has just announced that they will be conducting complex post-payment reviews for a series of prefabricated ankle-foot-orthoses. The reviews will be focused on claims for the HCPCS codes: L1902, L1906, L1971, L4396, and L4397.

If you receive additional documentation requests as part of these reviews be sure to respond to them, however suppliers should be reminded that CMS has implied that the DME MACs may allow for flexibility with extensions based on the supplier's ability to complete the audit; based on the current public health emergency.

Questions? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

Introducing AOPA Connection

Welcome to AOPA Connection, your one-stop-shop for all things AOPA.

Logging into AOPA Connection you will instantly have access to all your AOPA benefits, including:

- AOPAversity
- Your Membership Record
- Your Individual Profile
- Event Calendar
- Bookstore (including past purchases)
- Co-OP

But, it doesn't stop there! We are pleased to introduce a new benefit accessible through AOPA Connection, My O&P Community. In this online community of your O&P colleagues you can get guidance, share advice, have one-on-one and group conversations, and access resources.

For Primary/Principal Member Contacts:

- For security reasons, we couldn't bring over passwords during conversion from our old database, so you get to start fresh. To access AOPA Connection click here and enter your unique email address to reset your password. Then, just follow the instructions for logging in. Note: accounts are tied to email addresses.
- If for some reason you are told your email is not found, create an account here.

- If, you had multiple emails addresses in the old database and receive this email to all accounts please contact us at info@AOPAnet.org and we will help you reconcile your accounts.
- Once logged in be sure to complete your profile, this will help us better meet your needs as well as allow others to connect with you. Once you do this, play around with all the features, re-familiarize yourself with all the AOPA benefits, check out the discussions happening in My O&P Community.
- You can set all your employees up with their own credentials so they too can access all the AOPA member benefits. Spread the word, send them here and tell them to setup an account using their unique email and follow the instructions to link to your organization's name.

For Employees of Members:

- Accessing AOPA Connection is simple, all you need to do is set up your account here using your unique email and follow the instructions to link to your organization's name.
- Once logged in be sure to complete your profile, this will help us better meet your needs as well as allow others to connect with you. Once you do this, play around with all the features, re-familiarize yourself with all the AOPA benefits, check out the discussions happening in My O&P Community.

Questions? Check out these Tips for Logging In. Still have questions? Contact Betty Leppin at bleppin@AOPAnet.org or 571-431-0876.

Appeals Update: The Amounts in Controversy for 2021 Have Been Released

The Amount in Controversy (AIC) is the monetary threshold required to file an appeal at the Administrative Law Judge (ALG), third level of appeal, or the Federal District Court Review, the fifth level of appeal. The AIC for ALJ hearing requests filed on or before December 31, 2020, will remain $170. ALJ hearing requests filed on or after January 1, 2021 the AIC will increase to $180. The AIC for the fifth level is currently $1,670 and will increase to $1,760 for filed on or after January 1, 2021.

Questions? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org .

Important Information on Medicare Accelerated and Advance Payment Program

Congress has passed a short-term spending bill to keep government programs operating at 2020 funding levels through December 11. Included in the 115-page bill are important revisions to the Medicare Accelerated and Advance Payments Program (AAP) that extends the deadline for providers to start repaying Medicare advance payment loans. AOPA worked closely with our congressional champions to ensure this was included in the final bill.

Under the AAP program, the Centers for Medicare and Medicaid Services (CMS) offered to advance money to providers to help keep their doors open during the early months of the pandemic. These loans, however, had to be paid back later out of Medicare payments to practices. As currently written, the terms for repayment are problematic, especially considering the current financial

difficulties being experienced by providers during the pandemic. Providers would have 100 percent of their Medicare claims withheld to repay the loans on a short timeline, and after a few months any outstanding balances, would be subject to a 10.25 percent interest rate.

However, the bill passed today by Congress and expected be signed into law shortly by President Trump:

- Postpones the recoupment of disbursed funds until one year after the advance payment has been issued to a physician practice; the balance would be due by September 2022.
- Reduces the per claim recoupment amount from 100 percent to 25 percent for the first 11 months and 50 percent of claims withheld for an additional six months. The interest rate kicks in if not repaid in full; however, the bill lowers the interest rate from 10.25 percent to four percent.

AOPA was pleased to see our efforts on this issue pay off. We continue to push Congress for additional benefits for orthotists and prosthetists, including a statutory separation of O&P from DME, tax deductions on Personal Protective Equipment, and ensuring providers are not required to pay taxes on Provider Relief Fund disbursements. We encourage you to utilize our AOPAVotes.org page to write your legislators on these issues.

For questions, please contact Justin Beland, Director of Government Affairs.

COVID-19 Update: Provider Relief Fund Reporting

On September 19, 2020, the US Department of Health and Human Services (HHS) released guidance articulating how to account for lost revenues and expenses and addressing recipient reporting requirements for those receiving Provider Relief Fund (PRF) payments. The guidance applies generally to PRF recipients that received one or more PRF payments exceeding $10,000.

The $10,000 reporting threshold is a notable change from the statutory requirement in Section 15011 of the CARES ACT; which (and the Provider Relief Fund Terms and Conditions) had required recipients of more than $150,000 in total funds appropriated under the CARES Act to submit a report to HHS within 10 days following the end of each calendar quarter. While the new guidance lowers the reporting threshold to $10,000, it does not clarify if HHS's public reporting will continue to satisfy the Section 15011 requirement and did not further specify how (or whether) the reporting information announced in the guidance relates to the Section 15011 requirement. We expect further guidance on the issue, and will report when additional guidance is released. Recipients should continue to monitor the PRF FAQs for additional clarifications on reporting requirements.

The new guidance stipulates that recipients will report on the use of their PRF payments by first submitting information on healthcare-related expenses that are directly attributable to coronavirus. This may include general and administrative expenses and/or healthcare-related operating expenses. Any PRF payment amounts that were not fully expended on healthcare-related expenses attributable to coronavirus are then applied to the provider's "lost revenues," which, under the new guidance, are now defined as "year-over-year net patient care operating income (i.e., patient care revenue less patient care related

expenses)." This definition is more limited than previous HHS guidance which permitted "any reasonable method of estimating lost revenue;" providers could compare budgeted to actual or use a year-over-year comparison. In addition, HHS appears to cap the application PRF payments toward lost revenues up to either the amount of a provider's 2019 net gain from healthcare related sources or up to a net zero gain/loss in 2020, if the provider reported negative net operating income in 2019. HHS seems to have provided this clarification because, under previous guidance, if lost revenues could be applied to expenses irrespective of the impact on margin, it would have introduced the possibility of PRF funding making a healthcare provider more profitable in 2020 than it was in 2019. AOPA is concerned about the potential impact of this approach for some providers and will continue to monitor the issue.

Recipients that do not use the full amount of their PRF funds by the end of calendar year 2020 will have an additional six months to use the remaining amounts. The extra six-month reporting period (January-June 2021) will be compared to the same period in 2019 for the purposes of making calculations.

The new guidance stipulates that recipients will be required to report several data elements, including demographic information, information about their expenses attributable to coronavirus, information about their lost revenues, and other non-financial information (such as metrics on personnel, patients, and facilities). Recipients that received between $10,000 and $499,999 in aggregated PRF payments must report healthcare-related expenses attributable to coronavirus in two aggregated categories: (1) general and administrative expenses and (2) other healthcare-related expenses. Providers receiving $500,000 or more in PRF payments will report their expenses in greater detail within each of these categories.

The guidance has also pushed the reporting window, the reporting portal will be available in early 2021 (instead of on October 1, 2020). The other deadlines appear to remain unchanged, but these deadlines may be adjusted as the reporting mechanism is gradually rolled out. Important reporting deadlines include:

- All recipients must report within 45 days of the end of the calendar year 2020. (This would fall on Sunday, February 14; the actual deadline will likely be clarified as Monday, February 15.)
- Recipients who have expended funds in full prior to December 31, 2020, may submit a single final report at any time during the first reporting window (early 2021 through February 15, 2021).
- Recipients with funds still unexpended after December 31, 2020, must submit a second and final report no later than July 31, 2021.

Finally, the new guidance does not change HHS' previous clarifications that payments from the PRF qualify as disaster relief payments and are therefore taxable income. AOPA continues to work with Congress on bipartisan legislation which would ensure that CARES Act PRF payments are not includible in gross income.

AOPA will continue to follow this and all CARES Act-related guidance. If you have any questions, please contact Justin Beland, Director of Government Affairs.

AFO/KAFO Policy Article

Recently, AOPA asked the DME MACs to clarify this existing language in the AFO/KAFO Policy Article related to custom fabricated braces: *In addition, if the item is custom fabricated, a complete and clear description of the item, including what makes this item unique, and a breakdown of charges (material and labor used in fabrication). This information should be entered in the narrative field of an electronic claim.*

On September 3, AOPA reported and confirmed that there has been no change to the documentation requirements for custom fabricated AFOs/KAFOs and the above passage is in reference to miscellaneous or unlisted codes. The DME MACs also stated they will clarify this in a future Policy Article revision.

The DME MACs just released the following revised AFO/KAFO Policy Article, and as promised they clarified the custom fabrication language: *If the item is custom fabricated and does not have a specific HCPCS code, a complete and clear description of the item, including what makes this item unique, and a breakdown of charges (material and labor used in fabrication) should be entered in the narrative field of an electronic claim or on Item 19 of a paper claim. (Refer to the LCD-related Standard Documentation Requirements article (A55426) for more information regarding billing of items with HCPCS codes that include miscellaneous, NOC, unlisted, or non-specified in their narrative descriptions.)*

The revised AFO/KAFO Policy Article will be effective October 1, 2020. A copy of the revised article can be found here.

Questions? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org

2020 Virtual National Assembly, Content to Remain Available Through 2020

Thank you for attending the 2020 Virtual National Assembly, your participation helped make it a success!

A huge bonus to this year's Assembly is you still have access to all the content, both the education and the exhibits. And, we are excited to announce that the platform will remain open for the remainder of 2020 (not just through October 12). To access it, login like you did during the Assembly. Once in you can watch any presentations you missed or review a session you attended. If a presenter made their slides available, you can download these as well. The exhibit booths, including exhibitors' contact information are still accessible too, so stop by and check them out.

This means you now have until the end of 2020 to earn over 100 CE credits. AOPA will send CE credit information to ABC and BOC mid-October, mid-November, and at the end of the year.

Thank you again for your participation! Be sure to save the date for the 2021 National Assembly, September 9-12, 2021 in Boston.

Questions about any of this? Contact us at Assembly@AOPAnet.org or (571) 431-0876.

Thank You to AOPA's National Assembly Sponsors!

CGS Post Payment Review for L0650 Announcement

In July, we informed you that the Centers for Medicare and Medicaid Services (CMS) announced the resumption of certain audit activity beginning on August 3, 2020. CMS clarified that they will not be restarting all audits on August 3, but instead due to the continued Public Health Emergency (PHE) will be implementing a phased approach to allow suppliers time to prepare and adjust.

The audits will begin with limited Durable Medical Equipment Medicare Administrative Contractor (DME MAC) based post-payment reviews and will only involve claims with dates of service prior to the beginning of the declared PHE on March 1, 2020.

CGS, the DME MAC for Jurisdictions B & C, has just announced that they will be conducting a complex post-payment review for L0650, an off-the-shelf LSO. The review will be for claims with dates of service prior to March 1, 2020. If you receive additional documentation requests as part of this review be sure to respond to them, however be advised that CMS

has implied that the DME MACs may allow for flexibility with extensions and the cancelling of audits based on individual supplier's ability to complete the audit.

As of now, there is not a timeframe for when the Target, Probe, and Educate (TPE) program, and other audits will resume. AOPA will continue to monitor the resumption of CMS audit activity and provide you with timely updates.

Questions? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

CMS Delays Mandatory Use of Revised ABN Form

The Center for Medicare and Medicaid Services (CMS) has announced that mandatory use of the revised ABN (CMS-R-131 exp. 6/30/2023) form will now be January 1, 2021.

In late June CMS released the new and revised CMS-R-131, the ABN form with an expiration date of 6/30/2023, for immediate use. Mandatory use of the new form was to begin on August 31, 2020, but now will be January 1, 2021.

Suppliers can continue using the ABN form with the expiration date of 03/2020, or they may use the revised form.

The new ABN form with instructions may be found here.

Questions ? Contact Joe McTernan at jmcternan@AOPAnet.org or Devon Bernard at dbernard@AOPAnet.org.

Calling all AOPA Members, You Now Have FREE Access to AOPAversity

AOPA knows you and your employees are being tremendously impacted by COVID-19. To help, we are offering you, our AOPA members, the ability to access our online learning management system, AOPAversity, for **FREE** for the rest of 2020. It is our hope that this will make it easier to navigate the current unprecedented situation.

What does this mean? You and your employees can now access all 72 online offerings which are pre-recorded videos available on demand. That's 33 business offerings worth 34.5 Business Credits and 39 clinical offerings worth 60.5 Scientific Credits. **FREE.**

If you do not currently have an AOPAversity account, click here to create a profile. You will need your AOPA member ID and zip code affiliated with your membership when you create your profile to access the free offering. If you already have an AOPAversity account, log in here. Your username is the e-mail used to create your profile.

This offer is valid through December 31, 2020. It does exclude any refunds to purchases made prior to the start of this offer. We truly hope this offers you additional support during this uncertain time.

Upcoming Events

December 9, 2020	*New Year: New Codes, Fees, and Updates* AOPA Webinar Learn more and register
December 18, 2020	*Co-OP Tutorial* Learn more and register