Nephrology Times

Practical News, Trends, and Analysis

May 2026

VOLUME 18, NUMBER 4

TIME TO TURN THE DIAL

We have the tools to transform CKD care–if we're ready.

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CONTENTS

MAY 2026
VOLUME 18, NUMBER 4

ON THE COVER

Time to Turn the Dial

After several years of consecutive breakthroughs in the understanding and treatment of chronic kidney disease (CKD), the nephrology community is asking itself: Can we cure it?

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Bridging the Gap in Rural Kidney Care

Social drivers of health and community-driven solutions for CKD

Debra Hain,
PhD, APRN, AGPCNP-BC, PMHNP-BC, CNN-NP

*By **Debra Hain, PhD, APRN, AGPCNP-BC, PMHNP-BC, CNN-NP***

Rural communities, defined as any population, housing, or territory not located within an urban area,[1] have a high prevalence of chronic kidney disease (CKD). Despite increasing awareness of health disparities, residents of rural areas continue to face numerous social barriers that limit access to high-quality kidney care.[2]

Health disparities are closely connected to social drivers of health, which act as "upstream" factors that influence healthcare access and chronic disease outcomes. Social drivers of health—also referred to as *social determinants of health*—include factors such as income, food security, education, and access to healthcare. The term *social drivers of health* is increasingly preferred because it emphasizes environmental and social conditions as active forces that can be modified, whereas *determinants* may imply fixed or less modifiable factors.

Several social drivers of health including limited access to nephrology care, housing instability, unreliable transportation, safety concerns, food insecurity, and financial hardship, significantly affect individuals with CKD. Because of a shortage of kidney specialists in rural areas, individuals may experience delayed diagnosis and treatment of CKD, which increases the risk of disease onset and accelerates disease progression. These delays can lead to higher rates of comorbidities, lower survival rates among patients receiving dialysis, and a reduced likelihood of being wait-listed for kidney transplantation.[3]

Challenges Related to Dialysis

Another major concern is the limited number of dialysis centers in rural regions, even as the incidence of end-stage kidney disease (ESKD) continues to rise in these communities. Patients may face additional barriers to receiving dialysis, including workforce shortages leading to closures of healthcare facilities, high transportation costs, and lack of adequate health insurance coverage.

Compounding these challenges is the difficulty dialysis facilities face in recruiting and retaining qualified staff. Although dialysis centers experienced growth prior to 2023, more centers began closing rather than opening after that time.[4] Several factors contributed to this shift, including later initiation of dialysis therapy, which reduced patient volume, and persistent workforce shortages.

These challenges are particularly concerning because stable relationships between dialysis staff and patients are essential for delivering high-quality care. When dialysis facilities close, patients must travel longer distances to receive treatment, creating additional burdens and potentially worsening health outcomes.[5] Home dialysis therapies, such as in-home hemodialysis and peritoneal dialysis, may provide alternative treatment options for patients in rural communities. However, adoption of these therapies remains limited due to infrastructure barriers, workforce limitations, and insufficient patient support systems.[3] Given these challenges, the kidney care community must work collaboratively to address the growing crisis of limited access to high-quality kidney care in rural populations.

Engaging With Community

One promising strategy is the co-creation of a kidney care model in partnership with community stakeholders. Co-creating a model of kidney care with community partners may be an effective way to ensure that interventions are culturally appropriate, accessible, and responsive to the unique needs of rural populations. Community engagement should begin with listening to residents and identifying nontraditional locations for outreach that promote kidney health awareness and prevention.

For example, I participate in a community-based interdisciplinary group composed of pastors, social workers, business leaders, health professionals, and nursing faculty from a local university. This group meets weekly to discuss the needs of the rural community and develop outreach initiatives. The success of this collaborative effort has been reflected in increased community awareness and health-seeking behaviors related to chronic conditions such as kidney disease, diabetes, hypertension, mental health disorders, and dementia. Through networking and ongoing assessment of community needs, the group has been able to implement initiatives that support improved health outcomes in the rural community.

Outreach events have been hosted in community settings such as libraries, churches, and golf courses. However, research suggests that other community locations—such as laundromats, barbershops, and fire stations—can also serve as effective venues for health outreach because they are trusted and frequently visited spaces within the community.[6] Partnerships like these allow healthcare professionals to think creatively and identify the most effective environments for community engagement.

Programs to Bridge the Care Gap

Developing a kidney care model that incorporates social drivers of health is critical for improving outcomes among individuals with CKD. Effective programs should prioritize awareness, prevention, early detection, and strategies to slow disease progression, while also ensuring that these services are supported through sustainable reimbursement structures. Telemedicine may also play an important role in expanding access to nephrology expertise for patients living in rural areas. In addition, collaboration with primary care professionals—who deliver most healthcare services in rural communities—has demonstrated promising results.

One example is the Kidney Coordinated HeAlth Management Partnership (K-CHAMP), an electronic health record–based population health management approach designed to improve CKD care within primary care settings.[7] This program uses electronic health record data to identify high-risk patients who are not currently receiving nephrology care. Identified patients are offered consultations with nephrologists and receive kidney disease education from nurses, while primary care professionals receive additional pharmacy support. The program has been successful in strengthening collaboration between primary care and nephrology professionals and promoting proactive care for patients with CKD. Notably, this approach has demonstrated potential for slowing CKD progression by improving early intervention and care coordination.

Programs such as K-CHAMP highlight the importance of integrating population health strategies, interdisciplinary collaboration, and technology to improve CKD outcomes in rural communities. Expanding similar initiatives could increase the implementation of preventive strategies, improve timely referrals to nephrology specialists, and ultimately reduce the risk of progression to ESKD and the need for dialysis. Bridging the gap in rural kidney care through community-driven solutions creates a pathway for addressing social drivers of health among individuals with or at risk for CKD.

Debra Hain is a professor at the Christine E. Lynn College of Nursing at Florida Atlantic University, a psychiatric mental health nurse practitioner for ActivateCr, and a member of the American Nephrology Nurses Association Board of Directors. ●

REFERENCES

1. USDA. National Agricultural Library. Accessed April 13, 2026. https://www.nal.usda.gov/rural-development-communities/what-is-rural
2. Crouch E, et al. *Am J Nephrol.* 2024;55(3):361-368. doi:10.1159/000537763
3. Koppula S, et al. *Am J Kidney Dis.* 2025;86(4):543-549. doi:10.1053/j.ajkd.2025.03.017
4. Kalantar-Zadeh K, et al. *Clin J Am Soc Nephrol.* 2024;19(6):778-781. doi:10.2215/CJN.0000000000000421
5. Niu J, et al. *Clin J Am Soc Nephrol.* 2023;18(12):1610-1612. doi:10.2215/CJN.0000000000000274
6. Hole MK, et a. *Mayo Clin Proc.* 2023;98(12):1833-1841. doi:10.1016/j.mayocp.2023.07.031
7. Weltman MR, et al. *J Am Soc Nephrol.* 2025;36(5):869-881. doi:10.1681/ASN.0000000544

New Milestone in Targeted FSGS Therapy

By ***Charlotte Robinson***

Howard Trachtman, MD

Howard Trachtman, MD, of the University of Michigan was an investigator on two notable trials of targeted treatments for focal segmental glomerulosclerosis (FSGS). In 2023, DUPLEX showed that sparsentan—a dual endothelin–angiotensin receptor antagonist—produced meaningful and sustained reductions in proteinuria among patients with FSGS.[1] More recently, a phase 2 trial of BI 764198, an oral selective TRPC6 inhibitor, showed that a 20-mg dose reduced proteinuria by 44% in just 12 weeks, marking the first clinical evidence that modulating TRPC6 activity can improve a key indicator of kidney damage.[2] Dr. Trachtman discussed these emerging therapies and how they might shape the future treatment landscape for FSGS.

This transcript has been edited for length and clarity.

The BI 764198 study is the first to show that a podocyte-targeted therapy can reduce proteinuria. Why is that such a meaningful milestone?

As we currently think of FSGS as a podocytopathy, a disease of the podocyte, it's the multiple ways that the podocyte can be injured and not function right that we think leads to the occurrence and the development and progression of FSGS. The TRPC6 channel has been implicated in the pathogenesis of FSGS based on the occurrence of patients who have activating genetic variants. And therefore, this implicates overactivity of this [channel], and that provided the rationale for developing a drug that could block that channel. So, what's exciting is that this is the first—I use the word advisedly—logical and thoughtful attempt to approach the therapy of FSGS in a process that reflects it as a distinct disease entity.

How do the sparsentan and BI 764198 trials complement each other?

In many ways, as I think of these two drugs—though they're different, though their development was different—what's promising about the findings in DUPLEX and the phase 2 [BI 764198 trial] are that, regardless of where they start, these pathways may be shared across the spectrum of FSGS.

I am hopeful that there will be broad utility of both these drugs in the treatment of FSGS, potentially selectively in patients in whom there's predominant activity of one of the pathways involved that's blocked by each drug, or potentially in combination, in a thoughtful way that matches the administration of the drug to what's happening actually within the podocyte, within the patients themselves.

How close are we to being able to offer personalized FSGS treatment based on a patient's underlying biology or genetics?

I think work is being done across the world, and part of the effort at NEPTUNE (Nephrotic Syndrome Study Network), University of Michigan, in which people are mining the biopsy data, looking at the sophisticated omics, transcriptomics, the genomic profiling, metabolomic profiling, and defining, using noninvasive sampling—urine, blood, the genome—to characterize patients with FSGS more discretely, not based on how it looks under the microscope per se, but rather by what is biologically perturbed in the kidney. Characterizing them noninvasively and using that as a way of selecting, in a precision medicine manner, picking the right medicine for the right patient at the right time. We're getting there. We're not there yet, and we're at the preliminary stages of this effort, but I think it's promising. ●

REFERENCES

1. Rheault MN, et al. *N Engl J Med.* 2023;389(26):2436-2445. doi:10.1056/NEJMoa2308550
2. Trachtman H, et al. *Lancet.* 2026;407(10528):587-598. doi:10.1016/S0140-6736(25)02255-X

Scan to watch the full interview.

Making the Case for Case Reports

*By **Charlotte Robinson***

Swapnil Hiremath, MD, MPH

The International Society of Nephrology recently launched a new open-access journal, *Kidney International Case Reports,* dedicated to case reports, focused reviews, and short clinical communications. We spoke with the new journal's editor in chief, **Swapnil Hiremath, MD, MPH,** of the University of Ottawa, Canada, about the enduring importance of case reports in nephrology, a format that has often been overlooked in contemporary medical publishing.

This transcript has been edited for length and clarity.

What gap in nephrology education or publishing are you hoping to address with the launch of a journal focused on case reports?

Case reports are often useful for diagnosis, for different presentations, and sometimes for weird presentations and different ways of managing and dealing with those things. There are many reasons why case reports are important. But the problem has been that it has become harder and harder for people to publish case reports, possibly because they are thought to be lower in impact and lower in importance.

Why do you think case reports receive limited attention and publication despite their value?

Partly it is because ... there are these evidence-based pyramids, which we should not have any more. ... Any good study with a good study design is a good one, whether it's an observational study, whether it's a case series, whether it's a meta-analysis or a trial. We don't need to have a top-down hierarchy, the Cochrane top-down hierarchy pyramid EBM [evidence-based medicine] that people talked about.

Mostly, the currency for journal publications is citations. I would argue it's a false currency because things get cited for many different reasons. It's more about how many people read it, how many people find it useful, and that is harder to measure.

What kinds of clinical insights can a case report offer that a trial cannot?

Sometimes you will have an initial presentation of a new disease. ... I may see a patient with a common disease but having an uncommon presentation. ... There are often diagnostic dilemmas. It's even hard to make a diagnosis because the presentation is so different. The thought process of how you do the investigations, how do you work through the differential diagnosis, how do you make that diagnosis is very useful.

How do case reports function for trainees and early-career clinicians versus senior nephrologists?

Especially for trainees and for early-career researchers, often, the case report might be their first publication. That may be their entry into the publication world. It is hard as a trainee to do a randomized control trial or a large observational study, but you may see a patient which and a situation which you think you learned something from and which others could learn from. We would clearly want something like that to be widely disseminated. ●

Kidney International Case Reports *seeks submissions from authors worldwide, particularly trainees and early-career faculty members. Publication fees for all authors will be waived through December 31, 2026, and a 50% discount will apply in 2027. The journal's full aims and scope are available on its website: https://www.sciencedirect.com/journal/kidney-international-case-reports.*

Want more insights? Scan to watch the full interview.

Cardiorenal Benefits of SGLT2 Inhibitors Among Kidney Transplant Recipients

By ***Victoria Socha***

The optimal treatment for kidney failure is kidney transplantation, resulting in improved survival and quality of life for patients and lower costs for healthcare systems. While short-term outcomes after transplantation have continuously improved, the long-term graft survival rate has plateaued, and more than 50% of transplant recipients experience graft loss within 10 years.

Studies in nontransplant populations have demonstrated associations between sodium-glucose cotransporter-2 (SGLT2) inhibitors and significant cardiovascular and kidney benefits. Effective cardiovascular-kidney-metabolic protection may improve graft survival rates for kidney transplant recipients (KTRs).

Vikas S. Sridhar, MD, and colleagues conducted a randomized, double-blind, parallel-group, placebo-controlled study designed to examine the mechanistic effects and safety of SGLT2 inhibitors among KRTs.

The primary outcome of interest was a comparison of the effects of 12 weeks of dapagliflozin 10 mg versus placebo on systolic BP (SBP). Secondary outcomes included assessment of the mechanisms associated with cardio-kidney-metabolic protection and safety.

Of the 52 KTRs who were randomly assigned 1:1 to dapagliflozin (n=26) or placebo (n=26), 51 completed all assessments. Their mean age was 53 years, 79% were male, mean BMI was 37.8 kg/m^2, and time since transplantation was 7.9 years. Sixty-two percent had hypertension, 57% had type 2 diabetes, 50% were receiving renin-angiotensin-aldosterone system inhibitors, and the mean estimated glomerular filtration rate was 68.2 mL/min/1.73 m^2.

Dapagliflozin decreased sitting SBP at 1 and 12 weeks; however, the decrease was not statistically different from placebo. While dapagliflozin reduced mean arterial pressure after 1 week, it did not lower SBP versus placebo at week 12.

The researchers observed significant, placebo-adjusted reductions in iohexol-measured GFR (iohexol-mGFR) from baseline to week 1 (4.19 mL/min/1.73 m^2; 95% CI, –7.14 to –1.24). The reduction in iohexol-mGFR remained significant after 12 weeks (–3.49 mL/min/1.73 m^2; 95% CI, –6.33 to –0.64). No significant, placebo-adjusted changes in proteinuria occurred. There was a significant increase in total glucose excretion with dapagliflozin versus placebo after week 1, sustained at week 12.

Acute decreases in arterial stiffness occurred in the dapagliflozin group; however, the decreases were not significant compared with the placebo group. Significant increases in glucosuria occurred in the dapagliflozin group without altering proximal sodium handling or evidence of sympathetic activation.

Dapagliflozin was generally safe and well tolerated.

The researchers cited some limitations to the study findings, including the lack of kidney blood flow assessment, the inability to use gold standard measures of sympathetic activity, limiting the cohort to patients who underwent a transplant at least 6 months earlier, and the higher percentage of males versus females in the study population.

In summary, the authors wrote, "Dapagliflozin was safe and well tolerated in KTR, although observed mechanistic differences may suggest potential heterogeneity in therapeutic response between KTR and other patient populations in which [SGLT2 inhibitors] have demonstrated cardio-kidney-metabolic benefits. Dedicated outcome trials evaluating composite cardiorenal outcomes in KTR are warranted to determine whether these agents confer similar clinical benefits in the transplant setting." ●

REFERENCE

Sridhar VS, et al. *Clin J Am Soc Nephrol.* 2026;21(4):664-679. doi:10.2215/CJN.0000000951

What nephrology invention are you most hoping will exist in 10 years?

This month's question was addressed to current nephrology fellows.

"We have made great progress in treating glomerular diseases but lag in noninvasive diagnostics. Building on the success of PLA2R [phospholipase A2 receptor] in membranous nephropathy, I hope for a molecular panel with antibodies such as anti-nephrin and anti-CRB2 [crumbs homolog 2] to identify the accurate culprits in podocytopathies without relying on histology alone. Similarly, I envision urine proteomics replacing lupus nephritis rebiopsies; markers like urinary tenascin-C would allow real-time monitoring of histological activity for agile treatment adjustments. Finally, for ANCA [anti-neutrophil cytoplasm antibody] vasculitis, I hope we discover markers such as urinary CD163 to evaluate relapse, as serial ANCA measurements remain unreliable."

Srinath Yadlapalli, MD
Indiana University School of Medicine
X: @IUNEPHRO

"In the next 10 years, I hope we move toward molecularly defined CKD [chronic kidney disease] through biomarker panels interpreted with AI [artificial intelligence] assistance. Current classification often relies on clinical labels that incompletely capture underlying biology and prognosis. An integrated and easily accessible 'liquid biopsy' combining blood and urine markers, genetics, and longitudinal clinical data could help identify disease pathways, refine etiology, and estimate progression risk at an individual level. If validated across diverse CKD populations, such tools may enable more precise therapy selection and earlier targeting of disease-modifying treatments with feasible implementation."

Komal Safdar, MD
Duke University
X: @KOMAL_SAFDAR

"Mathieu Jaboulay performed the first pig-to-human organ transplantation in 1906. Progress has lagged for many decades, but recently we have seen significant breakthroughs with genetic engineering and immunologic innovations. Using CRISPR [clustered regularly interspaced short palindromic repeats]-modified pigs, scientists have reduced hyperacute rejection by deleting key swine carbohydrate antigen, adding human complement-regulatory proteins and inactivation of porcine endogenous retroviruses. Between 2022 and 2024, experimental pig kidney transplants into humans demonstrated short-term survival, marking historic milestones. As a future transplant nephrologist, I am most excited to be training right as we pick up the torch that was lit 120 years ago!"

Adedamola O. Akinsiku, MD, MBBS
Medical College of Wisconsin

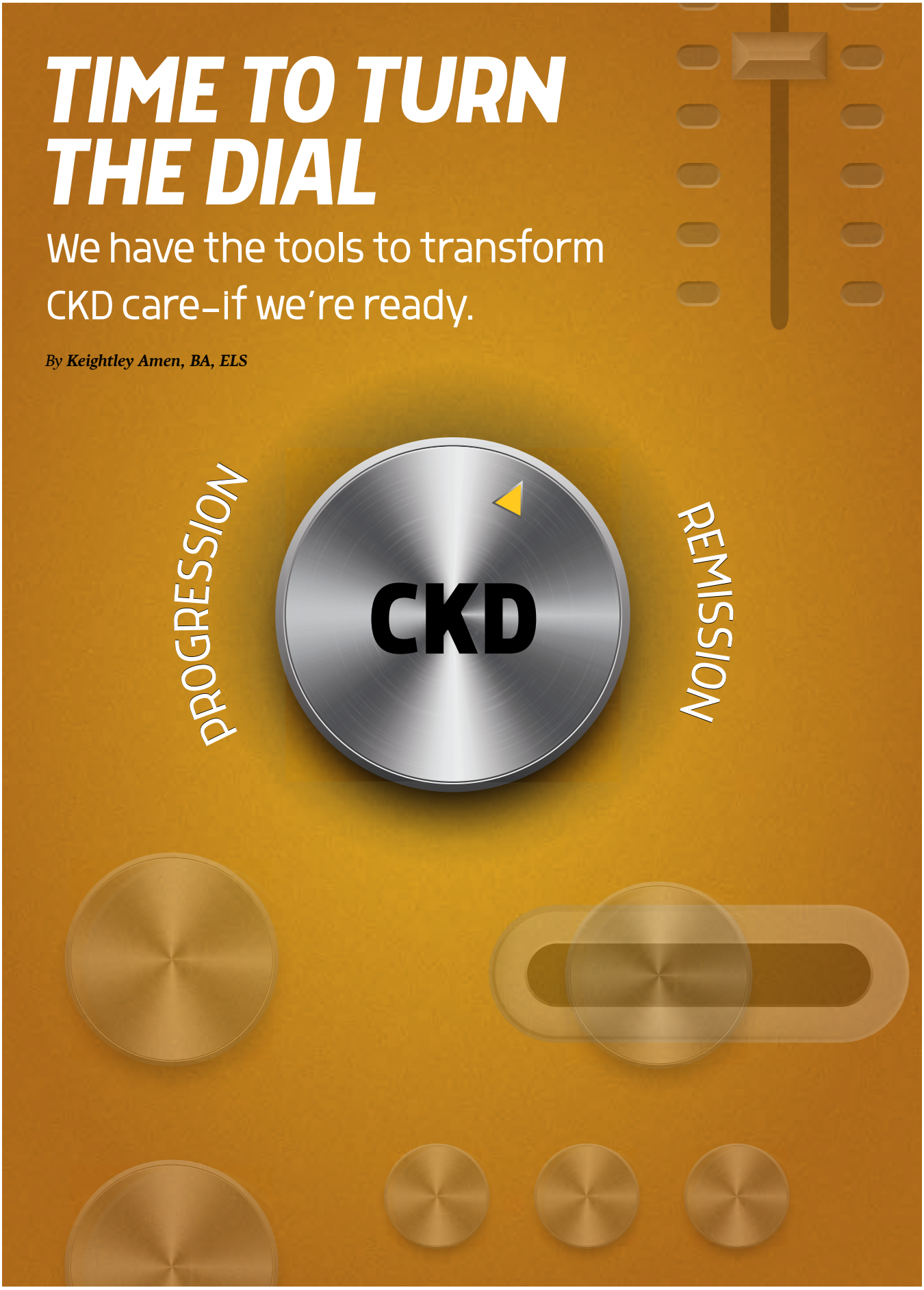
"I am excited about xenotransplant. It would help solve the problem of organ shortage and patients having to resign themselves to a life of dialysis or death. If established, it will not just help our patients with kidney failure but also open up a new frontier for research and innovation in genetics and immunology. Although it seems farfetched, a world without the need for dialysis units may be possible. I do worry about the ethical implications, and I hope there will be a way to benefit humans without causing animal suffering." ●

Nigar Rumane, MBBS
University of Wisconsin-Madison

TIME TO TURN THE DIAL

We have the tools to transform CKD care–if we're ready.

By ***Keightley Amen, BA, ELS***



After several years of consecutive breakthroughs in the understanding and treatment of chronic kidney disease (CKD), the nephrology community is asking itself: Can we cure CKD? Many experts argue that the answer is yes.

But the first step is to focus on the very realistic goal of remission. They want nephrology professionals, other specialists, primary care providers, and the public to understand that it is now a practical therapeutic goal to achieve CKD remission. The aim should not be mere damage control and slower progression, as in the past. Rather, preservation or restoration of organ function must become the new normal.[1]

This was a hot topic at the American Society of Nephrology Kidney Week in fall 2025. **Vlado Perkovic, MBBS, PhD,** professor and provost at the University of New South Wales in Sydney, Australia, opened the conference with a presentation outlining this new paradigm.

"We have the treatments available, for the first time in history, that can dramatically change the trajectory. We can get most people to a scenario where they lose a roughly similar amount of kidney function each year as someone who's perfectly healthy. We have the tools available to do that for a large number of people, perhaps even the majority with diabetes and IgA nephropathy, for example, two of our most common kidney diseases," he told *Nephrology Times.* "That was unthinkable 5 years ago."

Navdeep Tangri, MD, PhD, professor in the Max Rady College of Medicine at the University of Manitoba in Canada, acknowledges that this major change in mindset and practice can be rather daunting. But he implores the medical community to confront any hesitation they may have, overcome clinical inertia, and address barriers to achieving remission in large numbers of patients.

"We can get most people to a scenario where they lose a roughly similar amount of kidney function each year as someone who's perfectly healthy."

Remission Versus Cure

In a recent editorial in *Kidney International,* Drs. Tangri, Perkovic, and colleagues highlighted the importance of differentiating between remission and cure.[2] They defined remission as estimated glomerular filtration rate (eGFR) slopes of less than 1 mL/min/1.73 m^2 per year or the absence of albuminuria with a normal eGFR.

"To me, remission is a condition that's no longer evident but will come back if the treatments are stopped; cure is something that is treated and will not return," Dr. Perkovic said. "In the context of kidney disease at the moment, we're primarily talking about remission. We're talking about getting people onto treatments that effectively make the condition and its consequences go away, returning them to the health broadly of someone without that condition."

Although curing CKD is not currently a realistic goal, many believe it is possible in the future. "Cure in kidney disease is a little more challenging, but there are some sparks of light on the horizon with the possibility of gene editing to make permanent some of the effects that these drugs are causing, as we learn more about some of these conditions," Dr. Perkovic said.

Why Remission Has Become a Realistic and Practical Therapeutic Goal

In the past 5 to 10 years, drastic changes have occurred in CKD treatment options and efficacy.

"Nephrology today is an entirely different specialty to what it was 10 years ago," Dr. Perkovic said.

"Up until 2019, we only had a single treatment for people with diabetic kidney disease: RAS [renin–angiotensin system] inhibitors. We didn't have any specific treatments at all for people with IgA nephropathy or many other kidney diseases. So, we have gone from an environment where we could only offer our patients supportive care to one now where we have almost an embarrassment of riches with regards to treatments that have been clearly proven to be highly effective at protecting kidney function in a number of kidney diseases."

Examples of new treatments that have shown clear improvements in cardiovascular and kidney outcomes across multiple landmark trials include [3]:

- Glucagon-like peptide 1 (GLP-1) receptor agonists
- Nonsteroidal mineralocorticoid receptor antagonists
- Sodium-glucose cotransporter 2 (SGLT2) inhibitors
- Targeted immunotherapies for IgA nephropathy

Barriers to Changing the Paradigm

Despite clear evidence about the safety and efficacy of those new treatments, patients with CKD receive them far less often than they should, Drs. Perkovic and Tangri argued. The onus is on the nephrology community to overcome associated challenges to deliver these therapies to more patients.

Clinical Inertia

Dr. Tangri described clinical inertia that affects medicine overall and the specialty of nephrology.

"In medicine, clinical inertia often comes from a failure to see primary prevention as something achievable. We are very good at secondary prevention in medicine. When someone already has had a heart attack, a stroke, heart failure, or kidney disease, physicians recognize that and want to treat that patient with multiple therapies," he told *Nephrology Times.* "Where we have a harder time is the patient who looks OK in front of you and all the labs are just a little bit off. That constellation of things is pointing to a very high risk of an event happening. But because the event hasn't happened, everyone becomes complacent."

"The truth is that in medicine, we're just very bad at this. Multiple studies show that even treatments that have been around for decades, like renin-angiotensin system blockade, are only used in perhaps two-thirds of people who might benefit from them, and perhaps even less in areas that aren't as well-resourced or informed," Dr. Perkovic said.

"Similarly, SGLT2 inhibitors were demonstrated to be effective in diabetic kidney disease in 2019 and shortly thereafter in other kidney diseases. But in the United States, fewer than a quarter of the people who should be getting them get them today. So, the majority of people are missing out on the very substantial benefits, not just for kidney function, but also for cardiovascular disease and prolongation of life that these treatments have been shown to produce. For GLP-1 receptor agonists and mineralocorticoid receptor antagonists, which have also been shown to be effective, it's even worse. It's more like 10% of people are receiving them."

He encourages nephrologists to consider the relatively new field of implementation science, to borrow strategies from other specialties that have had success implementing guideline-directed medical therapies (cardiovascular disease and vaccination) and conduct studies to discover and test strategies that work to implement new treatments.

"[I]n the United States, fewer than a quarter of the people who should be getting [SGLT2 inhibitors] get them today."

Fear of Adverse Outcomes

The lack of implementation may also be related to fear of side effects or adverse outcomes, such as hyperkalemia, hypotension, and worsening eGFR, despite the presence of robust efficacy data showing that these outcomes are not common.

Dr. Tangri encourages healthcare providers to rely on "the mountain of evidence" demonstrating the safety and efficacy of these treatments, rather than anecdotal experiences of a few patients they saw in practice who experienced side effects.

In addition, the medical community may be able to overcome these concerns with risk stratification, frequent lab checks, and titration protocols (such as temporary hold thresholds).[2]

Affordability and Cost-Effectiveness

Cost has been a barrier with some of the new treatments, particularly in IgA nephropathy. But as time goes on, the treatments are becoming more affordable, and many are covered by insurance. Dr. Tangri emphasized that cost-effectiveness should be the most important driver.

"In chronic disease, the treatments pay dividends over years," he said. "If we were to invest in increasing uptake of these agents, ultimately the overall costs of the community and to the insurers would be reduced" over the course of kidney disease, which poses a large economic burden.

This has been proven by several studies involving SGLT2 inhibitors, and work is starting on examining the long-term cost-effectiveness of other treatments.

CKD Awareness

About 90% of people with CKD don't know they have it, even when it has been demonstrated through blood or urine tests or both.[4]

"We need to make sure that people who have kidney disease know that, so they can seek out appropriate protective therapies. In the past, making a diagnosis was arguably less important because there wasn't much you could do about it. That's not true today. We now have the treatments available that can make a difference," Dr. Perkovic said.

He and Dr. Tangri advocate for public education campaigns, stronger visibility of kidney disease in the community, and screening programs, particularly in high-risk populations. They also encourage nephrologists to work with primary care practices so that kidney disease is identified earlier.

However, Dr. Tangri noted that screening alone is not enough. "You have to connect screening to treatment. We have to screen, risk stratify, and then treat accordingly. We need to have processes that control it end-to-end."

One concern with increased screening is that it will ultimately identify many more patients with CKD, who will then seek specialist care, straining the system and limiting access.

"If we had suddenly 10 times the number of people seeking nephrologists, clearly, the nephrology community wouldn't be able to cope with that workload," Dr. Perkovic said. To handle substantially more patients, the field will have to rely on task sharing with allied health professionals and physician extenders, such as nurse practitioners. "I think we also have to trust our patients a little bit and give them a little more responsibility as part of this process."

Patient Education

Dr. Tangri agreed that patients can take greater responsibility for their own health and their own care, but in an informed fashion. He likens these conversations to those about blood pressure and cholesterol: "The patient can ask the question: What's my target?"

"Kidney failure is comparable to cancer in terms of prognosis," Dr. Perkovic said. "People who are at risk of cancer are generally very proactive in getting that risk mitigated. We need to move toward the same sort of approach in nephrology, where we activate, inform, and educate our patient population so that they can go out and seek and have agency themselves to understand what treatments might be beneficial for them and make their own decisions about what they'd like to take."

Because now they have options.

"We all need to talk more about the long-term benefit of achieving remission. It's a very hopeful message. It's one that patients and physicians can rally around," Dr. Tangri said. "And that obviously goes beyond just kidney disease because you also have a lower downstream risk of heart disease, heart failure, and other related events. We need to capture the totality of benefits." ●

REFERENCES

1. Medina E, et al. NephJC. Accessed April 13, 2026. https://www.nephjc.com/news/2025/1/3/top-stories-in-nephrology-2025
2. Tangri N, et al. *Kidney Int*. 2026;109(1):17-21. doi:10.1016/j.kint.2025.10.004
3. Jayachandran A. NephJC. Accessed April 13, 2026. https://www.nephjc.com/news/2025/1/3/top-stories-in-nephrology-2025
4. National Institute of Diabetes and Digestive and Kidney Diseases. Accessed April 1, 2026. https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease

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Nephrology Times

FDA Grants Premarket Clearance to Updated Tablo Hemodialysis Platform

The FDA granted 510(k) clearance to Outset Medical's next-generation Tablo hemodialysis platform, featuring upgrades to the hardware, software, operating system, and exterior. The new platform also incorporates the FDA's most recent guidance regarding medical device cybersecurity, making Tablo the first hemodialysis system to meet those standards.

Outset plans to begin distributing the upgraded version of Tablo during the second quarter of 2026. Current users can upgrade to the new cybersecurity platform.

This progress represents a significant turnaround after recent FDA hurdles, including a 2023 warning letter over Tablo's promotional materials and the need for separate 510(k) clearance for its TabloCart with Prefiltration accessory. With labeling updates completed and the clearance process underway, the company appears to be moving past these regulatory setbacks.

SOURCE: MASSDEVICE

FDA Issues Alert About Liver Injuries Linked to Avacopan

The FDA issued an alert about serious liver injuries in patients receiving avacopan for severe active anti–neutrophil cytoplasmic autoantibody (ANCA)–associated vasculitis. In a statement on its website, the agency said the drug has been linked to cases of drug-induced liver injury (DILI), some involving vanishing bile duct syndrome (VBDS) and some fatal.

"Although hepatotoxicity is a serious adverse reaction for [avacopan] identified in premarket clinical trials and described in product labeling, VBDS and DILI cases with fatal outcomes represent new safety concerns," the alert said.

The agency instructed healthcare professionals to conduct liver panel testing every 2 weeks in the first month of treatment, monthly for the next 5 months, and then as clinically indicated and to discontinue the drug if alanine aminotransferase or aspartate aminotransferase is more than three times the upper limit of normal (ULN), if alkaline phosphatase is more than twice the ULN, or if a patient demonstrates evidence of symptomatic cholestasis, such as jaundice or pruritus.

In January, the FDA requested that Amgen withdraw the drug, but the pharmaceutical company declined. "In 2024, Amgen proactively submitted a proposed update to the FDA to add VBDS to the [avacopan] label, a request that is still pending, and we continue to monitor safety through post-marketing and observational studies," an Amgen spokesperson said.

SOURCES: AMGEN, FDA

Phase 2 CRAC Channel Inhibitor Study for AKI Discontinued

A phase 2 study of a calcium release–activated calcium (CRAC) channel inhibitor for acute kidney injury (AKI) has shut down due to a safety concern, according to the agent's developer, CalciMedica.

The KOURAGE trial was evaluating the agent as a treatment for patients with stage 2 or 3 AKI with associated acute hypoxemic respiratory failure. This patient population experiences high mortality and lacks approved therapies.

The trial's Independent Data Monitoring Committee raised the concern during a prescheduled interim data review. CalciMedica did not disclose details but stated that no deaths or serious adverse events requiring expedited reporting to the FDA occurred.

The company said in a press release that it would review the unblinded study data and consider trial design modifications, specifically patient enrollment criteria, that may support additional clinical testing among patients with AKI.

SOURCE: CALCIMEDICA

Obinutuzumab Meets Study End Point of Membranous Nephropathy Remission

The phase 3 MAJESTY study, which evaluated obinutuzumab for the treatment of primary membranous nephropathy, met its primary end point of complete remission at 2 years.

Obinutuzumab, a humanized type II anti-CD20 monoclonal antibody, is approved in the US and European Union to treat adults with active lupus nephritis. Currently, there are no approved treatments for membranous nephropathy, and up to 30% of patients with the disease progress to kidney failure within 10 years.

MAJESTY was a randomized, open-label, multicenter study enrolling 142 people who were randomly assigned 1:1 to receive obinutuzumab or tacrolimus. Study data will be presented at an upcoming medical meeting and shared with the FDA and the European Medicines Agency. ●

SOURCE: ROCHE

ACUTE KIDNEY INJURY

Preventive Care Strategy Reduces Occurrence of AKI After Major Surgery

Lancet. 2025;406(10521):2782-2791. doi:10.1016/S0140-6736(25)01717-9

Patients undergoing major surgery commonly experience acute kidney injury (AKI); however, according to researchers led by **Alexander Zarbock, MD, PhD,** "recommended preventive care is rarely administered."

The researchers reported results of the BigpAK-2 trial conducted in 34 hospitals in Europe (NCT04647396). The randomized study examined the use of urinary biomarkers to identify patients at high risk for AKI and developed a preventive care strategy to minimize the risk for AKI during the 72 hours after major surgery.

Adult patients at high risk for AKI were randomized to usual care (control) or to a preventive care strategy (intervention) based on recommendations from the Kidney Disease: Improving Global Outcomes guidelines. The primary outcome of interest, the occurrence of moderate or severe AKI within 72 hours after surgery, was assessed in the intention-to-treat population. Comparison of rates of adverse events between the two groups was used to assess safety.

The total study cohort included 1,180 patients. Of those, 589 were randomized to the intervention group, and 591 to the control group. Of the patients with available data for the primary end-point analysis (n=1,176), 14.4% (n=84) in the intervention group experienced moderate or severe AKI, compared with 22.3% (n=131) in the control group (odds ratio, 0.57; 95% CI, 0.40-0.79; *P*=0.002; number needed to treat, 12).

The two groups were similar in adverse events. The most common adverse events were atrial fibrillation, hemodynamically relevant arrhythmias, significant bleeding, and unplanned return to the operating room.

In summary, the authors wrote, "Among adults at high risk for AKI undergoing major surgery, a preventive care strategy consisting of supportive measures and avoidance of nephrotoxins significantly reduced the occurrence of moderate or severe AKI without increasing adverse events."

CHRONIC KIDNEY DISEASE

Combination of Loop Diuretics and RAS Inhibitor May Improve Kidney Function in CKD

Kidney360. doi:10.34067/KID.0000001080

Loop diuretics are used to manage the hypertension and congestion often caused by chronic kidney disease (CKD), but they also activate the renin-angiotensin system (RAS), leading to potential cardiovascular and kidney damage. Renin-angiotensin system inhibitors may help protect against this damage.

In a post hoc analysis, **Sunil Bhandari, MBChB, MRCP, PhD, MClinEd,** and colleagues investigated the interaction between RAS inhibitors and loop diuretics among patients with advanced CKD. The study used data from the STOP-ACEi (angiotensin-converting enzyme inhibitor) trial, in which patients with an estimated glomerular filtration rate (eGFR) below 30 mL/min/1.73 m^2 and progressive CKD were randomly assigned to either stop or continue treatment with a RAS inhibitor.

The researchers compared outcomes between the 133 patients who were being treated with loop diuretics and 278 who were not. At baseline, eGFR, arterial pressure, and proteinuria were similar between these two groups. However, the researchers identified differences in kidney function at 3 years in relation to whether patients stopped or continued treatment with a RAS inhibitor.

Among patients being treated with loop diuretics, researchers observed a trend toward better kidney function in those who stopped taking a RAS inhibitor, with a least-squares mean eGFR (± standard error) of 12.3 mL/min/1.73 m^2 (±1.1) at 3 years in this group compared with 10.1 mL/min/1.73 m^2 (±1.2) for those continuing treatment with a RAS inhibitor. However, the eGFR slope over this period was similar regardless of RAS inhibitor discontinuation (–7.2 vs –7.7 mL/min/1.73 m^2). Among participants not receiving loop diuretics, the researchers observed worse outcomes for those who stopped treatment with a RAS inhibitor, with eGFR of 8.8 mL/min/1.73 m^2 (±0.8) compared with 11.6 mL/min/1.73 m^2 (±0.8) among those who continued the treatment. They also noted a steeper eGFR slope among those who discontinued treatment with a RAS inhibitor (–9.9 vs –7.6 mL/min/1.73 m^2).

In addition, those taking loop diuretics had poorer outcomes in terms of mortality, with 55% developing end-stage kidney disease (ESKD) or initiating kidney replacement therapy (KRT) and 17% dying, whereas 61% of those not taking loop diuretics developed ESKD or initiated KRT, and only 7% died.

In summary, the interaction between treatment with a loop diuretic and the effect of a RAS inhibitor on eGFR was statistically significant at 3 years (*P*=0.01). These findings indicate that treatment with a RAS inhibitor leads to different outcomes depending on whether a patient is receiving loop diuretics, with evidence showing that treatment with loop diuretics and a RAS inhibitor in combination can improve patient outcomes but also that loop diuretics may have adverse effects on mortality. The researchers conclude that further research is needed to investigate the efficacy and safety of loop diuretic therapy among patients with advanced CKD.

Competing Mortality Risk Improves Risk Prediction in Patients With CKD and Multimorbidity

Nephrol Dial Transplant. 2025:gfaf252. doi:10.1093/ndt/gfaf252

Clinical guidelines for CKD recommend using risk prediction models, such as the four-variable Kidney Failure Risk Equation (KFRE), to determine patients' risk for kidney failure. However, validation of these models is lacking for patients with multimorbidity, defined as two or more long-term conditions in addition to CKD, which is common among patients with CKD and may increase their risk for kidney failure and death.

In an observational cohort study, **Heather Walker, MBChB,** and colleagues validated the KFRE in patients with CKD and

compared it with an updated model that uses the same variables but also accounts for competing mortality risks.

The study authors used data from 14,998 of 24,489 individuals in the research-based cohort UK Biobank and 30,147 of 42,902 individuals in the population-based cohort Stockholm Creatinine Measurements (SCREAM) project. In the UK Biobank cohort, 61.2% of patients experienced multimorbidity, compared with 70.3% of the SCREAM cohort.

After conducting a KFRE performance assessment, the researchers determined that discrimination of KFRE was good (area under curve ≥0.86 across eGFR equations in all cohorts, multimorbidity groups, and time horizons). However, calibration was suboptimal for patients with CKD and multimorbidity. The updated model, meanwhile, showed improved calibration performance compared with the KFRE, with an observed-to-expected ratio of 0.98 in the multimorbidity groups at 5 years.

The authors also compared the KFRE's performance using both creatinine and cystatin C, finding that use of cystatin C did not improve the model's performance when compared with use of creatinine.

These findings indicate that competing mortality risk is an important factor in predicting the risk for kidney failure in patients with CKD and multimorbidity, meaning that using a model that accounts for this could improve model performance.

CKD Among Risk Factors for Complications of West Nile Virus

JAMA Netw Open. 2025;8(12):e2548229. doi:10.1001/jamanetworkopen.2025.48229

West Nile virus, the leading mosquito-borne infection in the United States, can contribute to severe complications such as West Nile fever and West Nile neuroinvasive disease (WNND). However, the factors that lead to a greater risk for these outcomes remain unclear, making it difficult to target interventions for patients infected with the virus.

In a retrospective cohort study published in *JAMA Network Open*, **Seth D. Judson, MD,** and **David Dowdy, MD, PhD,** used deidentified electronic medical record data from the TriNetX research network to assess the risk factors associated with these outcomes in 3,064 patients who were diagnosed with West Nile infections between January 2013 and December 2024. They accessed data from March 28 to April 30, 2025.

The primary outcomes included the development of WNND and all-cause mortality at 30 days, 90 days, and overall. A total of 1,249 (53%) patients demonstrated clinical consistency with West Nile virus, and 1,127 (47%) showed clinical consistency with WNND. The researchers identified several risk factors associated with WNND, including age (adjusted hazard ratio [aHR], 1.10; 95% CI, 1.06-1.15 per decade), male sex (aHR, 1.29; 95% CI, 1.15-1.45), CKD (aHR, 1.21; 95% CI, 1.00-1.45), cerebrovascular disease (CEVD) (aHR, 1.22; 95% CI, 1.03-1.45), hematologic malignant neoplasms (aHR, 1.38; 95% CI, 1.09-1.76), immunosuppressant use (aHR, 1.43; 95% CI, 1.11-1.83), hypertension (aHR, 1.18; 95% CI, 1.04-1.34), alcohol-related disorders (aHR, 1.54; 95% CI, 1.20-1.97), and multiple sclerosis (aHR, 2.34; 95% CI, 1.62-3.37).

Risk factors associated with all-cause mortality included WNND (aHR, 2.49; 95% CI, 1.37-4.52 for 30-day mortality), increased age (aHR, 1.32; 95% CI, 1.07-1.60 per decade), CKD (aHR, 2.08; 95% CI, 1.01-3.93), and CEVD (aHR, 2.00; 95% CI, 1.14-3.50).

The researchers noted that the aging US population is experiencing increasing comorbidities, putting a growing number of people at risk for severe disease from West Nile virus infection.

These findings provide key insights into risk factors, which can be used to develop targeted prevention strategies.

ELECTROLYTE DISORDERS

Increasing Potassium Levels Benefits Patients With Cardiovascular Disease

N Engl J Med. 2025;393(20):1979-1989. doi:10.1056/NEJMoa2509542

Patients with cardiovascular disease who experience low-normal plasma potassium levels or hypokalemia face increased risk of ventricular arrhythmias. **Christian Jøns, MD, PhD,** and colleagues in Denmark conducted a multicenter, open-label, event-driven, randomized superiority study designed to describe a strategy to actively increase plasma potassium levels to the high-normal range in that patient population (NCT03833089).

Eligible participants had an implantable cardioverter-defibrillator (ICD) and a baseline plasma potassium level of 4.3 mmol/L or lower. Participants were randomly assigned 1:1 to an intervention designed to increase plasma potassium to a high-normal level, defined as 4.5 to 5.0 mmol/L. The study intervention was potassium supplementation, a mineralocorticoid receptor antagonist, or both in combination

with dietary guidance and standard care (high-normal potassium group, n=600) versus standard care only (standard care group, n=600).

Median duration of follow-up was 39.6 months. The primary end point (composite of documented sustained ventricular tachycardia or appropriate ICD therapy, unplanned hospitalization >24 hours for arrhythmia or heart failure, or death from any cause) occurred in 136 participants in the high-normal potassium group (22.7%; 7.3 events per 100 person-years) compared with 175 in the standard care group (29.2%; 9.6 events per 100 person-years) for a hazard ratio of 0.76 (95% CI, 0.61-0.95; *P*=0.01). The groups were similar in the incidence of hospitalization for hyperkalemia or hypokalemia.

In conclusion, the authors wrote, "Among participants with any cardiovascular disease who had an ICD and were at high risk for ventricular arrhythmias, a treatment-induced increase in plasma potassium levels led to a significantly lower risk of appropriate ICD therapy, unplanned hospitalization for arrhythmia or heart failure, or death from any cause than standard care."

FSGS

BI 764198 Safe and Efficacious in FSGS

Lancet. 2026;407(10528):587-598. doi:10.1016/S0140-6736(25)02255-X

Among patients with focal segmental glomerulosclerosis (FSGS), overactivity in the transient receptor potential cation channel, subfamily C, member 6 (TRPC6) may result in podocyte loss and progressive decline in kidney function. **Howard Trachtman, MD,** and colleagues conducted a multicenter phase 2, double-blind, placebo-controlled, randomized controlled trial (NCT05213624) designed to examine the safety and efficacy of BI 764198, a novel once-daily oral selective TRPC6 inhibitor.

The study was conducted at 31 sites in 10 countries. Over a study period of 12 weeks, participants aged 18 to 75 years with biopsy-confirmed primary FSGS or a disease-causing TRPC6 variant received either BI 764198 (20 mg, 40 mg, or 80 mg once daily) or placebo.

The primary end point was the proportion of study participants with proteinuria response, defined as a reduction of at least 25% from baseline in urine protein-creatinine ratio (UPCR) at week 12, as well as safety and tolerability. Of the 62 participants in the final cohort, two had missing data for UPCR and were not included in the full analysis set. Sixty percent of the 62 participants were male (n=37), mean age was 40.7 years, and 39 participants (63%) were White.

In the intervention group, proteinuria responses were seen in 44% (n=8 of 18), 14% (n=2 of 14), and 43% (n=6 of 14) of those in the 20-mg, 40-mg, and 80-mg groups, respectively (16 of 46 for all doses of BI 764198). In the placebo group, 7% (n=1 of 14) had a proteinuria response. The corresponding odds ratios versus placebo were 10.0 (95% CI, 1.6-118.1), 1.5 (95% CI, 0.2-19.5), and 6.0 (95% CI, 0.9-73.6) for the three doses and 4.9 (95% CI, 1.0-48.8) for all doses combined.

BI 764198 was well tolerated. The two groups were similar in the frequency of adverse events across all treatment arms: 71% of participants in each group reported treatment-emergent adverse events.

The researchers wrote, "BI 764198 lowered proteinuria and was well tolerated by participants in this trial. This is the first evidence of efficacy with a podocyte-targeted therapy in FSGS. Larger randomised controlled trials over longer treatment durations, enabling meaningful subgroup analyses, are planned to evaluate the safety and efficacy of BI 764198 treatment in FSGS and other conditions affected by podocytopathy."

IGA NEPHROPATHY

Complete Proteinuria Remission and Kidney Function in PROTECT Trial Participants

Clin J Am Soc Nephrol. 2026;21(4):578-592. doi:10.2215/CJN.0000000961

Sparsentan is a single-molecule dual endothelin-angiotensin receptor antagonist that reduced proteinuria and preserved kidney function versus maximum labeled dose of irbesartan in the PROTECT trial. **Hiddo J. L. Heerspink, PhD,** and colleagues reported results of a post hoc analysis of data from the PROTECT trial to assess the association between complete remission (CR) of proteinuria and preservation of kidney function. Complete remission was defined as urine protein excretion of less than 0.3 g/day.

The analysis compared kidney function in patients who achieved CR by week 36 (CR36) or any time up to week 110 (CR110) with that in patients who did not achieve CR (non-CR), regardless of original treatment allocation.

Of 404 patients who received the study drug, 11% (n=43) achieved CR36 and 21% (n=85) achieved CR110. Compared with non-CR patients, those who achieved CR had greater and more rapid reductions in proteinuria. The change in absolute eGFR was smaller in CR110 patients than in non-CR patients (–4.0 vs –8.6 mL/min/1.73 m^2). CR110 patients also had a slower rate of eGFR decline (day 1 to week 110; –0.7 vs –4.2 mL/min/1.73 m^2/year). One percent of CR110 patients reached the composite kidney end point compared with 14% of non-CR patients.

Compared with non-CR patients, CR110 patients were more likely to experience treatment-emergent adverse events (TEAEs) associated with hypotension and less likely to experience TEAEs of hypertension. Percentages of patients who discontinued treatment due to adverse events or patient decision were greater among non-CR patients than CR110 patients (11% vs 4% and 8% vs 2%, respectively).

In conclusion, the researchers wrote, "Participants in PROTECT who achieved CR36 or CR110 showed a greater eGFR preservation, fewer kidney failure events, and similar safety profiles compared to non-CR participants. These data reinforce recommendations to maintain proteinuria levels ideally <0.3 g/d and underscore its relationship with kidney function preservation." ●

Sarah Tolson

The Hidden Cost of Prior Authorization in Nephrology

By ***Sarah Tolson***

If you want to take a peek at the administrative strain in modern renal care, a good place to start would be prior authorizations for dialysis.

Prior authorization requirements under Medicare Advantage (MA) plans were originally framed as a utilization management tool. In theory, they exist to prevent unnecessary services and control costs. In practice, when applied to dialysis, they often function as a costly administrative exercise that adds little clinical value while creating measurable operational risk.

Dialysis: A Lifesaving Therapy That Rarely "Expires"

Many MA plans require prior authorization for outpatient dialysis treatments—even when the facility is contracted and in network. This is difficult to reconcile with clinical reality.

Dialysis is not an elective imaging study or a short-term course of physical therapy. It is a life-sustaining therapy for patients with irreversible kidney failure. Although dialysis carries risk, it is rarely initiated casually and even more rarely discontinued because kidney function has spontaneously recovered. Yet some MA plans require reauthorization as frequently as every 90 days.

From a clinical perspective, the likelihood that a patient's need for dialysis will "evaporate" within a 90-day window is exceedingly low. From an administrative perspective, however, that 90-day cycle creates a recurring workload that never ends.

The Inefficiency Multiplier

In many specialties, authorizations can be submitted through online portals with standardized clinical questions and near real-time determinations. Dialysis often does not fit neatly into those workflows.

It is common for dialysis authorizations to require phone calls to utilization management departments or faxed submission of medical records. Teams may spend extended time on hold, repeatedly transmitting documentation and calling back to confirm receipt. In some cases, authorizations are misplaced or never fully processed, requiring further follow-up.

The burden does not end once an authorization is "approved." Dialysis teams must track effective dates, monitor expiration timelines and the number of treatments authorized, and proactively initiate reauthorizations to avoid gaps in coverage. Given the volume of treatments—often three times per week per patient—even a brief lapse can expose the facility to significant financial risk.

Revenue Cycle Leakage

The administrative cost of prior authorization is not limited to staff time. It directly impacts reimbursement.

It is not uncommon for dialysis claims to be denied for "no authorization," even when authorization was obtained. Whether due to payer system issues, mismatched authorization numbers, or processing errors, these denials require appeals, documentation resubmission, and persistent follow-up.

Each denial represents:

- Additional billing staff time
- Delayed cash flow
- Increased accounts receivable days
- Elevated write-off risk if appeals are not pursued in a timely manner

When this occurs across multiple patients and multiple reauthorization cycles per year, the financial impact becomes meaningful. This is what I often refer to as *revenue cycle leakage*—small administrative failures that accumulate into measurable margin erosion.

Beyond Dialysis: Medication Authorizations

Although less common, some payers require prior authorization for medications routinely administered in dialysis facilities, such as erythropoiesis-stimulating agents and IV iron.

When authorization is required for drugs that are clinically standard and protocol driven, the workflow becomes even more fragmented. Clinical staff must generate supporting

documentation, billing teams must track approval status, and treatment decisions may be delayed while clinicians or facilities are waiting for payer confirmation.

Practical Mitigation Strategies

Although individual facilities cannot eliminate payer requirements, the following operational steps can reduce risk:

1. ***Centralized Authorization Tracking***
   Maintain a live tracking tool that includes authorization numbers, effective dates, expiration dates, and reauthorization trigger timelines.
2. ***Proactive Reauthorization Cycles***
   Initiate reauthorizations well before expiration—often 2 to 3 weeks in advance—to account for payer processing delays.
3. ***Denial Pattern Monitoring***
   Track "no authorization" denials by payer and escalate recurring issues through the appropriate channels.
4. ***Standardized Documentation Packets***
   Develop checklists of the types of documentation to include in all authorization requests to reduce variability and expedite submission.
5. ***Data-Driven Advocacy***
   Quantify staff hours spent on dialysis authorizations and related denials. Hard data are powerful when engaging payer contracting teams or participating in industry advocacy efforts.

A System Misaligned With Clinical Reality

Prior authorization has a role in healthcare. However, applying recurring authorizations to irreversible, life-sustaining therapy for a chronic disease raises legitimate questions about value versus administrative burden.

For nephrology practices and dialysis providers, the hidden cost is not just the time spent on the phone or the frustration of a misplaced fax. It is the cumulative financial and operational strain created by a system that treats ongoing kidney failure as if it were a temporary condition requiring repeated validation.

As the industry continues to navigate evolving payment models and workforce pressures, reducing unnecessary administrative friction is not merely a convenience—it is a sustainability issue.

And dialysis providers are feeling it every 90 days. ●

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