of Tennessee

FEBRUARY 2023

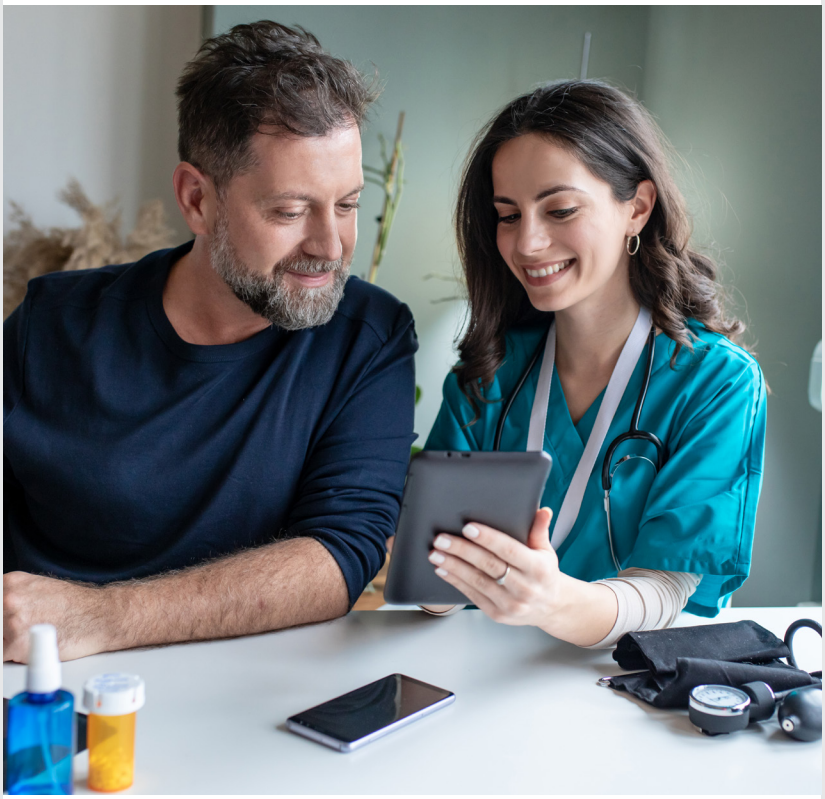
BlueAlert℠

of Tennessee | Mission driven FOR 75 Years

A monthly newsletter for our provider community, featuring important updates and reminders about our company's policies and procedures. All information is broken out by line of business.

BlueCross BlueShield of Tennessee, Inc.

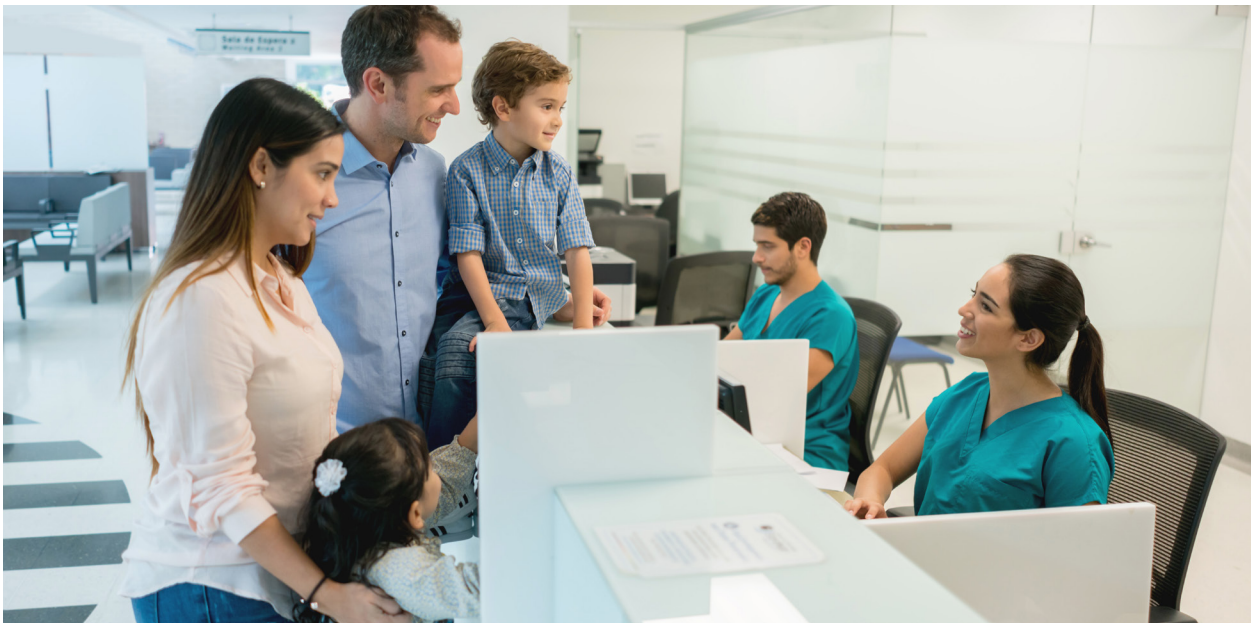
This information applies to all lines of business unless stated otherwise.



COVID-19 Updates

Throughout the COVID-19 pandemic, we've made changes to help our members and providers stay safe. Please continue to visit the Provider FAQs at **bcbstupdates.com** for up-to-date guidelines on how we've updated our policies to help you care for our members.

INSIDE THIS ISSUE



News About Digital Member ID Cards

This year, you may notice more members using a digital Member ID. While we've offered the option for some time, we're now encouraging increased use of digital IDs for many of our commercial members.

You'll be able to find the same information as that listed on the plastic Member ID card. Simply ask your patient to share their digital ID through our BCBSTN℠ app or Apple Wallet. You can also find useful Member ID information behind Availity®.

New Member Service Resource Team for Tennessee Providers

To help support Tennessee-based providers and members, we've assigned a specially trained member service team to answer provider questions about medical benefits, coverage and eligibility for members who are pregnant as the result of rape or incest, or who are facing a non-viable pregnancy. These representatives are also able to provide information about behavioral health benefits, coverage and eligibility.

To reach the team, please call **1-866-268-3502**, from 8 a.m. to 6 p.m. ET.

HEDIS® MY2022 Medical Record Requests to Begin Soon

Each year, we're required to report Healthcare Effectiveness Data and Information Set (HEDIS®) measures to maintain National Committee for Quality Assurance (NCQA) accreditation. NCQA uses these measures to determine whether members received the care and screenings they needed and if the care improved their health.

You'll soon receive a request for medical records related to prevention and screenings, diabetes care, cardiovascular conditions, prenatal/postpartum care, medication management and well-child visits.

Please note it's the provider's contractual responsibility to ensure that the records requested are provided. If you need help submitting your records using any of the following methods, please call us at **(423) 535-3187**.

- Remote access to your electronic medical records
- Secure email
- Fax
- On-site collection
- Our web-based portal

HEDIS is a registered trademark of NCQA.

About the Provider Exclusion Screening Process

The health and safety of our members and your employees are important, which is why we'd like to remind you of your contractual obligation to screen all employees, agents and contractors (the "Exclusion Screening Process") against the exclusion lists.

You also need to conduct criminal background checks and registry checks in accordance with state law to determine whether any of them are "ineligible persons," and therefore, excluded from participation in the Medicare or Medicaid programs. At minimum, registry checks should include the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry, and Social Security Death Master File.

The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and every month following. Providers are also required to have employees and contractors disclose if they're ineligible persons prior to providing any services on behalf of the provider.

If you have questions, please refer to the "Provider Networks — Federal Exclusion Screening Requirement" section of the **BlueCross BlueShield of Tennessee** and **BlueCare Tennessee Provider Administration Manuals**.

Help Your Patients Prepare for Medicaid Reverification

Starting April 1, 2023, the Division of TennCare will begin the reverification process for Tennesseans with BlueCare, TennCare*Select* and CoverKids coverage. As part of this process, TennCare will review each members' eligibility to continue receiving benefits.

- To help ensure your patients don't experience a gap in coverage during this process, please encourage them to:
- Sign up for **TennCareConnect**, the state's free, online portal. There, they can select how they want to receive communications (text, email or mail) about their benefits.
- Verify their contact information in TennCare Connect or by calling **1-855-259-0701**.
- Open and respond to all mail from TennCare.

For more information, please visit the Division of TennCare's **Preparing for Renewals web page**.

Update Your Contact Preferences in Availity for Added Efficiency

Considering increases in telehealth visits, changes in office staff and office locations, we've noticed more providers are asking to receive important communications by email. If you'd like to switch to email, it couldn't be easier. Simply update your **Contact Preferences** through our Payer Spaces in **Availity**. There, you can make email your preferred communication method for each of these communication types and learn more about the roles required for each contact type:

Contact Types	Contact Type Description	Availity Roles*
Contracting	Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs), medical policies or annual updates to Commercial BlueCross Performance Ratings	Provider Enrollment and Contracting
Credentialing	Information about your credentialing status or credentialing appeals inquiries	Provider Credentialing
Network Operations	Updates about network enrollment and your listing in our Provider Directory	Provider Enrollment
Network Updates	General business announcements, newsletter updates and surveys	Base Role
Quality & Clinical	Notifications about available clinical data, performance data and payment reporting for our value-based programs, which providers can view and download in our secure Quality Care Rewards application **Note:** You'll need to have a contact listed here to receive the Quality Care Quarterly newsletter by email.	Office Staff, Medical Staff, Quality & Clinical, Quality Care Rewards**
Financial	Transactional notices about billing, electronic funds transfers and tax-related items	Financial Reports

* Individuals assigned these roles in Availity can update contact information and download the messages and attachments at their convenience.

** For the Quality & Clinical contact type, you only need one of the roles listed.

You Can Update Your Contact Preferences By:

1. Logging in to **BlueCross Payer Spaces** in Availity.
2. Selecting the **Contact Preferences & Communication Viewer** tile.
3. Choosing your **Contact Type** and then your **Organization** (based on Tax ID Number).
4. Verifying your **Provider Name** and **National Provider Identifier (NPI)** and clicking **Submit**.

   Tip: If you don't see your name in the drop-down list, you can add it through **Express Entry** or enter your NPI. For contracting contact, you may have multiple provider names in the left pane, so select the name(s) you want to update.
5. Follow the remaining cues, including checking the email **Opt-In** box and making sure email is the first option in the **Communication Preference** list on the right side. Then, click **Save & Submit**. You can apply the same updates to other contact types by checking **Contact Type** boxes – or the **Select All** box, which automatically checks all your possible contact types.

In some cases, it may take time to receive these messages via email, and you may temporarily receive them as you did before. A **Contact Preference Quick Reference Guide** is available under the **Payer Spaces Resources** tab in Availity. Please visit our **Provider Service page** where you can find links to our Enrollment and Technical Support teams. If you have questions, please log in to **Availity** or contact eBusiness Technical Support at **(423) 535-5717** (option 2).

New Enrolling Providers Must Register for Electronic Funds Transfer to Complete BlueCross Enrollment

As of September 2022, all new enrolling providers are required to register for Electronic Funds Transfer (EFT) with Change Healthcare before they can be enrolled with us. To sign up, just visit Change Healthcare's Payer Enrollment Services portal at **payerenrollservices.com**, which is also accessible through Availity and **provider.bcbst.com**. It's easy and Change Healthcare can process your EFT request within 10 business days. You can sign up for Electronic Remittance Advice (ERA) through their portal as well.

If you're already an in-network provider and you're receiving payments and remittance advice as intended today, there's nothing you need to do. If you have questions, please call **1-800-924-7141** and follow the prompts to eBusiness Technical Support. You can also reach out to your Provider Network Manager.

BlueCross Offering Contracts in North Georgia

As of Nov. 1, 2022, we began offering certain employer group health plans in Catoosa, Dade and Walker counties in Georgia. We're able to do this because we're licensed by the Blue Cross Blue Shield Association for these specific counties outside Tennessee. Providers interested in becoming contracted in our Commercial and Medicare Advantage networks should visit our website and follow the steps for enrollment and credentialing or contact our Provider Service line at **1-800-924-7141**, then follow the prompts to select **Contracts and Credentialing**.

Note: The information in the article above doesn't apply to the Federal Employee Program (FEP). Additionally, all providers located in Catoosa, Dade and Walker Counties should know that with this change, our BlueCross BlueShield of Tennessee member claims for services rendered in these three counties are no longer processed through BlueCard®. Instead, pricing and benefits are handled by BlueCross BlueShield of Tennessee directly. Now, providers located in one of these counties that treat our members must be contracted with us for our members to receive in-network benefits. For questions about these claims, please contact your Provider Network Manager or call our Provider Service line at **1-800-924-7141**.

Commercial

This information applies to Blue Network P℠, Blue Network S℠, Blue Network L℠ and Blue Network E℠ unless stated otherwise.

Changes to Genetic Testing Program Prior Authorization

Beginning **March 1, 2023**, CPT® code 84999 won't require prior authorization through eviCore's Genetic Testing Program. However, the following CPT® codes will be added to the Genetic Testing Prior Authorization List and will require prior authorization through eviCore's Genetic Testing Program:

0355U	0357U	0359U	0361U	0363U
0356U	0358U	0360U	0362U	

Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity**, clicking **Patient Registration** and then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity, by fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

Changes to Radiation Therapy Prior Authorizations

Beginning **April 1, 2023**, these codes will require prior authorization through the eviCore Radiation Oncology Therapy Program for certain Commercial Administrative Service Only (ASO) Plans:

0745T 0746T 0747T

Before requesting prior authorization, please verify member benefits and eligibility by logging in to **Availity**, clicking **Patient Registration** and then **Eligibility and Benefits Inquiry**.

Prior authorization requests can be submitted through Availity, by fax to eviCore at **1-888-693-3210** or by calling **1-888-693-3211**.

Quest*Select*™ Program Coming Soon

Beginning early 2023, we're adding the Quest*Select* program for our Marketplace members and members who are part of our AmplifyHealth advocacy program. It'll also be optional for self-funded employer groups.

With this program, members can show their Quest*Select* card at their appointment and request that their provider send their lab work to Quest. This is a voluntary, member-driven program designed to lower member costs for outpatient lab testing. If the member chooses not to use Quest, their normal lab benefits will apply.

The testing must be covered and approved by the member's benefit plan, and the provider or lab technician must indicate Quest*Select* coverage on a Quest Diagnostics requisition that accompanies the specimens to Quest Diagnostics. Although there is not a unique benefit tied to the QuestSelect program, member benefits do vary by plan design. Benefits should always be verified prior to services being performed.

Providers can collect specimens in their office and be reimbursed for the collection by submitting a claim with the office charge. Quest Diagnostics will bill us directly for lab testing services.

Call Quest*Select* at **1-800-646-7788** for:

- A faxed copy of the necessary paperwork for your immediate use
- Personalized test order pads for requisitions
- Courier service
- Patient results

If you don't normally collect patient specimens, your patients can call **1-800-646-7788** or visit **QuestSelect.com** to find a Patient Service Center.

BlueCare Tennessee

This information applies to BlueCare [SM], TennCareSelect and CoverKids [SM] plans unless stated otherwise.

Expanded Dental Benefits Now Available

The Division of TennCare has expanded dental benefits for patients with Medicaid coverage. Effective Jan. 1, 2023, all patients with BlueCare or TennCare*Select* coverage have dental benefits. Previously, benefits were only available to those under age 21, during pregnancy and for 12 months after giving, and to those enrolled in Employment and Community First CHOICES or a 1915(c) waiver.

Please let your patients know about this coverage expansion. If you have questions or would like more information, please visit **bluecare.bcbst.com** or **dentaquest.com**. DentaQuest handles dental care and claims for our BlueCare Tennessee members.

Note: These new benefits don't apply to CoverKids members.

Guidance for Combining Well-Child and Sick Visits

Many kids, especially teenagers, go several years between checkups. Sometimes, an office visit for an illness, shots, prescription refill or other reason is the only chance you have to perform a well-child exam. That's why TennCare Kids screening guidelines allow providers to receive reimbursement for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) visits performed at the same time as other visits.

When patients visit your office for care, consider checking your patient roster in the Availity **Quality Care Rewards** application to see if they're up to date on preventive care. As a reminder, stand-alone sports physicals aren't covered services for BlueCare Tennessee members. However, by converting a sports physical appointment into a complete well-care visit, if appropriate, you can meet all requirements of the sports physical and be reimbursed for a covered service.

For more information, please see our **EPSDT Provider Booklet**.

Note: The information in this article doesn't apply to CoverKids.

Stay Up to Date on the Provider Appeals Process

If you disagree with the amount we paid you for a particular claim, you may use our claims reconsideration and appeal process to request a second look. We've put together a few reminders to help make sure reconsideration and appeal requests are processed quickly and correctly. Please note that the below process differs from the process used for utilization management and clinical authorization appeals.

Step 1: Reconsideration – Reconsideration requests must be received within 18 months of the date of the event causing the dispute. Please submit requests for reconsideration, including all supporting medical records, by calling us or filling out the **Provider Reconsideration Form**. **Each form should only include one patient, one claim and one date of service. We can't accept forms for multiple patients or multiple claims.**

Please note, you must file a request for reconsideration before submitting an appeal unless your request is related to a non-compliance denial. A claim may be denied for non-compliance if prior authorization guidelines aren't followed before giving care. You can read more about non-compliance denials and the process for appealing them in our **BlueCare Tennessee Provider Administration Manual (PAM)**.

Step 2: Appeal – An appeal must be received in writing with all supporting medical records within 60 days after receiving the other party's response to its inquiry/reconsideration. Please use the **Provider Appeal Form** to submit appeal requests. Like the Reconsideration Form, each document should only include one patient, one claim and one date of service.

For more information about our claims reconsideration and appeal process, please see the **BlueCare Tennessee PAM**.

BlueCare Plus (HMO D-SNP)SM

This information applies to our Medicare and Medicaid dual-eligible special needs plans.

Transition of Care Measure

We're working with providers to educate our members on the importance of primary care and medication reconciliation after inpatient discharge. Providers can utilize home, face-to-face or telehealth visits to complete most post-discharge follow-up visits and use CPT® billing codes to meet the STAR measure components of patient engagement and medication reconciliation post discharge. The other two components for the Transition of Care gap require medical records confirming notification of inpatient admission and discharge.

Please refer to your **2023 Provider Quality Program Information Guide** for specific details about these measures and the contact information for the Provider Quality Managers and the Member Health Promotion team members.

Medicare Advantage

This information applies to our BlueAdvantage (PPO)℠ plans unless stated otherwise.

New Over-the-Counter (OTC) Program

Our members now have access to quarterly supplemental benefit credits that allow them to purchase from a catalog of covered over-the-counter health and wellness products. We're working with CVS® to provide this ordering service at no cost to our members. Here's what you need to know about this program:

- Members are eligible for four quarterly benefit credits (amounts vary between $115 and $210 per quarter depending on the member's plan).
- Quarterly benefits don't carry over from quarter-to-quarter.
- Items can be purchased in-store or ordered and shipped directly to the member.

It's also important to note, not all CVS stores accept this benefit and only items listed in the catalog are eligible for purchase

Members can view the catalog of eligible items and place an order at **bcbstmedicare.com/otc**, or they can contact us to request a printed copy of the catalog. We recommend members order online or by phone at **1-888-628-2770**.

Member Wellness and Rewards Program

This year, our members are eligible to earn a Walmart® gift card for following healthy behaviors and completing the screenings they need in 2023 through our My HealthPath® Wellness and Rewards program.* Members must opt in to participate and can join by calling member service, by logging in at **bcbstmyhealthpath.com**, downloading the **AlwaysOn® Wellness** mobile app or returning the business reply card attached to the 2023 My HealthPath introduction letter mailed to new members.

Once enrolled, members are eligible to earn gift cards for certain preventive services. Gift cards are earned once a year for each eligible activity, and the date of service must occur within the calendar year. Rewards are available for:

Measure/Activity (Based on Member Eligibility)	Gift Card Amount
Annual Wellness Visit (AWV)	$25
Breast Cancer Screening (BCS)	$25
Colorectal Cancer Screening (COL)	$20 - $50 (depending on type of screening)
Eye Exam for Patients With Diabetes (EED)	$40
Health Needs Assessment (HNA)	$20

For more information about the My HealthPath Wellness and Rewards program, please contact your local Provider Quality Outreach Consultant.

* Each gift card is restricted and prohibits the purchase alcohol, tobacco, firearms, lottery tickets and other gift cards.

Schedule Annual Wellness Visits for the New Year

Our members are eligible to receive an Annual Wellness Visit (AWV) each calendar year, and the beginning of a new year is a great time to schedule those exams. During the AWV, patients should receive a comprehensive preventive medicine evaluation and management-focused visit. This exam also presents a great opportunity for providers to evaluate, treat and document a patient's chronic conditions and their health status.

Chronic conditions and health status codes are very important to assess, and to document and code at least annually using the highest level of specificity. While the Z00.xx diagnosis code may be appropriate for the AWV, we encourage providers to document any chronic conditions assessed or treated during the visit. In addition, providers should add those conditions to the claim. Any condition that was previously treated and no longer exists can be coded using the appropriate "history of" codes to replace the previously acute or treated condition(s).

2023 Quality Program Measures

We've made some changes to the quality measures included in the Quality+ Partnerships 2023 program:

- The **Kidney Health Evaluation for Patients with Diabetes (KED)** measure and the **Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)** moved from the monitoring section of the program into the scored section of the program as single-weighted measures.
- The **Member Experience – CAHPS** measure moved from a weight of two to a weight of **four**.
- The **Comprehensive Diabetes Care (CDC) A1C and Eye Exam** measure names update to **Hemoglobin A1c Control for Patients with Diabetes (HBP)** and **Eye Exam for Patients with Diabetes (EED)**.

The 2023 program year measures are listed in order of measure weight:

Measure	Source	Weight
Member Experience - CAHPS	CMS Member Survey	4
Controlling High Blood Pressure (CBP)	HEDIS®	3
Hemoglobin A1c Control for Patients with Diabetes (HBP)	HEDIS®	3
Medication Adherence for Cholesterol (Statins)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Hypertension (RAS Antagonists)	Prescription Drug Event (PDE) Files	3
Medication Adherence for Non-Insulin Diabetes Medications (OAD)	Prescription Drug Event (PDE) Files	3
Plan All-Cause Readmissions (PCR)	HEDIS®	3
Member Experience (HOS)	CMS Member Survey	2
Breast Cancer Screening (BCS)	HEDIS®	1
Colorectal Cancer Screening (COL)	HEDIS®	1
Eye Exam for Patients with Diabetes (EED)	HEDIS®	1
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	HEDIS®	1
Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS®	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS®	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	HEDIS®	1
Statin Use in Persons with Diabetes (SUPD)	Prescription Drug Event (PDE) Files	1
Transitions of Care (TRC)	HEDIS®	1

Note: These changes won't be reflected in the Quality Care Rewards (QCR) application until mid-February. Contact your Provider Quality Outreach Consultant if you have questions about the measures included in the 2023 quality program.

HEDIS® is a registered trademark of NCQA.

Pharmacy

This information applies to all lines of business unless stated otherwise.

STELARA® Coverage Changing

Starting March 2, 2023, STELARA® SC (J3357) will be covered as a pharmacy benefit only. Prior authorization requests should be directed to the member's Pharmacy Benefit Manager (PBM) for review. STELARA IV (J3358) will continue to be covered under the member's medical benefits.

Note: This article applies to Commercial members only.

Medicare Part D Non-Drug List Exception Requests

Non-drug list exceptions may be requested for coverage of a drug not currently included on our Medicare Part D drug list. The criteria below are utilized to decide if an exception can be made for the requested non-drug list medication:

- The patient has tried all available drug list alternatives, unless contraindicated, for at least 28 days of therapy with each alternative.
- The intended indication of the prescribed drug is consistent with FDA-labeling or CMS-recognized compendia and not excluded from Medicare Part D.
- Medical justification must be provided regarding why all drug list alternatives would be less effective or would cause adverse effects.

You can **find our drug lists** online. To request a coverage determination for your patients, contact:

BlueAdvantage
Phone: **1-800-831-2583**
Fax: **(423) 591-9514**

BlueCare Plus
Phone: **1-800-299-1407**
Fax: **(423) 591-9514**

Tips for Coding Professionals

This information applies to all lines of business unless stated otherwise. Please note these tips are educational only, providers remain responsible for completion of claims submitted to BlueCross.

Coding Updates: See the Latest and What Changes Are on the Way

You can easily find current coding updates and pending claim edit changes under **Coding Updates** in the Coding Information section of our **Coverage & Claims** page. You can access code edits 60 days before the effective date. If you have questions, please call us at **1-800-924-7141** and follow the prompts for providers.

Quality Care Rewards

This information applies to all lines of business unless stated otherwise.

THCII Episodes of Care Program Reports Available This Month

Quarterbacks participating in the Tennessee Health Care Innovation Initiative (THCII) Episodes of Care Program will receive their 2023 Interim Performance Reports for our BlueCare Plus and Commercial lines of business on Feb. 16. Please log in to **Availity** to review your reports.

If you have trouble accessing your reports in Availity, please call **(423) 535-5717** and choose option 2, or email **eBusiness_Service@bcbst.com** for assistance.

Note: This article applies to Commercial and BlueCare Tennessee.

BlueCross BlueShield of Tennessee, Inc., BlueCare Tennessee and their licensed health plan and insurance company affiliates comply with the applicable federal and state laws, rules and regulations and does not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age or disability. If a member or participant needs language, communication or disability assistance, or to report a discrimination complaint, please, call **1-800-468-9698** for BlueCare, **1-888-325-8386** for CoverKids or **1-800-263-5479** for TennCare*Select*. For TTY help call **771** and ask for **1-888-418-0008**.

This information is educational in nature and is not a coverage or payment determination, reconsideration or redetermination, medical advice, plan pre-authorization or a contract of any kind made by BlueCross BlueShield of Tennessee, Inc. or any of its licensed affiliates. Inclusion of a specific code or procedure is not a guarantee of claim payment and is not instructive as to billing and coding requirements. Coverage of a service or procedure is determined based upon the applicable member plan or benefit policy. For information about BlueCross BlueShield of Tennessee member benefits or claims, please call the number on the back of the member's ID card.

Archived editions of BlueAlert are available **online.**

Contact Us Through Availity

Availity® makes it easy for you to do business with us online anytime, offering faster prior authorizations, claims decisions and more. You can log in at **Availity.com** to:

- Check benefits, eligibility and coverage details
- Manage prior authorizations
- Enroll a provider
- Request claim status
- View fee schedules and remittance advice
- Manage your contact preferences

CAQH Solutions | PROVIEW™

Be sure your **CAQH ProView**™ profile is kept up to date at all times. We depend on this vital information.

Provider Service Lines:

Featuring "Touchtone" or "Voice Activated" Responses

Commercial Service Lines	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
Commercial UM	1-800-924-7141
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	
Federal Employee Program	1-800-572-1003
Monday-Friday, 8 a.m. to 6 pm. (ET)	
BlueCare	1-800-468-9736
TennCare*Select*	1-800-276-1978
CoverKids	1-800-924-7141
CHOICES	1-888-747-8955
ECF CHOICES	1-888-747-8955
BlueCare Plus℠	1-800-299-1407
***Select*Community**	1-800-292-8196
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
BlueCard	
Benefits & Eligibility	1-800-676-2583
All other inquiries	1-800-705-0391
Monday–Friday, 8 a.m. to 6 p.m. (ET)	
BlueAdvantage	1-800-924-7141
Monday-Friday, 8 a.m. to 6 p.m. (ET)	
eBusiness Technical Support	
Phone: Select Option 2 at	(423) 535-5717
Email:	**eBusiness_service@bcbst.com**
Monday-Thursday, 8 a.m. to 6 p.m. (ET) Friday, 9 a.m. to 6 p.m. (ET)	

Important Note:

If you have moved, acquired an additional location, changed your status for accepting new patients, or made other changes to your practice:

Please visit the BCBST payer space at **Availity.com** and update your information.

Update your provider profile on the **CAQH Proview®** website

Questions? Call **1-800-924-7141**.

23PED1935800-2 (2/23)