

Submitted electronically to insurance@finance.senate.gov

October 2, 2026

Senator Ron Wyden
Ranking Member
U.S. Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Re: American College of Radiology (ACR) Response to Senate Finance Democrats
Request for Information (RFI), “Health Coverage that Works for Everyone”

Dear Ranking Member Wyden and Members of the Senate Committee on Finance:

On behalf of the American College of Radiology (ACR)—a professional association representing more than 40,000 physicians practicing diagnostic radiology, intervention radiology, radiation oncology, and nuclear medicine, as well as medical physicists, across the United States, we welcome the opportunity to respond to the RFI, “Health Coverage that Works for Everyone,” and appreciate its intent to improve health coverage, affordability, and access to care. Radiologists are primarily non-patient facing physicians who, on average, serve the most unique beneficiaries across 56 distinct physician specialties and provide care to more clinically complex Medicare patients than most physicians nationally. Imaging plays an increasingly critical role in patient care, transforms clinical questions into actionable insights, enables early and accurate diagnosis, guides treatment decisions, and improves outcomes. ACR’s comments address the Committee’s questions about private health plan prior authorization, administrative burden, and alternatives to broad utilization management for advanced diagnostic imaging.

Recommendation

Congress should explore alternatives to broad prior authorization for advanced diagnostic imaging, including physician-led clinical decision support based on independently developed Appropriate Use Criteria (AUC). Physician-developed AUC offers a more transparent, evidence-based, and patient-centered approach to promoting appropriate imaging than broad prior authorization programs administered by health plans. The Radiology Outpatient Ordering Transmission (ROOT) Act (S. 1692/ H.R. 5737) reflects these principles within Medicare’s imaging AUC program and would provide a practical framework for supporting appropriate imaging without delaying care or interfering with physician decision-making.

Private Plan Prior Authorization Can Delay Needed Imaging

The RFI appropriately identifies imaging as one of the services increasingly subject to prior authorization and recognizes that these requirements can delay care and increase administrative burdens for patients and physicians. Diagnostic imaging often determines

the next step in a patient's care. Delays in obtaining an appropriate test can delay diagnosis, treatment planning, and follow-up care. For many patients, advanced imaging is the gateway to definitive diagnosis and treatment. Delays can postpone the diagnosis of cancer and other serious conditions, potentially resulting in worse outcomes and higher downstream healthcare costs.

Health plans often describe prior authorization as a way to discourage inappropriate care, encourage adherence to evidence-based standards, protect patient safety, and control costs. ACR supports those goals. For advanced diagnostic imaging, however, they can be pursued more effectively by giving ordering professionals access to physician-developed clinical guidance when the imaging decision is made, rather than waiting for a health plan to review the order after it has been submitted.

Clinical Decision Support Offers an Alternative to Broad Prior Authorization

Point-of-order clinical decision support allows the ordering professional to consult evidence-based AUC prior to ordering an imaging test. This approach can help the clinician identify a more appropriate exam, avoid unnecessary or duplicative imaging, or confirm that the order is supported by the available clinical evidence. It addresses utilization before the order reaches the health plan and without requiring the patient and physician to wait for payer approval.

As the Committee evaluates alternatives to broad prior authorization, it should consider the role of qualified, independently developed AUC and point-of-order clinical decision support. These tools can support appropriate imaging decisions in real time, providing a less burdensome approach to utilization management than routine case-by-case review.

The ROOT Act Provides a Medicare Framework for Prior Authorization Alternatives

The ROOT Act would modernize Medicare's imaging AUC program. Congress established the program through the Protecting Access to Medicare Act (PAMA) of 2014 to address increasing volume of advanced diagnostic imaging in Medicare Part B and encourage evidence-based ordering through clinical decision support. Although the statute required CMS to implement the program by January 1, 2017, CMS faced significant challenges operationalizing the real-time claims processing component. As a result, the CY 2024 PFS Final Rule, CMS indefinitely paused the implementation. However, they did acknowledge the clinical value of AUC and the potential significant savings.

Although implementation of the original PAMA AUC program has presented challenges, successful implementation with targeted updates remains achievable. Several health systems have voluntarily adopted consultative AUC programs, demonstrating the feasibility of the approach. Multiple studies have shown that [increased clinician exposure to clinical decision support mechanisms improves imaging-ordering appropriateness](#) and that the AUC consultative process can adapt to [advances in technology, including artificial intelligence](#), when the program is already in place.

More than a decade after being passed into law, these implementation challenges have prevented patients and taxpayers from realizing the full benefits of the program. The ROOT Act would make the program workable by allowing ordering professionals to consult multispecialty, provider-developed AUC through qualified clinical decision support tools at the point of care. Clinicians would retain their judgment and would only need to document that they consulted the applicable criteria. This approach recognizes that clinical guidelines should support, rather than replace, individualized patient care decisions.

In the House, the ROOT Act has been incorporated into the Patients First Act of 2026, H.R. 9693, a broader Medicare payment reform package, introduced by the physician leaders of the House Republican and Democratic Doctors Caucuses.

ACR has long been a proponent of optimizing patient care to ensure patients get the right imaging at the right time- even if that means no imaging is needed. Enacting the ROOT Act is projected to save approximately \$2 billion for the Medicare program and most importantly, \$1.5 billion for Medicare beneficiaries over 10 years. These savings would result from reducing unnecessary testing and associated beneficiary cost sharing while promoting more efficient use of Medicare resources.

While the ROOT Act applies to Medicare, its framework is relevant to the Committee's consideration of alternatives to broad prior authorization. The legislation incorporates several concepts raised in the RFI, including independent clinical criteria, point-of-order decision support, retrospective analysis of ordering patterns, and targeted oversight. Implementing this framework would offer policymakers practical experience evaluating whether evidence-based clinical decision support can promote appropriate imaging, lower costs, and avoid the delays and administrative burdens associated with traditional prior authorization.

Reform Must Preserve Individualized Clinical Judgment

AUC should inform, not replace, individualized medical decision-making. Under the ROOT Act, ordering professionals would be required to consult the applicable criteria, but they would not be required to follow every recommendation. Physicians could account for a patient's clinical circumstances and depart from the guidance when medically appropriate.

This safeguard should guide any broader consideration of clinical decision support. AUC consultation should inform care, not become an automatic coverage standard or another basis for denying services. Any future framework should preserve physician judgment and avoid creating duplicative administrative requirements.

Data-Driven Oversight Should Focus on Demonstrated Outliers

The RFI asks whether broad prior authorization could be replaced with auditing frameworks, retrospective review, and targeted utilization management for providers whose ordering patterns indicate a potential concern. The ROOT Act reflects this more

focused approach. Consultation data could be reviewed to identify ordering trends, support education, and direct oversight toward demonstrated outliers rather than subjecting every patient and imaging order to the same approval process.

This targeted approach is responsive to the RFI's interest in alternatives to reviewing every service prospectively. Transparent data, objective standards, and education can focus oversight on demonstrated concerns while avoiding unnecessary administrative requirements for patients and clinicians.

Implementation Should Protect Rural and Small Practices

Administrative requirements can have a disproportionate effect on small and rural practices with limited staff and technology resources. The ROOT Act includes protections for small and rural practices, helping ensure that implementation of the Medicare AUC program does not further burden communities where patients may already have fewer options for care.

The Committee should apply the same principle when considering broader utilization-management reforms. Any new requirements should avoid disproportionate technology or reporting burdens that could discourage smaller practices from participating in plan networks.

Conclusion

ACR urges Congress to explore alternatives to broad prior authorization for advanced diagnostic imaging, including physician-led clinical decision support based on independently developed AUC. Enacting the ROOT Act would advance this approach within Medicare and respond directly to the RFI's interest in independent clinical criteria, retrospective review, and targeted oversight.

Applicable to Medicare, the ROOT Act provides a practical framework that could inform broader utilization-management reforms across both public and private coverage programs. However, its Medicare framework reflects many of the principles the Committee is examining and offers a concrete, evidence-based approach to promoting appropriate imaging without delaying care or interfering with physician decision-making. Physician-developed AUC and clinical decision support can assist appropriate utilization while avoiding many of the delays, administrative burdens, and patient frustrations associated with traditional prior authorization programs.