These documents are related to billing & privileging issues.

The key issues to get to billing are, from a CMS standpoint:
1) provider must be privileged at facility to perform and interpret POCUS
2) order must be in EMR with indication. In our experience it is specifically important to be specific in the indications included for the study. Anything suggestive of “screening,” “pre-op assessment” etc - I.e., not describing the clinical scenario and specific question of interest - will lead to billing denial.
3) images must be permanently saved and accessible
4) report of study interpretation in EMR
5) Billing code for the limited (not “complete”) study of interest.

Attached is an example of the institutional privileging language at one institution.

The two CMS documents are to help people understand the perspective from which payors (CMS or insurers using CMS regulations to guide their own requirements payment of services, in this case TTE) approach this issue. The documents discuss covered indications and those not covered, which will help folks craft their reporting templates so they accurately represent the clinical indications for which a given study is performed. The documents also touch on ‘limited' studies, which is almost always applicable to POCUS echo studies. So orders in the EMS and reporting templates need to reflect the “limited TTE.” They are boring and wordy documents but for those wanting to interact with the billing side of operations, this is what they use as references. I know many POCUS programs seem to essentially forgo this billing aspect of their program, but many hospitals administrators, when asked to shell out money for machines or time, always to hear we are trying to be responsible financial stewards.