BlueCross BlueShield of Texas

PEAQ
Physician Efficiency, Appropriateness, & Quality

Program Overview and Provider FAQs

766228.0724

OVERVIEW

The **Physician Efficiency, Appropriateness, & Quality**℠ program evaluates physician performance in a transparent and multidimensional way. The goal is to measure and maximize efficiency, appropriateness and quality.

The **PEAQ**℠ program provides physicians with Physician Performance Insights reports that show how they've performed in comparison to peers. PEAQ also influences Provider Finder® search results, which can help our members choose high quality, cost-effective care. PEAQ can affect employer insights and may inform future benefit design and tiered network options. PEAQ uses may expand as we refine the program based on program review and feedback.

Below is information on what PEAQ means for you and how you can access PPI reports. It includes questions we've heard from providers, with answers from our PEAQ team. If you have additional questions, email PEAQ Inquiries.

Contents

General Questions

What specialties apply to PEAQ?

We measure physicians across medical, surgical and primary care specialties where there is sufficient share of practice. Measured specialties are:

Medical	Surgical	Primary Care
Cardiology	Cardiothoracic Surgery	Family Medicine
Endocrinology	General Surgery	Internal Medicine
Gastroenterology	Ophthalmology	Pediatrics
Nephrology	Orthopedic Surgery	
Neurology	Otolaryngology	
Obstetrics/ Gynecology	Urology	
Psychiatry*	Vascular Surgery	
Pulmonary Medicine		
Rheumatology		

*This specialty will be measured beginning in 2026.

We continually reevaluate measured specialties.

Will PEAQ add specialties?

The specialties we initially selected were part of former performance measurement programs and initiatives common in the marketplace. We may add specialties based on similar considerations. We continually evaluate measured specialties based on data availability, clinical relevance and volume.

Does the PEAQ program include a review of medical records?

No. We don't review medical records as part of PEAQ. Our data is either claims-based or obtained through other data streams.

How can I obtain my PEAQ results?

We distribute PPI reports via Availity® Essentials in the Payer Spaces section. Providers can also email PEAQ Inquiries or contact their Network Representative to obtain reports.

Where can I find PEAQ documentation?

You can find the methodology documents on our PEAQ page. Historical methodology documents are kept for reference.

How do you communicate updates to the program and methodology?

We communicate updates through Disclosure Notices on our provider website and other provider communications, such as *Blue Review*℠.

Can I opt out of the PEAQ program?

No. If you have enough claim volume in a specialty that is reviewed, you will receive a PPI report.

Why does my PEAQ report list a TIN that I'm no longer affiliated with?

To ensure credible results, PEAQ measurement uses historical look-back periods. A physician can be rated at a practice where they no longer work if they practiced there during the measurement period. Measurement periods are noted in the PPI report.

Do PEAQ results include Medicare and Medicaid claims?

Medicare and Medicaid claims are included for quality and appropriateness measurements. Medicaid claims are only applied to efficiency measurements.

Network-related Information

To what provider networks does PEAQ apply?

PEAQ performance applies to all networks. Physicians are rated at a National Provider Identifier level and can participate in multiple networks.

I practice in multiple locations. Do I have different PEAQ results for my various practice locations?

No. PEAQ is only at the physician level and is not tied specifically to the practice location. We assign only one rating for a provider within the same working specialty.

Does Provider Finder reflect PEAQ results?

Provider Finder displays a summary of physician scores for each PEAQ component. Physicians who perform well among peers receive a designation indicating their Top Performing Physician status.

Rating and Reporting

What data does PEAQ use as the benchmark?

The benchmark is a provider's peer group defined by working specialty.

How does PEAQ evaluate physicians?

PEAQ evaluates physicians in the three performance categories (efficiency, appropriateness and quality) and consolidates measures into a composite score. See the methodology document on our PEAQ page for more information on physician evaluation.

How are physicians' peer groups determined?

PEAQ compares physicians to peers within the same working specialty. See the methodology document on our PEAQ page for more information on peer groups.

I identify as a certain type of specialist, but the PPI report lists me as a different type of specialist. How did PEAQ come up with this specialty?

We start with the specialty a physician provided on their application, which is loaded into our system. Then we evaluate the type of care the physician provides. In rare cases when the type of care is highly inconsistent with the declared specialty, we modify that specialty to align with the physician's actual practice of care.

At what level does PEAQ measure physicians?

PEAQ measures physicians at the individual contracted physician level (MD/DO) using NPIs within working specialties. PEAQ may expand to include other provider types and levels, such as physician groups.

Why are my peer counts different for my efficiency, appropriateness and quality reports?

The minimum member, measure and episode thresholds vary across the components. Some physicians measured for efficiency are not measured for appropriateness or quality, resulting in different peer groups for different components.

Can I compare historical PPI reports with current reports?

Only current PPI reports are made available. Trending reports aren't offered. We encourage physicians to keep their reports for future reference.

The methodology says that providers are compared to peers in the same working specialty and geographic market. Why doesn't my report show my market?

Some specialties have only a few providers within a geographic market. This may lead to skewed results and/or provider exclusions due to small sample sizes. Provider scoring compares peers to the same working specialty across a state for broader and more accurate results.

Why didn't I receive a PPI report?

For a variety of reasons, not all physicians are evaluated by the PEAQ program. These reasons may include:

- Specialty not included in current measurement
- Non-MD/DO physician
- Limited volume of our members
- Limited number of patients in the denominator of measures

Does PEAQ rate physician assistants, nurse practitioners or hospitalists?

No. PEAQ is limited to MDs and DOs. In the future, we may add other clinical designations.

My patients are more costly and have more complex underlying conditions than other groups. Do you adjust my results to reflect that?

Yes. Efficiency, appropriateness and quality results are risk-adjusted on multiple factors, such as patient comorbidities, demographics, disease severity and disease category.

Who else can see my PEAQ results?

Only those in your practice who have Availity TIN permissions to pull the reports and disseminate them can see your full PPI reports. We don't share your report with other providers. The data is used in Provider Finder and by our network teams to understand the network's composition. Provider Finder displays a summary of physician scores for each PEAQ component.

Can I get credit for a service that another provider administered to one of my patients?

Yes. We determine measure adherence using claims data as evidence that a service occurred. If claims data shows that a patient received service related to a PEAQ measure, credit for it extends to everyone on the patient's care team.

Appeals and Reconsideration Process

How can I challenge an evaluation?

You may request reconsideration of your PEAQ designation before results are finalized. You have 45 calendar days following initial notification of report release to submit a reconsideration request. Reconsideration request forms are available on our PEAQ page. Submit requests to PEAQ Inquiries. Our PEAQ team will answer questions sent to this mailbox beyond the reconsideration request period, but scores will already be finalized.

A panel of one or more medical directors, network representatives, quality specialists and data scientists will review your reconsideration request. We will notify you of the response to your request.

How can I request updates to my provider-level data, demographic data or working specialty?

You or your administrator can request updates to certain data using the Availity Provider Data Management feature or our Demographic Change Form. See our Verify and Update Your Information page for details on the update process. Note: PEAQ results will not factor in updated data until the next PEAQ refresh.

What if I don't agree with one of the measure specifications and believe it shouldn't be used in my PEAQ results?

You may appeal the inclusion of measures on your report by emailing PEAQ Inquiries.

Measures used in PEAQ are taken from clinical practice guidelines from national specialty and subspecialty societies and other high quality clinical evidence. Every year, PEAQ program physicians review the measure lists for relevance and for any changes made by the governing bodies. We update the methodology to include these changes and the feedback received since publication of the previous version.

Timeline

How often are physicians evaluated?

We update PEAQ results annually. The evaluation frequency is subject to change. We notify physicians through News and Updates prior to release of new PPI reports. Information is also included in *Blue Review*.

How often do you share PEAQ results?

We share PEAQ results annually with physicians through PPI reports. The evaluation frequency is subject to change. We notify physicians about upcoming PPI reports in News and Updates and *Blue Review*.

What are the evaluation periods?

The Quality component is based on one year of claims data. Efficiency is based on two years of claims data. Appropriateness is based on two years of claims data but includes extra months for potential runouts to capture additional claims. Exact timelines that correspond to scoring for each component are on the Versioning page of PPI reports.

Efficiency Component

How is cost attributed to physicians for efficiency measurement?

Cost is attributed to physicians using diagnostic-based episodes of care. Episodes are created using a Medical Episode Grouper algorithm, which clusters completed episodes of care from a patient's medical and pharmacy claims into one of over 500 episode categories. Physicians who treat a patient for an episode are attributed cost, based on the amount of work they do to treat the episode. The amount of work is based on the proportion of Relative Value Units each physician's services comprise. For more information, see Terminology questions in this FAQ or the methodology on our PEAQ page.

What risk adjustment methodology is used for efficiency?

Efficiency uses MEG output groups and other demographic factors within an internally developed risk adjustment methodology. The risk adjustment uses machine learning techniques to accurately adjust for patient population differences related to comorbidities and demographics. The risk model determines a risk factor at a geographic and episodic level by referencing comorbidity data determined by conditions.

The process runs two models:

- The first model determines an accurate cost by using all attributes (member and episode) as features.
- The second model assesses cost but uses features of the episode only with the same parameters as the first model.

The ratio between the two models reflects the impact the member features have on the episode cost, therefore the additional risk.

Appropriateness Component

How does PEAQ define appropriateness?

Our appropriateness metrics evaluate the extent to which physicians make decisions about patient care that are **consistent with current evidence-based guidelines**. We've partnered with Motive Medical Intelligence to deliver these measures using the Practicing Wisely Solutions appropriateness of care measurement methodology.

Appropriateness of care measures are determined through a systematic examination of data, evidence and expert opinion. Data are abstracted from national claims data sets. Evidence is culled by Motive Medical Intelligence from peer-reviewed literature, which is analyzed with quantitative bibliometrics. Input is derived from physicians who are in active clinical practice in the areas being measured, and who are identified by quantitative indices of expertise.

How does a physician know which appropriateness measures were used for their specialty?

The appropriateness measures are listed in the methodology on our PEAQ page.

How are patients attributed to physicians for appropriateness measurement?

Measures are attributed to the physician responsible for the care decision. Cases that can't be definitively attributed to a physician are excluded. Several considerations are involved in proper attribution, depending on the measure:

- Specialty procedures are attributed only to physicians within the specialty of interest.
- The timing of interventions relative to physician visits may be a factor in determining attribution.
- For episodes of care in which the physician rendering the service is responsible for the decision to deliver that service (e.g., cardiac catheterization), the event of interest is attributed to the physician identified on the claim by the rendering NPI.
- For evaluation and management measures, the event of interest is attributed to the presumptive ordering physician at the most proximate prior E&M visit instead of the rendering NPI. This approach is used because the physician rendering the service may be different from the physician responsible for the decision to deliver that service.

Which appropriateness components are risk-adjusted?

All appropriateness measures are adjusted for risk and severity through the use of detailed denominator exclusion criteria within the measure logic. This ensures all cases included in the case mix for a given measure are similar in terms of their level of risk or severity. For example, measures that evaluate the use of high-cost resources exclude cases in which the use of those resources is more frequently justified, such as the use of advanced imaging in the context of cancer. By logically embedding risk and severity adjustment, this approach to measurement mirrors clinical decision-making.

What is the methodology for the measure rates?

Appropriateness measure rates are formulated as numerator-denominator statements, using a standardized denominator, exclusion, attribution and numerator methodology. Cases meeting the numerator and denominator inclusion criteria and exclusion criteria requirements are identified within claims datasets to identify patterns of inappropriate decision-making across cases.

A minimum threshold number of cases is established to generate statistically significant analyses, while ensuring that physicians are evaluated based on the care decisions they make regularly.

Although the appropriateness measures look at both overuse and underuse, all individual appropriateness measures are structured as evaluations of inappropriateness. This means that lower individual measure rates are always better. Overuse measures evaluate whether services were provided that were inappropriate (e.g., ordering an MRI for low back pain). Underuse measures show the absence of appropriate services (e.g., strep test underuse in antibiotic treatment pharyngitis, or underuse of conservative therapy before surgery).

How does PEAQ account for complex cases, including those with secondary and tertiary referrals and patients with increased disease burden? What about extenuating circumstances that require physicians to go against their better judgment, such as school district policies requiring an antibiotic prescription for conjunctivitis?

While lower rates are always preferred for both overuse and underuse measures, the appropriateness measures account for situations in which it might be reasonable to provide a service that would otherwise be considered inappropriate. The appropriateness measures address these variations in two ways:

First, a **range of better practice threshold** is applied according to a two-step process.

- The first step is statistical. It uses standardized testing and rigorous methodology – such as information in published, peer-reviewed studies – to assess the range of physician performance variation.
- The second step is expert curation. Motive's 600-member board of subject matter experts curates the data using systematic algorithms and quantitative techniques to account for factors that inform the real-world practice of medicine.

The resultant ROBP brings objectivity and reproducibility to assessments that would otherwise be subjective and irreproducible. The ROBP threshold is set generously to ensure that any rate of performance over the threshold is clearly inappropriate. Factors considered in setting the ROBP threshold include variations in medical coding practices, gaps in claims data and the realities of clinical medicine. These may include regional resource limitations, reliance on tertiary referral and individual patient factors.

Second, **cases that can't be attributed** to an individual physician with complete certainty **are excluded**. For example, if multiple physicians of the same specialty are involved in a case – including any instances of secondary or tertiary referral – the case can't be attributed to a single individual and is disregarded for the purposes of measurement.

How do you decide what to measure?

The appropriateness measures must meet strict criteria to be considered for development, and they must pass rigorous testing and clinical validation before they are included in our methodology.

First, all appropriateness measures are specifically focused on **low-value care**. This means services that have the potential to lead to harm to members and the unnecessary use of costly resources, and for which there is great variability in practice patterns.

Second, every measure must **meet the American College of Physicians criteria** for performance measurement. This means the measures must address issues that:

- Are important and have meaningful clinical impact
- Address inappropriate use including both overuse and underuse
- Have a clearly defined and well-established evidence base
- Are clear and transparent in their measure specifications and methodology, and
- Can be measured fairly and accurately and provide actionable guidance without creating undue burden for data collection[1]

Third, every measure must pass a battery of tests for **statistical validity**. This includes analyses to set and validate minimum denominator thresholds, analyses of measure stability over time and analyses of reliability across multiple datasets. Every measure is subjected to extensive scrutiny by multiple subject matter expert physicians with relevant expertise at each step in the measure development process. This is to ensure that the measures are fair and accurate and that they will be acceptable to practicing physicians while providing actionable insights for helping them improve the care they provide.

1. Maclean CH, Kerr EA, Qaseem A. Time Out — Charting a Path for Improving Performance Measurement. N Engl J Med. 2018:378;19(1757-1761).

Quality Component

How are patients attributed to physicians for quality measurement?

PCPs: A patient's PCP attribution is derived from their historic claims data. Attributed patients must have a full year of coverage before they are included in measurement.

Specialists: Patients are attributed to specialists based on claims data from diagnosis codes for medical specialties or procedure codes for surgical specialties. Attributed patients must have a full year of coverage before they are included in measurement.

For a PCP or specialist to be rated, they must meet a minimum patient volume threshold. Additionally, providers with extremely high patient volumes are considered outliers and not included in results.

Why are there so few quality measures in my specialty?

Several specialties have few relevant measures that we can analyze. Many potential measures require clinical data that is not available to us. We are constantly evaluating new potential metrics to improve the breadth of measurement.

How do I know which quality measures were used for my specialty?

The quality measures are listed in the methodology document posted on our PEAQ page.

Where can I go to find out more information about HEDIS® measurements?

For more information on Healthcare Effectiveness Data and Information Set measures, refer to the National Committee for Quality Assurance website. Also see the Clinical Resources Quality Improvement section of our provider website for related resources.

Terminology

What is a working specialty?

Providers are matched to other providers within the same working specialty. The working specialty represents a provider's specialty and/or sub-specialty and is determined using information from our provider demographics database and claims providers submit. The working specialty may be more specific than a provider's self-declared specialty. For example, working specialty may distinguish an interventional cardiologist from a non-interventional cardiologist based on claims submitted by the physician.

What is an episode of care?

Episodes of care are diagnostic-based groupings of claims (one or more claims that correspond to a single patient and a single diagnosis) from MEG. There are over 500 episode categories that are further segmented by severity and disease stage progression and grouped as acute or chronic. Only episodes marked as complete are used in efficiency results.

What is standard deviation?

Standard deviation is a measure of the amount of variation or dispersion of a set of values.