AAVBC

AMERICAN ACADEMY OF VALUE BASED CARE

# Renal Cancer

## Quick Reference Guide

2026

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# 1 CLINICAL SNAPSHOT

**Definition**: **Renal cell carcinoma** (**RCC**) is a malignancy arising from the renal tubular epithelium and accounts for the large majority of adult kidney cancers.[1] In the Medicare population it is predominantly a disease of **silent presentation**: more than **60%**[1] of cases are discovered incidentally on abdominal imaging ordered for unrelated reasons, and the classic triad of flank pain, hematuria, and a palpable mass now occurs in fewer than **10%** of patients.[1,2] **Clear cell RCC** is the most common histology (**70-80%** of RCC), followed by papillary (**10-15%**) and chromophobe (**3-5%**) subtypes; each carries distinct biology and treatment implications.[1] Urothelial carcinoma of the renal pelvis is a **separate disease with a** distinct histology and treatment pathway, and is coded under **C65** rather than **C64**.[2,3] Peak incidence falls in the **65-74** age band, placing RCC squarely within primary-care and geriatric oncology practice.[1]

## ICD-10 Codes:

Active RCC of the kidney parenchyma is reported with **laterality-specific codes**:[3] **C64.1** (right kidney) and **C64.2** (left kidney); **C64.9** (unspecified laterality) should be used only when laterality is **genuinely undocumented** after review of imaging and operative reports. Renal pelvis tumors (urothelial, not RCC) use **C65.1** (right) and **C65.2** (left) = a distinct anatomic site and histology that is **commonly miscoded as C64**. Metastatic spread to the kidney is captured with **C79.0-** secondary-neoplasm codes, and every confirmed metastatic site is coded separately (for example **C78.00** lung, **C79.51** bone, **C78.7** liver, **C79.31** brain) in addition to the primary **C64.x** code. Presenting hematuria is documented with **R31.0** (gross) or **R31.21** (asymptomatic microscopic). **Z85.528** (personal history of kidney malignancy) is reserved for patients who have **completed treatment with no evidence of disease**; it must not be used while a patient is **on adjuvant therapy or under active surveillance**, where the active **C64.x** code applies.[3,4]

**Prevalence and Burden**: An estimated ~**81,000** new kidney cancer diagnoses are expected in the United States for 2025, with approximately **735,000 people** living with a prior kidney cancer diagnosis as of January 1, 2025.[5] SEER data show that RCC incidence has been increasing at approximately **1.1% annually** (95% CI: 0.6%–1.5%) from 2008 to 2019, with projected continued increases from **6.92 per 100,000** (2015–2019) to **9.59 per 100,000** by 2040–2044.[6] Peak incidence occurs between ages **60 and 70 years**, with the highest age-standardized incidence rates in individuals aged **70–84 years**.[1,7] About **49%** of U.S. kidney cancer diagnoses occur in adults aged **65 and older**, and approximately 67% of kidney cancer survivors are aged ≥65.[1,5] At presentation, **70%** of cases are **Stage I** and **11%** are **Stage IV**.[1] Five-year relative survival is **stage-dependent**: approximately **93%** for localized disease, **75%** for regional disease, and **17–18%** for distant (Stage IV) disease.[8] The male-to-female ratio is approximately **3:2**.[1] Because incidence rises steeply with age, most disease is found **incidentally** (37–61% of cases), and modifiable risk factors such as hypertension, obesity, and smoking are shared with conditions managed in routine primary care, RCC detection and management are increasingly a **shared primary-care responsibility**.[1]

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