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A Guide to Point-of-Care Ultrasound Credentialing in Family Medicine



ABOUT THE AUTHORS

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Whether you are navigating your organization's POCUS credentialing process or trying to establish one, three elements are key: training, scope of practice, and quality review.

Point-of-care ultrasound (POCUS) is increasingly integrated into family medicine as training opportunities expand and residency programs graduate physicians with longitudinal ultrasound experience. Still, many physicians in established practice may be uncertain about how to incorporate POCUS, particularly when it comes to credentialing. Understanding how credentialing works can help family physicians preserve and expand their scope of care while meeting (or establishing) local institutional requirements.

CREDENTIALING BASICS

Credentialing is the structured process by which an organization verifies a physician's education, training, experience, current

competence, and licensure to provide services.¹ It is usually administered locally, but there are exceptions, such as large, multi-location or even multi-state organizations that have system-wide credentialing. Even in these settings, it is feasible for primary care physicians to develop local credentialing pathways, though it may require additional administrative support.

Credentialing is different than certification. Certification requires training through an external, often national, organization. While certification may help document competency, it is neither required nor sufficient for POCUS credentialing in most organizations.

Clinicians in private practice generally have no formal credentialing requirements for procedures allowed within their scope of care under state law — including POCUS — unless their liability insurance carrier specifies otherwise. But employed clinicians cede some control over their scope of practice to their employers. Employers may restrict certain procedures, including POCUS, to specific types of clinicians. Becoming credentialed for POCUS creates a pathway to integrate it into everyday practice and to bill for it. Billing is often key to demonstrating the value of POCUS to employers and justifying equipment purchases and clinician time.

But it's not just about billing. POCUS is now widely recognized as a tool that improves access to care, diagnostic efficiency, procedural safety, and patient satisfaction.^{2,3} Robust credentialing processes ensure clinicians can deploy this tool safely, protecting patients and maintaining practice standards.

CORE COMPONENTS OF A POCUS CREDENTIALING PATHWAY

POCUS credentialing requirements vary widely by organization. But three elements are key: training, scope of practice, and quality review. (See Table 1 for a starter checklist.)

Training. POCUS training can occur multiple ways. Newer clinicians may have received POCUS education during residency, while more established clinicians can pursue CME courses or mentorship with experienced colleagues. Regardless of how they received POCUS training,

clinicians should save and document the following information, which organizations commonly request during credentialing:

- Total hours of POCUS education,
- Number and type of studies performed and reviewed,

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- Available outcome or comparison data, which can include comprehensive ultrasound or other imaging results and patient outcomes.

Establishing a specific recommended depth of training — such as required hours of didactics, hands-on practice, or educational activities for each POCUS procedure — is beyond the scope of this article and should be determined locally based on community needs.

Scope of practice. Because POCUS includes many distinct applications, the level of specificity in credentialing is determined locally. Depending on institutional needs, organizations may credential clinicians to use ultrasound broadly or grant defined privileges for specific applications or service lines. Primary care physicians play a critical role in defining this scope of practice within their organization, ensuring that credentialing aligns with patient needs and practice realities.

Quality review. Ongoing quality review

KEY POINTS

- Becoming credentialed for POCUS creates a pathway to integrate it into everyday practice.
- Successful credentialing programs define required training, scope of practice (broad use vs. specific uses of the procedure), and ongoing quality review.
- Data on community need and reimbursement potential can help convince administrators to adopt POCUS, while ongoing data on patient outcomes and payment can help make programs sustainable.

is a key component of POCUS credentialing. This typically involves a committee of peers who review selected images and clinical outcomes at defined intervals (e.g., twice a year). While third-party vendor software can facilitate this process — particularly in early stages — it may also be effective to use a locally developed document or spreadsheet to track studies, outcomes, and feedback.

In our experience, quality review is most effective when led by a primary care physician or group of clinicians who actively perform POCUS. When conducting ongoing quality review sessions, key elements to assess include technical adequacy (e.g., appropriate probe selection, gain, and depth settings) and overall image adequacy to ensure it sufficiently supports

the intended diagnosis. At present, there are no specific procedure numbers required for clinicians to maintain competency in individual POCUS applications. To balance patient access with care quality, such standards should be determined locally, based on the needs of the patient population in an organization's service area.

IDENTIFYING AND ENGAGING STAKEHOLDERS

If your organization does not have an established POCUS credentialing process but you want to add the procedure to your practice, you will need to make the case to leadership. This requires early identification and engagement of key stakeholders, which often includes the following groups.

Administration. Initial conversations typically involve a medical director, chief medical officer, or medical staff leadership. To make these discussions more productive, approach them with a clear plan and supporting data:

- Estimated patient volume and unmet clinical need,
- Equipment and maintenance costs,
- Staffing and workflow impact,
- Relevant billing codes and potential revenue.

Providing administrators with data demonstrating how POCUS benefits patients, clinicians, and the organization helps illustrate the value of integrating this service into primary care. Multiple studies show that POCUS increases patient and clinician satisfaction, fills care gaps, provides positive income flow, and can reduce medicolegal risks.^{4,5}

Information technology. Billing for POCUS requires the ability to store images securely, which makes it essential to involve information technology (IT) staff. Collaborating with IT will help you determine appropriate equipment, software, and workflows that meet institutional requirements and integrate smoothly into existing operations.

Other clinical stakeholders. It is also helpful to understand how POCUS may intersect with services other specialties provide. For example, if radiologists currently perform abdominal aortic aneurysm (AAA) screening or obstetrician-gynecologists provide obstetric

TABLE 1
POCUS CREDENTIALING STARTER CHECKLIST

Before you start	☐ Identify which POCUS applications to target (e.g., AAA or obstetric ultrasound). ☐ Identify local stakeholders (administrators, IT staff, and other specialists). ☐ Identify a local POCUS champion.
Design the credentialing pathway	☐ Define acceptable training standards. ☐ Define the scope of practice (broad use vs. specific uses of the procedure). ☐ Define initial and ongoing image quality review processes.
Prepare your case	☐ Determine patient volume and unmet need. ☐ Determine CPT codes and potential revenue. ☐ Determine equipment and maintenance costs. ☐ Determine how to add billing for POCUS.
Engage stakeholders	☐ Engage with medical staff leadership. ☐ Engage with relevant specialties (e.g., radiology and obstetrics-gynecology) while maintaining your own responsibility for credentialing and quality assurance. ☐ Engage with IT for equipment purchase, image storage, and EHR integration. ☐ Engage with medical staff for approval.
Implement and monitor	☐ Create or join a POCUS subcommittee to oversee the credentialing program. ☐ Schedule regular image review for the subcommittee. ☐ Track patient outcomes and financial metrics.

ultrasound, understanding their volume, capacity, and existing access limitations can clarify how POCUS can enhance existing services, as opposed to competing with them. Focusing on the positive contributions your service line will make to patient care and access can help you anticipate and navigate concerns from other clinicians regarding expertise, scope, volume, quality oversight, financial implications, and image storage. Understanding these issues in advance allows you to present your case more clearly, fairly, and effectively.

PUTTING CREDENTIALING INTO PRACTICE

Consider two fictional physicians seeking to implement AAA screening using POCUS in a hospital-employed outpatient family medicine clinic, which does not currently have a POCUS credentialing process. (Note that the same principles could apply to other practice settings such as urgent care, hospitalist, or emergency medicine.)

Dr. Smith completed longitudinal training in AAA screening using POCUS during residency. She provides documentation of her completed studies, along with a faculty letter attesting to her competence.

Dr. Jones has been in practice for 20 years and completed an AAFP POCUS training course. He provides documentation that he has performed AAA ultrasounds, recorded his findings, and ordered standard imaging for confirmation.

Together, Dr. Smith and Dr. Jones draft a proposed credentialing pathway for their clinic that includes the following elements:

- Documentation of completed training,
- Documentation of quality-reviewed AAA studies completed during residency, reviewed by a credentialed colleague, or compared with standard imaging results,
- Semiannual quality review of at least three images per credentialed clinician.

Before approaching clinic leadership, they obtain EHR data comparing current AAA screening volume with the number of eligible patients in their practice. The analysis identifies a gap of approximately 60% of eligible patients, supporting the need for expanded access.

By speaking with the IT department, Dr. Jones and Dr. Smith identify vendors who are already contracting with the hospital, have software and cloud services compatible with the existing EHR, and will allow them to easily place orders and save images to their local archiving system.

They present their proposal and data to medical staff leadership. While leadership is initially skeptical, the two doctors are well-prepared with supporting data, and their proposal is placed on the agenda for the

next medical staff meeting. Following discussion, it passes with a 70% affirmative vote.

The organization forms a POCUS subcommittee, which includes the primary care team, to meet twice a year and oversee credentialing and quality review. They keep a log of testimonials and clinical cases in which POCUS significantly improved patient care —

Understand how POCUS may intersect with services other specialties provide.

for instance, catching an AAA that resulted in a successful emergent repair. They share the log with leadership to maintain buy-in for the POCUS program and share it with other clinicians to inspire them to adopt POCUS as well. The group also works with the billing and coding team to compare pre- and post-implementation procedural volume and RVU data to track increased revenue.

Over time, this evidence supports expanding the credentialing program to include additional POCUS applications beyond AAA imaging.

CREDENTIALING: WORTH THE EFFORT

Developing a local credentialing process for POCUS requires effort, preparation, and collaboration. When approached thoughtfully, however, it can expand patient access, strengthen clinical care, and support meaningful professional growth for practicing clinicians. Additionally, clinicians can adapt the credentialing framework outlined in this article to other emerging service lines they want to implement in their clinical settings. **FPM**

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