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**

ICD-10	V28 HCC	CNA RAF	DOCUMENTATION REQUIREMENT
D69.42 Congenital/ hereditary thrombocytopenia purpura	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Requires **family history** or **genetic documentation**
D69.49 Other primary thrombocytopenia	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Use when **primary etiology confirmed** but does not fit above specifics
D69.51 Posttransfusion purpura	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Requires documented **temporal link to transfusion event**
D69.59 Other secondary thrombocytopenia	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Link to underlying cause **(HIV, Hep C, lupus, drug)**; pair with cause code
D69.6 (unspecified)	No HCC	N/A	Coding traps - **do NOT map to HCC 112 under V28**
D75.822 Immune-mediated heparin-induced thrombocytopenia (HIT)	**HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions	0.450	Requires additional adverse effect code (e.g., **T45.515A**); do not code as **D69.3**

ABBREVIATIONS: ICD-10-CM = International Classification of Diseases, 10th Revision, Clinical Modification; HCC = Hierarchical Condition Category; CNA = Community Non-Dual Eligible, Aged; RAF = Risk Adjustment Factor; HIT = Heparin-Induced Thrombocytopenia; V28 = CMS-HCC Model Version 28 *RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model;11 values vary across patient populations based on eligibility and care setting

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Risk-Adjusted Care Resources per Patient/Year[6,7]

Risk-adjusted care resource allocation — MA base rate (~$10,402.34) × RAF coefficient

ITP Coagulation Defects

$4,681

HCC 112 · RAF 0.450

RAF values represent the Community Non-Dual Eligible Aged (CNA) coefficient from the 2026 CMS-HCC model; values vary across patient populations based on eligibility and care setting

2 RECOGNITION AND DIAGNOSIS

Medicare Screenings and Surveillance

SERVICE (CPT)	ROLE IN ITP PATHWAY	COVERAGE NOTE
CBC with differential (85025/85027)[2]	**Confirms and trends isolated thrombocytopenia**; first step in every evaluation	Covered when medically necessary; no frequency limit during active management
Peripheral blood smear (85060)[2,3]	Essential to exclude pseudothrombocytopenia (clumping), schistocytes (TTP/DIC), and dysplasia	**Covered**; central to the diagnosis of exclusion
Bone marrow biopsy + aspiration (38222, interp 85097)[2]	Strongly considered in adults ≥60 with new thrombocytopenia to exclude MDS	**Covered** when medically necessary; confirm current MAC LCD
HIV/HBV/HCV testing (86803, 87340, 87389)[2]	Secondary-cause screen;infection-associated ITP is coded **D69.59** with the infection code	**Covered** as part of the ITP workup
H. pylori stool antigen (87338)[2]	Recommended in the ITP secondary-cause workup; eradication can raise platelet counts in responders	**Covered**
IVIg infusion (96365; J1459/ J1599)[2]	Rapid, transient platelet rise for severe bleeding;outpatient infusion avoids inpatient cost	Part B in office/outpatient; **Part D may cover home IVIg** (Q2052)

SERVICE (CPT)	ROLE IN ITP PATHWAY	COVERAGE NOTE

ABBREVIATIONS: CBC = Complete Blood Count; CPT = Current Procedural Terminology; TTP = Thrombotic Thrombocytopenic Purpura; DIC = Disseminated Intravascular Coagulation; MDS = Myelodysplastic Syndrome; HIV = Human Immunodeficiency Virus; HBV = Hepatitis B Virus; HCV = Hepatitis C Virus; IVIg = Intravenous Immunoglobulin; MAC = Medicare Administrative Contractor; LCD = Local Coverage Determination

Subtle Early Signs in Older Adults (>65)

SUBTLE SIGN	WHY IT IS MISSED	ACTION
Petechiae on the lower legs[9]	Attributed to chronic venous changes, aging skin, or minor trauma rather than thrombocytopenia	Examine **dependent skin** and **oral mucosa**; order a **CBC** before dismissing[8]
Spontaneous bruising/ ecchymoses[2]	Blamed on falls, anticoagulants, or fragile skin, masking an immune cause	**Quantify and date lesions**; correlate with platelet count and medication review
Mucosal blood blisters, gum bleeding, epistaxis	"Wet purpura" signals higher bleeding risk but is under-reported by patients[10]	Treat **new wet-purpura** findings as a marker of more severe disease
Disproportionate fatigue[2]	Common in ITP regardless of platelet count but ascribed to age or depression	Document **fatigue** as a patient-reported outcome, not a platelet surrogate
Occult GI or genitourinary bleeding[11]	Hematuria or melena attributed to other geriatric conditions	Investigate any **new bleeding** in a thrombocytopenic patient **promptly**

ABBREVIATIONS: CBC = Complete Blood Count; GI = Gastrointestinal; ITP = Immune Thrombocytopenia

Geriatric Risk Factors

RISK FACTOR	STATISTICAL SIGNAL	CLINICAL MEANING
Age ≥65 years	Independently predicts **≥grade 2 hemorrhage** (P = 0.01) and **thrombosis** (P = 0.01)[12]	**Age itself shifts both bleeding and clotting risk**; individualize the platelet target
Platelet count <20 x 10^9/L at onset	**OR 10.05** (95% CI 4.83-67.39) for bleeding in very elderly patients (≥80 years)[13]	Very **low counts** at presentation warrant prompt treatment in older adults

RISK FACTOR	STATISTICAL SIGNAL	CLINICAL MEANING
Anticoagulant exposure	**OR 7.61** (95% CI 1.77-32.83) for severe bleeding in very elderly patients[13]	**Concurrent anticoagulation** is the dominant modifiable bleeding driver; co-manage carefully
Female sex (very elderly)	**OR 4.75** (95% CI 1.31-17.32) for bleeding at ITP onset[13]	**Sex modifies presentation risk** in the oldest patients
History of thrombosis	Subdistribution **HR 2.04** (P = 0.05) for major thrombosis during TPO-RA therapy at ≥60 years[12]	Prior VTE is the strongest predictor of TPO-RA-associated clotting; influences agent choice
Active hemorrhage at diagnosis	Independently predicts ≥grade 2 hemorrhage during follow-up (P = 0.01)[12]	**Bleeding at presentation**, not the count alone, should drive urgency

ABBREVIATIONS: OR = Odds Ratio; CI = Confidence Interval; HR = Hazard Ratio; VTE = Venous Thromboembolism; TPO-RA = Thrombopoietin Receptor Agonist; ITP = Immune Thrombocytopenia

Diagnostic Thresholds and Classification

FRAMEWORK	DEFINITION	PRACTICAL USE
Diagnostic threshold (IWG)[2,14]	Platelet count below **100 x 10^9/L** with isolated thrombocytopenia and no morphologic abnormality on smear, after exclusion of secondary causes	Establishes ITP as a diagnosis of exclusion, **not a single positive test**
Newly diagnosed ITP[14,15]	Within **3** months of diagnosis	Many asymptomatic patients above **30 x 10^9/L** may be observed rather than treated
Persistent ITP[14,15]	**3-12 months** from diagnosis without sustained off-therapy remission	Prompts review of secondary causes and second-line planning
Chronic ITP[14,15]	Lasting more than **12 months**	**Most common adult pattern**; favors steroid-sparing maintenance

FRAMEWORK	DEFINITION	PRACTICAL USE
ISTH critical-bleed definition[16]	Bleed in a **critical anatomical site**, OR **ongoing bleed** with hemodynamic instability or respiratory compromise	Most recent standardized definition; best suited to emergency triage
ITP-BAT (SMOG)/IBLS/Khellaf scales[14]	Grade bleeding by **Skin, Mucosa, and Organ involvement**; consensus tools with limited large-study validation	**Useful to standardize bleeding severity**; none is universally adopted in US guidelines

ABBREVIATIONS: IWG = International Working Group; ISTH = International Society on Thrombosis and Haemostasis; ITP-BAT = ITP Bleeding Assessment Tool; SMOG = Skin-Mucosa-Organs Grading; IBLS = ITP Bleeding Scale; ITP = Immune Thrombocytopenia

Clues to Dig Deeper

CLUE	WHAT IT MAY SIGNAL	NEXT STEP
Macrocytosis or other cytopenias	Possible MDS rather than primary ITP, especially at **≥60 years**[2]	Expedited **bone marrow biopsy** with cytogenetics and molecular testing
New thrombocytopenia on heparin (4Ts score ≥4)[17]	Heparin-induced thrombocytopenia (HIT), a prothrombotic emergency	**Stop heparin immediately**; PF4 antibody testing; urgent hematology contact
Splenomegaly, lymphadenopathy, or weight loss	Lymphoproliferative disorder; lymphoma **IRR 5.91** and leukemia **IRR 19.83** in chronic ITP[18]	Image, examine nodes, and refer for hematologic evaluation
Positive ANA or hepatitis serologies[2]	Secondary ITP (SLE, antiphospholipid syndrome, HCV) coded **D69.59** with the underlying disease	Complete the **autoimmune/infectious workup** before assigning primary ITP
Concurrent hemolytic anemia with positive DAT[19]	Evans syndrome **(D69.41)**, often missed when the hemolytic component is overlooked	Send DAT, haptoglobin, LDH, and reticulocyte count
Schistocytes, fever, neurologic or renal changes[20]	TTP/HUS - a hematologic emergency distinct from ITP	**Urgent smear review**, LDH, haptoglobin; emergent plasma exchange if confirmed

ABBREVIATIONS: MDS = Myelodysplastic Syndrome; HIT = Heparin-Induced Thrombocytopenia; PF4 = Platelet Factor 4; IRR = Incidence Rate Ratio; ANA = Antinuclear Antibody; SLE = Systemic Lupus Erythematosus; HCV = Hepatitis C Virus; DAT = Direct Antiglobulin Test; LDH = Lactate Dehydrogenase; TTP = Thrombotic Thrombocytopenic Purpura; HUS = Hemolytic Uremic Syndrome; ITP = Immune Thrombocytopenia

Common Oversights

CLINICAL OVERSIGHT	CONSEQUENCE	BETTER PRACTICE
Skipping the secondary-cause workup[2]	Drug-induced, infectious, or autoimmune thrombocytopenia treated as primary ITP, **delaying** the right therapy	Screen **medications, HIV/HBV/HCV, H. pylori, and ANA/DAT before** labeling ITP
Not excluding MDS in adults ≥60[21]	Early MDS managed as ITP; steroids given for a disease needing disease-modifying or supportive care	Strongly consider **marrow biopsy** in new thrombocytopenia at ≥60, especially with macrocytosis
Missing drug-induced thrombocytopenia[22]	Up to **25%** of acutely ill patients develop it; continued exposure and unnecessary immunosuppression follow	Review heparin, quinine, PPIs, carbamazepine, vancomycin, and sulfonamides **at every visit**
Treating the number, not the patient[23]	**Overtreatment of asymptomatic patients exposes older adults to steroid and thrombotic harm**	Target **bleeding prevention and individualized thresholds**, not platelet normalization
Not reassessing wet purpura or fatigue[2]	Mucosal bleeding and disabling fatigue under-recognized as markers of disease activity	**Re-examine mucosa and document fatigue** as a patient-reported outcome

ABBREVIATIONS: MDS = Myelodysplastic Syndrome; PPI = Proton Pump Inhibitor; VTE = Venous Thromboembolism; TPO-RA = Thrombopoietin Receptor Agonist; ANA = Antinuclear Antibody; DAT = Direct Antiglobulin Test; ITP = Immune Thrombocytopenia; HIV = Human Immunodeficiency Virus; HBV = Hepatitis B Virus; HCV = Hepatitis C Virus

CLINICAL PEARL

ITP carries **2x the VTE risk** of the general population despite being a bleeding disorder, and platelet activation and inflammation drive thrombosis risk independent of platelet count. **TPO-receptor agonists** raise platelet count but can further increase this risk, with major thrombosis occurring at **3.4 per 100 patient-years** in patients **≥60**. VTE history should be assessed before initiating therapy, as low platelet count does not indicate low thrombosis risk.[2]

Key Differentials in Elderly

DIFFERENTIAL	DISTINGUISHING FEATURES	CONFIRMATORY STEP
Myelodysplastic syndrome (MDS)[21]	Median age **~71 years**; macrocytosis, multilineage cytopenias, dysplasia; mimics ITP	**Bone marrow biopsy** with cytogenetics and molecular testing
Drug-induced thrombocytopenia[2,8]	**Temporal link to a culprit drug** (heparin, quinine, vancomycin, carbamazepine)	**Medication timeline**; recovery on withdrawal; drug-dependent antibody testing where available
Secondary (autoimmune/ infectious) ITP[2]	SLE, antiphospholipid syndrome, HIV, HCV, or H. pylori as the **underlying cause**	ANA, hepatitis and HIV serologies, H. pylori testing
TTP/HUS[2,20]	Microangiopathic hemolysis with schistocytes, neurologic or renal signs	**Smear, LDH, haptoglobin**; ADAMTS13 if TTP suspected - emergent
Pseudothrombocytopenia[8]	EDTA-induced platelet clumping; no true bleeding risk	**Repeat count in citrate tube**; review smear for clumps
Pancytopenia/marrow failure[2]	All three lineages depressed; code pancytopenia **(D61.818)** rather than ITP unless distinct etiology	**Marrow evaluation**; do not code ITP separately without a distinct documented cause

ABBREVIATIONS: MDS = Myelodysplastic Syndrome; SLE = Systemic Lupus Erythematosus; HIV = Human Immunodeficiency Virus; HCV = Hepatitis C Virus; TTP = Thrombotic Thrombocytopenic Purpura; HUS = Hemolytic Uremic Syndrome; EDTA = Ethylenediaminetetraacetic Acid; LDH = Lactate Dehydrogenase; ADAMTS13 = A Disintegrin and Metalloproteinase with Thrombospondin Motifs 13; ITP = Immune Thrombocytopenia

Comorbidity Screening

COMORBIDITY	SIGNAL IN CHRONIC ITP*	WHY IT MATTERS
Diabetes mellitus	**IRR 1.73** (95% CI 1.36-2.20) versus controls[15,18]	**Corticosteroids worsen hyperglycemia**; favors steroid-sparing strategy and glucose monitoring
Renal impairment	**IRR 2.05** (95% CI 1.67-2.51)[18]	**IVIg carries acute renal-failure risk in CKD**; dose-adjust and hydrate; raises bleeding risk

COMORBIDITY	SIGNAL IN CHRONIC ITP*	WHY IT MATTERS
Vascular events	Any vascular event **IRR 1.70**(95% CI 1.41-2.05); VTE risk 2x general population[18]	**Balancing bleeding and thrombosis** is the central management challenge
Hematologic malignancy	Lymphoma **IRR 5.91**; leukemia IRR 19.83[18]	**Lymphoproliferative disorders are secondary ITP causes**; investigate red-flag features
Infection/immunosuppression	**Rituximab causes hypogammaglobulinemia**; splenectomy raises encapsulated-organism risk[24]	Screen HIV/HBV/HCV and H. pylori; **vaccinate before splenectomy**
Frailty/cognitive impairment	**No dedicated geriatric ITP guidelines exis**t; recommendations rest on expert opinion[15]	**Incorporate frailty, fall risk, and caregiver support** into shared decisions

ABBREVIATIONS: IRR = Incidence Rate Ratio; CI = Confidence Interval; IVIg = Intravenous Immunoglobulin; CKD = Chronic Kidney Disease; VTE = Venous Thromboembolism; HIV = Human Immunodeficiency Virus; HBV = Hepatitis B Virus; HCV = Hepatitis C Virus; ITP = Immune Thrombocytopenia
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

⚠ RED FLAG — EMERGENCY/ACTIVATE CRISIS RESPONSE

- Severe thrombocytopenia with new severe headache, altered mental status, focal neurologic deficit, or seizure — suspected **intracranial hemorrhage**, the most feared ITP complication
- Hemodynamic instability from active GI, genitourinary, or other bleeding
- Bleeding into a critical site (intraspinal, intraocular, retroperitoneal, pericardial, or intramuscular with compartment syndrome)
- Thrombocytopenia with schistocytes, elevated **LDH**, and neurologic or renal signs suggesting **TTP/HUS** — requires emergent plasma exchange

RED FLAG — URGENT (24-72 HOURS)

- **Platelet count <20 x 10^9/L** with active mucocutaneous bleeding (epistaxis requiring packing, oral blood blisters, hematuria, menorrhagia) — same-day or next-day hematology contact
- New thrombocytopenia on heparin with a **4Ts score ≥4** — stop heparin, start alternative anticoagulation
- Failure to respond to first-line corticosteroids within **1-2 weeks**, or relapse on taper
- New cytopenias beyond isolated thrombocytopenia — suggests **MDS**, aplastic anemia, or leukemia
- Expedited referral (within days) for **platelets <30 x 10^9/L** in a patient on anticoagulants, with corticosteroid dependence, or suspected secondary ITP

AAVBC PERSPECTIVE

AAVBC encourages primary care providers to approach immune thrombocytopenia as a **diagnosis of exclusion** requiring active clinical reasoning, rather than a reflexive response to a low platelet count. ITP is defined by **isolated thrombocytopenia** without anemia or leukopenia after all secondary causes have been ruled out, and the distinction between **primary and secondary ITP** must be established before a code is assigned or treatment is initiated. Secondary ITP is triggered by identifiable underlying conditions (including **HIV, Hepatitis C, H. pylori, lupus**, and drug exposures such as heparin, sulfa drugs, and carbamazepine) each of which carries a different management pathway. Documentation must reflect that secondary causes were actively considered and excluded through history, physical examination, peripheral smear, and targeted infectious and autoimmune screening.

AAVBC supports a management approach centered on bleeding risk and functional impact rather than platelet number alone. Treatment decisions should reflect established thresholds: platelet counts **below 10,000/µL** generally warrant **prophylactic transfusion** to prevent spontaneous, life-threatening bleeding; counts **below 50,000/µL** often require **treatment before major invasive procedures**; and **above 50,000/µL**, **treatment is typically reserved for patients with active, visible bleeding.** Bleeding symptoms such as petechiae, purpura, menorrhagia, and spontaneous bruising are the clinically meaningful markers that should guide treatment decisions, alongside fatigue, which is a prominent and frequently underdocumented symptom that does not correlate with platelet count severity. **This helps ensure the right patients receive the right level of intervention at the right time.**

3 MEAT DOCUMENTATION ESSENTIALS

MEAT documentation (Monitor, Evaluate, Assess, Treat) allows an ITP encounter to reflect the patient's true clinical complexity, which overall supports accurate **HCC 112** documentation. For ITP, the highest-value documentation is the **etiology** and the **bleeding picture** — the two elements most often omitted from the record.

Female patient, 74, on apixaban for atrial fibrillation, is found to have a platelet count of 18 x 10^9/L with oral blood blisters and lower-leg petechiae. A medication review, peripheral smear, HIV/HCV testing, and ANA are documented; macrocytosis prompts a bone marrow biopsy that excludes MDS. The note records "primary immune thrombocytopenia, chronic, with wet purpura; secondary causes excluded; anticoagulation held," supporting a specified D69.3 diagnosis and an individualized platelet target above 50 x 10^9/L while anticoagulation is needed.

Monitor: "Platelet count: **18 x 10^9/L** (down from prior baseline), rechecked and confirmed. Bleeding symptoms: oral blood blisters, lower-leg petechiae — consistent with **wet purpura**. Fatigue: reported, tracked as patient-reported outcome. Steroid-related monitoring: glucose and blood pressure at baseline pending initiation of therapy"

Evaluate: "Secondary-cause workup: medication review confirms **apixaban** as current anticoagulant; HIV and HCV negative; **ANA**negative. Macrocytosis noted on peripheral smear prompted bone marrow biopsy, which **excludes MDS** — appropriate given age **≥60**. No evidence of lymphoproliferative or autoimmune secondary cause identified"

Assess: "**Primary immune thrombocytopenia, chronic**, with wet purpura; secondary causes excluded (**D69.3**). Bleeding severity: significant mucocutaneous bleeding (oral blood blisters, petechiae) at platelet count **18 x 10^9/L**. Thrombosis risk: atrial fibrillation on anticoagulation — competing bleeding/thrombosis risk requires individualized management"

Treat: "**Apixaban held** given active bleeding and severe thrombocytopenia. Individualized platelet target **>50 x 10^9/L** while anticoagulation is needed, per shared decision-making with hematology. Plan: corticosteroid initiation, close platelet monitoring, reassess anticoagulation resumption once target platelet count achieved and bleeding resolved"

Clinical Documentation Elements

- **Specify the type of thrombocytopenia** (immune/idiopathic, secondary, Evans) - never "thrombocytopenia" alone
- **Document that secondary causes were considered and excluded** (drugs, infection, autoimmune disease)
- **Record the bleeding picture and severity**, including wet purpura and any critical-site bleeding
- **Note the disease phase** - newly diagnosed, persistent, or chronic - at each visit
- **Document comorbidities** (diabetes, renal impairment, vascular disease) to their highest specificity

- In adults ≥60, **document MDS consideration or exclusion** and the rationale for biopsy or its deferral
- **Confirm the ITP diagnosis and current status** at the annual wellness visit so HCC 112 is redocumented

Reframing Common Documentation Shortcuts

COMMON SHORTCUT	WHY IT FALLS SHORT	REFRAME
"Thrombocytopenia"	Unspecified language defaults to **D69.6**, which carries no HCC and zero RAF under V28	"Primary immune thrombocytopenia, chronic" with the **etiology stated**
"ITP" with no workup noted	Primary ITP without documented exclusion is vulnerable on review and may misrepresent a secondary cause	"Primary ITP; HIV/HCV, ANA, medication review negative" - **exclusion made explicit**
"Low platelets, on steroids"	Omits phase, bleeding severity, and comorbidity, understating complexity	**Phase, bleeding grade, and steroid-toxicity monitoring** documented together
Drug-induced case coded as D69.3	Misclassifies a secondary cause and obscures the offending drug	"Drug-induced (secondary) thrombocytopenia" - **D69.59** with the adverse-effect T-code
ITP managed only by hematology	Diagnosis absent from primary-care notes -> not redocumented -> RAF drops between years	**Add ITP to the problem list and confirm status at the AWV every year**

ABBREVIATIONS: ITP = Immune Thrombocytopenia; HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; V28 = CMS-HCC Model Version 28; HIV = Human Immunodeficiency Virus; HCV = Hepatitis C Virus; ANA = Antinuclear Antibody; AWV = Annual Wellness Visit

DOCUMENTATION REMINDER IS GOOD CLINICAL CARE

Documentation that names the etiology, the phase, and the bleeding picture is simply good clinical care written down. It lets the next clinician see why this is primary or secondary ITP, keeps the patient off unnecessary immunosuppression, and represents the patient's complexity accurately for risk adjustment.

4 TREATMENT AND REFERRAL QUICK GUIDE

Treatment in older adults follows **ASH 2019** guidance, but is individualized: the overarching intent is to prevent major bleeding while minimizing treatment toxicity, rather than normalizing the platelet count.[15]

Therapy Escalation Criteria

ESCALATION TRIGGER	THRESHOLD/SIGNAL	ACTION
Treatment generally indicated	Platelets **<30 x 10^9/L**, or active bleeding at any count[2,25]	**Start first-line therapy**; observe asymptomatic patients above this threshold
Corticosteroid course exceeding limit	ASH recommends against courses **>6 weeks** including taper[15,25]	Transition to a **steroid-sparing agent** — typically a **TPO-receptor agonist** (eltrombopag, romiplostim, or avatrombopag) or **rituximab** — rather than prolong steroids
Corticosteroid dependence	>5 mg/day prednisone equivalent or frequent courses to hold platelets **≥30 x 10^9/L**[25]	Expedited referral for second-line therapy; about **80%** of adults fail or depend on steroids[26]
First-line failure/relapse	No response within **1-2 weeks** or relapse on taper[2,26]	Urgent hematology discussion of second-line options
Anticoagulation needed	Maintain platelets **>50 x 10^9/L** when anticoagulation is required[2]	**Co-manage bleeding and thrombosis**; choose TPO-RA by thrombosis history

ABBREVIATIONS: ASH = American Society of Hematology; TPO-RA = Thrombopoietin Receptor Agonist; ITP = Immune Thrombocytopenia

ASH 2019 Guideline-Aligned Treatment by Line and Patient Profile

LINE/PROFILE	AGENTS AND DOSING*	GERIATRIC NOTES
First-line (ASH 2019)	**Prednisone 0.5-2.0 mg/kg/day** (lower end preferred in elderly) or **dexamethasone 40 mg/day x4 days**; course ≤6 weeks. IVIg 0.4 g/kg x5 days or 1 g/kg x1-2 days for severe bleeding[2,12,15]	**Dexamethasone when rapid response needed**; IVIg risks renal failure and volume overload in elderly
Second-line: TPO-RAs	Romiplostim 1 µg/kg SC weekly (max 10); eltrombopag 25-75 mg PO daily; avatrombopag 20 mg PO daily[2]	**70-95% initial response**; preferred over splenectomy in elderly. Prefer romiplostim if prior VTE or ≥75 years
Second-line: alternatives (biologics, antibiotics, anti-androgen)	Rituximab [OFF-LABEL] **375 mg/m^2 IV weekly x4**; fostamatinib **100-150 mg PO BID** dapsone [OFF-LABEL] **75-100 mg/day** danazol [OFF-LABEL] **400-800 mg/day**[2,27]	Rituximab **~60%** response at **6 months**, **~30%** at **2 years**; **avoid in active HBV** Check G6PD before dapsone[28,29]
Third-line: splenectomy	Surgical; definitive for refractory disease[2]	Less effective and higher thrombosis/infection risk in elderly; defer ≥12 months after diagnosis

ABBREVIATIONS: ASH = American Society of Hematology; TPO-RA = Thrombopoietin Receptor Agonist; IVIg = Intravenous Immunoglobulin; SC = Subcutaneous; PO = By Mouth; BID = Twice Daily; IV = Intravenous; VTE = Venous Thromboembolism; HBV = Hepatitis B Virus; G6PD = Glucose-6-Phosphate Dehydrogenase
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

CLINICAL PEARL: BLEEDING RISK > PLATELET NUMBER

In older adults the decision driver is bleeding risk and comorbidity, not the platelet number. A patient at 25 x 10^9/L with no bleeding and no anticoagulation may be observed, while a patient at 45 x 10^9/L on apixaban with wet purpura needs treatment. Match the platelet target to the bleeding context, and reach for steroid-sparing agents early to avoid the diabetes, infection, and fracture harms that fall hardest on Medicare-age patients.

Non-Pharmacologic Care and Supportive Interventions

INTERVENTION	RATIONALE	NOTE
Avoid NSAIDs and aspirin[2]	Antiplatelet effect **compounds bleeding risk** in thrombocytopenia	**Review OTC products**; offer acetaminophen for analgesia where appropriate
Bleeding-precaution counseling[2]	**Reduces avoidable trauma and emergency visits**	Soft toothbrush, electric razor, fall-proofing; clear return-to-ED criteria
Avoid high-risk contact activity[2]	**Limits trauma-related bleeding at low counts**	**Individualize to functional status**; do not impose unnecessary restriction
Medication reconciliation each visit[2]	**Identifies drug-induced thrombocytopenia and bleeding-promoting agents**	Aligns with the **HEDIS Medication Reconciliation Post-Discharge measure**
Platelet transfusion only for severe active bleeding[2]	Transfused platelets are rapidly destroyed in ITP and are not a reflex for low counts	Reserve for critical bleeding alongside definitive therapy

ABBREVIATIONS: NSAID = Nonsteroidal Anti-Inflammatory Drug; OTC = Over-the-Counter; ED = Emergency Department; HEDIS = Healthcare Effectiveness Data and Information Set; ITP = Immune Thrombocytopenia

Medication Safety and Key Interactions

DRUG*	ITP USE AND STATUS	KEY SAFETY/INTERACTION
Prednisone/dexamethasone[2,18]	First-line, approved	Hyperglycemia (diabetes **IRR 1.73**), hypertension, infection, osteoporosis, mood/cognition; **limit to ≤6 weeks**
IVIg[2]	Approved for ITP; rapid transient rise	**Acute renal failure and volume overload** in elderly/CKD; hydrate and dose-adjust
Romiplostim (Nplate)[12,30]	Second-line TPO-RA, approved	**Thrombosis risk rises with age**;weekly SC injection; monitor CBC, marrow reticulin with prolonged use

DRUG*	ITP USE AND STATUS	KEY SAFETY/INTERACTION
Eltrombopag (Promacta)[2]	Second-line TPO-RA, approved	Higher thrombosis risk than romiplostim after 6 months **(adjusted HR 1.93, 95% CI 1.11-3.34)**, notably ≥75 years; separate from calcium/iron by 2-4 hours; monitor LFTs31,32,33
Avatrombopag (Doptelet)[34]	Second-line TPO-RA, approved	No dietary restriction and no hepatotoxicity signal; convenient oral option
Rituximab[2]	Second-line, [OFF-LABEL] for ITP	**Avoid in active HBV or hypogammaglobulinemia**; screen HBV; onset 1-8 weeks
Fostamatinib (Tavalisse)[35]	Approved for chronic ITP after prior therapy	**Monitor for hypertension and diarrhea**
Dapsone/danazol[2]	Second-line, [OFF-LABEL] for ITP	Check **G6PD before dapsone** (hemolysis); danazol has hepatic and androgenic effects

ABBREVIATIONS: IVIg = Intravenous Immunoglobulin; TPO-RA = Thrombopoietin Receptor Agonist; SC = Subcutaneous; CBC = Complete Blood Count; HR = Hazard Ratio; CI = Confidence Interval; LFT = Liver Function Test; HBV = Hepatitis B Virus; G6PD = Glucose-6-Phosphate Dehydrogenase; IRR = Incidence Rate Ratio; ITP = Immune Thrombocytopenia
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

When to Refer

SITUATION	REFER TO	TIMING
Diagnosis confirmation/first treatment decision[15]	Hematology	At diagnosis, especially if treatment is needed
First-line failure or relapse on taper[2,26]	Hematology	**Urgent -** within 1-2 weeks
Suspected MDS or new multilineage cytopenias[2]	Hematology for bone marrow biopsy	Expedited
Suspected HIT (4Ts ≥4)[2]	Hematology; stop heparin immediately	**Emergent**/same day
Suspected secondary ITP (autoimmune, infectious, lymphoproliferative)[2]	Hematology ± relevant subspecialty	Expedited workup

SITUATION	REFER TO	TIMING
Critical-site or hemodynamically significant bleeding[2]	Emergency department	**Emergent**/same day

ABBREVIATIONS: MDS = Myelodysplastic Syndrome; HIT = Heparin-Induced Thrombocytopenia; ITP = Immune Thrombocytopenia

Follow-Up Timing

PHASE/SETTING	MONITORING	INTERVAL
Starting or titrating a TPO-RA[36]	CBC for platelet response and safety	**Weekly until stable**, then monthly
On corticosteroids[15]	Glucose, blood pressure, mood/ cognition, bone health	**Each visit** during the course
Post-discharge after bleeding hospitalization[15]	Platelet recheck, medication reconciliation, bleeding-precaution review	Within **5-7 days**; supports the Plan All-Cause Readmission measure
Stable chronic ITP[2,8]	Platelet trend, bleeding symptoms, fatigue, comorbidity status	Every **3-6 months** and at the annual wellness visit
On eltrombopag[33]	Liver function tests in addition to CBC	**Per labeling** alongside platelet monitoring

ABBREVIATIONS: TPO-RA = Thrombopoietin Receptor Agonist; CBC = Complete Blood Count; ITP = Immune Thrombocytopenia

Comorbidity Management – Primary Care Role

COMORBIDITY	PRIMARY-CARE ROLE	DOCUMENTATION TIE-IN
Steroid-induced hyperglycemia/ diabetes[37]	Monitor glucose during steroid courses; manage or co-manage diabetes	Code steroid-induced diabetes to highest specificity; supports the diabetes-care measures
Hypertension[2,27]	Track BP on corticosteroids and fostamatinib;treat to target	Code steroid-related HTN separately; aligns with Controlling High Blood Pressure

COMORBIDITY	PRIMARY-CARE ROLE	DOCUMENTATION TIE-IN
Vascular risk[18]	Assess cardiovascular risk; address statin therapy where indicated	Vascular event **IRR 1.70**; document risk and therapy at the AWV
Renal impairment[38]	Adjust IVIg and hydrate; avoid nephrotoxins	Document CKD stage; renal **IRR 2.05** raises both bleeding and treatment risk[15]
Polypharmacy[2]	Reconcile medications at every visit for drug-induced causes	Supports Medication Reconciliation Post-Discharge; **D69.59** + T-code when drug-induced

ABBREVIATIONS: BP = Blood Pressure; HTN = Hypertension; IVIg = Intravenous Immunoglobulin; CKD = Chronic Kidney Disease; IRR = Incidence Rate Ratio; AWV = Annual Wellness Visit

Cost-Smart Options

BRAND (EST. COST)*	GENERIC (EST. COST)*	EST. SAVINGS	COST-SMART TIP
Brand Rayos (delayed-release prednisone) (~$450–600/month)[39]	Generic **prednisone** (**~$9–15/month**) — all other brands discontinued[40]	**~$435–585/ month**	Generic prednisone is the correct first-line choice — guideline-consistent and negligible cost; limit to **<6 weeks** and avoid prolonged courses especially in older adults due to infection, fracture, and metabolic risk; high-dose **dexamethasone 40 mg × 4 days** is an equivalent first-line alternative at similarly low cost

BRAND (EST. COST)*	GENERIC (EST. COST)*	EST. SAVINGS	COST-SMART TIP
Brand Gamunex-C (~$11,000–22,000/ treatment course for 70 kg patient at 1 g/ kg/day × 2 days)[41,42] **or brand Privigen(~$13,600/ course same dosing)**[43]	No generic IVIg exists in the US; multiple branded IVIg products priced comparably — formulary selection may yield modest cost differences	Variable by brand and site of care	IVIg is reserved for **life-threatening bleeding, urgent pre-surgical prep, or when steroids are contraindicated** — not a long-term strategy; route site-of-care to an **outpatient infusion center** rather than inpatient hospital when clinically safe- inpatient episodes average significantly higher total costs than outpatient administration
Brand Promacta (eltrombopag 50mg/ day, ~$13,852/ month)[44]	Generic **eltrombopag** (**~$6,676/month**; FDA approved September 2024)[45]	**~$7,176/ month**	Generic eltrombopag is FDA-approved and now available; confirm specialty pharmacy benefit allows generic substitution
Brand Nplate (romiplostim SC weekly injection, ~$5,679/month at 1 mcg/kg/week for 70 kg patient)[46, 47]	No biosimilar exists; generic **eltrombopag** (**~$6,676/month**) or brand Promacta (**~$13,852/month**) are oral TPO-RA alternatives[44,45]	Nplate modestly less costly than brand Promacta; slightly more than generic eltrombopag	Both Nplate and eltrombopag are FDA-approved for chronic ITP; Nplate (weekly SC injection, clinic-administered) may be preferred in **high thrombosis-risk elderly patients**; generic eltrombopag (oral, daily) is the lower-cost alternative when oral route is feasible; **TPO-RA selection and monitoring requires hematology management**
Brand Danocrine (danazol) — discontinued[48]	Generic **danazol** (**~$114/month**)[48]	N/A — brand discontinued	Generic danazol is a low-cost steroid-sparing alternative; primarily relevant in older adults and VBC frailty contexts; long-term use requires **hepatotoxicity monitoring**

ABBREVIATIONS: IVIg = Intravenous Immunoglobulin; TPO-RA = Thrombopoietin Receptor Agonist; G6PD = Glucose-6-Phosphate Dehydrogenase; ITP = Immune Thrombocytopenia; SC = subcutaneous; IRA = Inflation Reduction Act; MPPP = Medicare Prescription Payment Plan
***Consult FDA labels for the most up-to-date dosage information, contraindications, and drug-drug interactions**

Patient Education and Adherence

- Patient education centers on **bleeding awareness** and **treatment burden**
- Explain which symptoms require **emergency care** — severe headache, blood in urine or stool, uncontrolled bleeding — versus which warrant a **prompt call**: New bruising, gum bleeding, heavy periods
- Discuss treatment-burden trade-offs: **romiplostim** requires **weekly injections**, while **eltrombopag** and **avatrombopag are** oral with differing monitoring — administration route and visit frequency should reflect the patient's preferences
- Acknowledge that **fatigue** is common regardless of platelet count and is a legitimate target of care

DOCUMENTATION REMINDER - SHARED DECISION-MAKING

Record the shared decision: what was discussed (bleeding risk, treatment options, monitoring burden), what the patient preferred, and why the chosen approach (including observation) fits this individual. ASH explicitly bases second-line recommendations on shared decision-making.

Quality Metrics Tie-In

MEASURE/PROGRAM	STANDARD	APPLICABILITY TO ITP
Transitions of Care: Medication Reconciliation Post-Discharge (HEDIS TRC sub-measure 4; MIPS #46)	**Denominator:** patients ≥18 seen in outpatient setting within 30 days of inpatient discharge **Numerator:** discharge medication list reconciled with current medication list documented in outpatient record **Exclusions:** none specified	**Excluding Drug-Induced Mimics:** PCPs must actively screen for drug-induced thrombocytopenia (DITP). High-risk agents (e.g., heparin, sulfonamides, quinine, valproate, or linezolid) introduced during admission must be explicitly evaluated. Reconciliation note must appear in the outpatient record — verbal confirmation at the visit without documentation does not satisfy the measure

MEASURE/PROGRAM	STANDARD	APPLICABILITY TO ITP
Plan All-Cause Readmissions (CMS Stars PCR; MIPS #479)	**Denominator:** enrollees ≥18 with acute inpatient discharge **Numerator:** unplanned readmission within 30 days (lower is better) **Exclusions:** planned readmissions, hospice, psychiatric	**MIPS #479 is group-level only**; individual PCPs cannot submit it directly. ITP bleeding hospitalizations are a primary readmission driver; ensure 5-7 day post-discharge platelet count follow-up is scheduled before the patient leaves the hospital, and document explicit ED-return criteria (platelet threshold, bleeding signs) in the discharge summary
Comprehensive Diabetes Care: Glycemic Status (HEDIS GSD; MIPS #1)	**Denominator:** patients 18-75 with diabetes (≥2 diagnoses on different service dates in measurement period or prior year, or diagnosis + dispensed diabetes medication) **Numerator (inverse):** most recent HbA1c >9.0% or missing during measurement period **Exclusions:** hospice, palliative care, frailty + advanced illness (≥66)	MIPS #1 is an inverse measure — a higher rate indicates worse performance. Corticosteroid-induced hyperglycemia is a direct consequence of high-dose dexamethasone or prednisone induction in ITP. Monitor glucose or HbA1c during and after steroid courses and code any resulting diabetes to specificity (**E08.–** when steroid-induced)
Controlling High Blood Pressure (HEDIS CBP; MIPS #236)	**Denominator:** patients 18-85 with hypertension (≥2 outpatient visits with HTN diagnosis in measurement period or year prior) **Numerator:** most recent BP <140/90 mmHg during measurement period **Exclusions:** ESRD, hospice, palliative care, pregnancy	Corticosteroids elevate BP through fluid retention and increased vascular resistance; fostamatinib also causes hypertension as a class effect in a meaningful proportion of treated patients. Monitor BP at every visit during active ITP therapy and document the medication context when BP is elevated to support accurate clinical decision-making

ABBREVIATIONS: HEDIS = Healthcare Effectiveness Data and Information Set; CMS = Centers for Medicare & Medicaid Services; CDC = Comprehensive Diabetes Care; HBD = HbA1c Control for Patients with Diabetes; BP = Blood Pressure; ITP = Immune Thrombocytopenia; HCC = Hierarchical Condition Category; AWV = Annual Wellness Visit; IRR = Incidence Rate Ratio

QUALITY OUTCOME

There are no ITP-specific HEDIS or Star measures. The outcomes that matter such as fewer bleeding hospitalizations, less steroid toxicity, and avoided readmissions, flow from the same individualized, steroid-sparing care these cross-cutting measures reward. Keeping a patient out of the hospital is the quality goal.

5 CODING REMINDERS AND CASE EXAMPLES

Coding Specificity

ICD-10 CODE	DESCRIPTION	DOCUMENTATION REQUIREMENT
D69.3	Immune (idiopathic) thrombocytopenic purpura - primary ITP	Use **ONLY** after secondary causes excluded (HIV, HCV, H. pylori, drugs, ANA, DAT); document "primary ITP" explicitly
D69.41	Evans syndrome (AIHA + thrombocytopenia)	Document concurrent autoimmune hemolytic anemia and thrombocytopenia with positive DAT
D69.42	Congenital and hereditary thrombocytopenic purpura	Document family history, congenital onset, genetic confirmation
D69.49	Other primary thrombocytopenia	Document a specific primary etiology not documented by **D69.3/.41/.42**; not a catch-all
D69.51	Posttransfusion purpura	Document the temporal relationship to transfusion and immune mechanism
D69.59	Other secondary thrombocytopenia	Document the underlying cause (infection, autoimmune, drug); pair with the etiology/ adverse-effect code (e.g., **T45.1X5A**)
D69.6	Thrombocytopenia, unspecified - AVOID	No HCC, zero RAF under V28. Use only when etiology is genuinely unknown after full workup, and document that the workup was done
D75.822	Immune-mediated heparin-induced thrombocytopenia - CODING TRAP	HIT codes **(D75.821/.822/.829)** carry no HCC under V28. Document heparin exposure, PF4 testing, 4Ts; pair with **T45.515A**

ICD-10 CODE	DESCRIPTION	DOCUMENTATION REQUIREMENT

ABBREVIATIONS: ITP = Immune Thrombocytopenia; HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; V28 = CMS-HCC Model Version 28; AIHA = Autoimmune Hemolytic Anemia; DAT = Direct Antiglobulin Test; HIT = Heparin-Induced Thrombocytopenia; PF4 = Platelet Factor 4; HIV = Human Immunodeficiency Virus; HCV = Hepatitis C Virus; ANA = Antinuclear Antibody

Annual Clinical Review and Confirmation

At each annual visit, complete the following:

- **Confirm the diagnosis on the problem list**, including current status and phase (e.g., chronic, in remission, relapsed)
- **Re-verify the secondary-cause exclusion** — confirm the workup (history, physical, peripheral smear, infectious/autoimmune screening) that ruled out secondary causes is still valid, or document any new findings
- **Document a single summary line** capturing the annual confirmation — e.g., "**chronic primary ITP**, stable on observation, secondary causes previously excluded" — this both reflects the care delivered and supports the diagnosis code
- **Assign the most specific code the record supports**: reserve **D69.6** only for genuinely unknown etiology after a documented workup; code drug-induced or infection-associated cases as **D69.59** with the specific cause named
- **Review and document comorbidities to their highest specificity**, since they reflect the genuine complexity of these patients:
- **Diabetes** (IRR **1.737**)
- **Renal impairment** (IRR **2.057**)
- **Vascular disease** (IRR **1.707**)
- **Confirm the record is accurate, not maximized** — a reviewing clinician should be able to read the note and understand why this patient carries this diagnosis, what was excluded, and how the condition is currently being managed

Good Documentation - EHR Tips

EHR TIP	HOW	WHY IT HELPS
Problem-list specificity	List "primary immune thrombocytopenia **(D69.3)**" rather than "thrombocytopenia"	Prevents the **D69.6** default

EHR TIP	HOW	WHY IT HELPS
Exclusion SmartPhrase	Build a phrase capturing medication review, HIV/HCV, H. pylori, ANA, DAT, and (if ≥60) MDS consideration	Makes the secondary-cause workup visible and defensible in one click
AWV redocumentation prompt	Flag established ITP for status confirmation at every annual wellness visit	Closes the specialist-to-PCP redocumentation gap that drops RAF
Bleeding-severity field	Record wet purpura and ISTH critical-bleed criteria as discrete fields	Documents complexity and supports urgency decisions
Drug-induced linkage	Link culprit drug to **D69.59** with the adverse-effect T-code in the encounter	Avoids misclassifying a secondary cause as primary ITP

ABBREVIATIONS: EHR = Electronic Health Record; ITP = Immune Thrombocytopenia; HCC = Hierarchical Condition Category; RAF = Risk Adjustment Factor; AWV = Annual Wellness Visit; HIV = Human Immunodeficiency Virus; HCV = Hepatitis C Virus; ANA = Antinuclear Antibody; DAT = Direct Antiglobulin Test; MDS = Myelodysplastic Syndrome; ISTH = International Society on Thrombosis and Haemostasis; PCP = Primary Care Physician

Brief Case Examples

SUCCESS - Etiology Specified, Complexity Represented

Patient: Female patient, 74, with chronic primary ITP and atrial fibrillation on apixaban

Documentation: Note records "chronic primary immune thrombocytopenia; secondary causes (HIV/HCV, ANA, drug review) excluded; MDS excluded by marrow biopsy; wet purpura present"

Outcome: Individualized platelet target above 50 x 10^9/L set for anticoagulation; steroid-sparing romiplostim chosen given prior VTE risk; no bleeding hospitalization

RAF Impact: Specified **D69.3** supports HCC 112 (CNA RAF 0.450); diabetes and vascular comorbidities coded to specificity, accurately representing complexity

Documentation as written: "Thrombocytopenia, on prednisone." No etiology, phase, or workup recorded.

PITFALL - Unspecified Coding and Omitted Workup

Consequence: Defaults to **D69.6** - no HCC, zero RAF; a possible drug-induced or MDS cause goes uninvestigated; prolonged steroids risk hyperglycemia and infection

RAF Impact: HCC 112 lost entirely; the patient's true complexity is under-represented and the record is hard to defend on review

Fix: Document type, phase, and exclusion: "primary immune thrombocytopenia, chronic; secondary causes excluded" -> specified code, HCC 112 documented, and a clearer clinical record

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