AAVBC
AMERICAN ACADEMY OF VALUE BASED CARE

Immune Thrombocytopenia

Quick Reference Guide

2026

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1 CLINICAL SNAPSHOT

Definition: Immune thrombocytopenia (ITP) is an acquired, immune-mediated disorder defined by isolated thrombocytopenia (platelet count below 100 x 10^9/L) in the **absence** of other identifiable causes.[1] Antibody-mediated platelet destruction and impaired platelet production drive the low count, yet diagnosis rests on clinical exclusion: there is no single confirmatory test, and **antiplatelet antibody assays are positive in only 50-60% of patients** and are **not recommended** in the routine workup.[2] **Bleeding** is the most **common clinical manifestation of ITP**, with the risk of bleeding and related morbidity increased in elderly patients. "ITP is further classified as primary, when no underlying cause is identified, or secondary, when platelet destruction is driven by an associated condition such as systemic lupus erythematosus, HIV, hepatitis C, chronic lymphocytic leukemia, or *Helicobacter pylori* infection — accounting for roughly **10-20%** of all ITP cases.[3]

IC-10 Codes:

The ITP and specified-coagulation-defect codes that carry risk-adjustment weight are the primary and other primary thrombocytopenia codes **D69.3** (immune/idiopathic thrombocytopenic purpura), **D69.41** (Evans syndrome), **D69.42** (congenital/hereditary thrombocytopenic purpura), **D69.49** (other primary thrombocytopenia), **D69.51** (posttransfusion purpura), and **D69.59** (other secondary thrombocytopenia), together with selected qualitative platelet and factor-deficiency codes (**D69.1**, **D68.0-D68.2**, **D68.311**). Avoid **D69.6** (thrombocytopenia, unspecified) and heparin-induced thrombocytopenia codes (**D75.821**, **D75.822**, **D75.829**) because none map to an HCC. Documenting "thrombocytopenia" without an etiology, or coding a drug-induced case as primary ITP, both misrepresent the clinical picture and forfeit accurate complexity documentation.[4]

Prevalence: ITP incidence is approximately **2-4 per 100,000** person-years overall, with a bimodal age distribution: an early peak at ages **20-30** and a larger peak after age 60 with equal sex distribution.[6] Incidence continues to rise and is highest in patients over 80 years, making ITP disproportionately a disease of the Medicare-age population.[6] Although only about **5%** of patients present with severe bleeding, bleeding leading to hospitalization within **5 years** develops in roughly **15%**, and that risk is higher in older adults with comorbidities. ITP is widely under-characterized rather than over-diagnosed.[2]

HCC/RAF V28 Mapping

ICD-10	V28 HCC	CNA RAF	DOCUMENTATION REQUIREMENT
D69.3 Immune thrombocytopenic purpura (Primary ITP)	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Use **ONLY** after secondary causes are excluded and documented
D69.41 Evans syndrome	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Requires **documentation of both autoimmune hemolysis AND thrombocytopenia**