Serum Testing for Evidence of Mild Traumatic Brain Injury

Policy Number: AHS – G2151 – Serum Testing for Evidence of Mild Traumatic Brain Injury

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Policy Description

Traumatic brain injury (TBI) is characterized by pathologic injuries to the brain resulting from external forces or trauma. A broad range of sequela of varying clinical severity include focal contusions and hematomas, diffuse axonal injury, cerebral edema and swelling, and a cascade of molecular injury mechanisms (Rajajee, 2018).

Concussion refers to the trauma-induced alteration in mental status, which may or may not involve loss of consciousness, after a mild TBI (Evans & Whitlow, 2018).

Related Policies

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Indications and/or Limitations of Coverage

Application of coverage criteria is dependent upon an individual’s benefit coverage at the time of the request.

Measurement of the blood markers for the evaluation of mild traumatic brain injury also known as concussion markers, including S100B, GFAP, and UCH-L1, is EXPERIMENTAL AND INVESTIGATIONAL. This also includes proprietary panel tests and kits, including Banyan BTI™.

Scientific Background

Traumatic brain injury (TBI) is an expanding public health epidemic, with at least 2.4 million emergency department visits, hospitalizations, or deaths related to a TBI occurring in 2009 (Wright, Kellermann, McGuire, Chen, & Popovic, 2013). Although approximately 75% of TBIs are mild, TBI can adversely affect a person’s quality of life in numerous ways, including cognitive functioning, emotional functioning, and physical effects (CDC, 2015; Wright et al., 2013). The CDC estimated 5.3 million U.S. residents are living with TBI-related disabilities, including long-term cognitive and psychologic impairments in 2001 (Selassie et al., 2008).
Accurate diagnosis of TBI is critical to effective management and intervention but can be challenging due to the nonspecific and variable presentation (Mondello et al., 2017). Tools available to objectively diagnose injury and prognosticate recovery are limited (Mannix, Eisenberg, Berry, Meehan, & Hayes, 2014). Clinical assessment usually includes a neurological exam, followed by a computed tomography (CT) scan of the head to detect brain tissue damage that may require treatment (FDA, 2018). However, as most patients with mild TBI do not have detectable intracranial lesions on a CT scan (Evans & Whitlow, 2018), this assessment relies heavily on nonspecific symptoms that can vary widely and ignores the mechanistic heterogeneity of TBI (Rajajee, 2018).

Brain damage in TBIs is initially caused by external mechanical forces being transferred to intracranial contents, generating shearing and strain forces which stretch and damage axons, and can result in contusions, hematomas, cerebral edema and swelling. Common mechanisms include direct impact, rapid acceleration/deceleration, penetrating injury, and blast waves. However, the pathophysiology of TBI is now understood to include not only the acute event, but also the resulting cascade of molecular injury mechanisms that are initiated at the time of initial trauma and continue for hours or days (Rajajee, 2018). The pathophysiology of even mild TBI is complex and may include both focal and diffuse injury patterns. Neuropathological changes found after mild TBI indicate mild multifocal axonal injury, including altered circuit dysfunction and traumatic axonal injury (Truettner, Bramlett, & Dietrich, 2018).

Cell death and the initiation of local metabolic and inflammatory processes resulting from TBI results in the release of a number of inflammatory mediators and damage-associated molecules that are able to cross a dysfunctional blood-brain barrier (Di Battista et al., 2015) or enter the circulation through the glymphatic pathway (Plog et al., 2015). Neurobiochemical marker levels in blood after TBI may reflect structural changes detected by neuroimaging (Mondello et al., 2017). Simpler, sensitive, and specific tests that provide early, quantitative information about the extent of brain tissue damage, identifying and stratifying TBI, would allow rapid and tailored diagnosis of TBI, while minimizing the time, risk, and cost associated with current standards (McMahon et al., 2015). No single ideal TBI biomarker exists (Halford et al., 2017). However, brain-specific markers of neuronal, glial, and axonal damage, identified in the peripheral blood, have shown potential clinical utility as diagnostic, prognostic, and monitoring adjuncts and have been investigated both individually and in combination (Di Battista et al., 2015; Mondello, Jeromin, et al., 2012). Acute-phase biomarkers, including S100 calcium-binding protein B (S100B), glial fibrillary acidic protein (GFAP), and ubiquitin C-terminal hydrolase-L1 (UCH-L1), have shown potential for use in initial screening of patients presenting with head trauma, the vast majority of whom will have normal brain CT findings (Evans & Whitlow, 2018; Maas et al., 2017).
Clinical Utility and Validity

**S100 calcium-binding protein B (S100B)** belongs to the calcium binding EF-hand protein group, and it has been associated with cytoskeleton structure, Ca\(^{2+}\) homeostasis, cell proliferation, protein phosphorylation and degradation (Chmielewska et al., 2018; Strathmann, Schulte, Goerl, & Petron, 2014). S100B is expressed in the cytoplasm and the nucleus of astrocytes and is present in the bloodstream when the bloodbrain barrier is disrupted. Several studies indicate that S100B measurement, either acutely or at several time points, can distinguish injured from non-injured patient (Strathmann et al., 2014) and guidelines intended to reduce the need for CT scan using S100B levels in the blood for the initial management of mild TBI have been published (Ingebrigtsen, Romner, & Kock-Jensen, 2000). These guidelines were recently validated in a large multicenter study where S100B was found to have a sensitivity of 97% and a specificity of 34% for the identification of intracranial hemorrhages confirmed by CT scans. The authors estimated CT scans would have been reduced by 32% with application of these guidelines (Unden, Calcagnile, Unden, Reinsstrup, & Bazarian, 2015). Although it has not been FDA approved, in 2008 the American College of Emergency Physicians suggested that in mild TBI patients without significant extracranial injuries and a serum S100β of level less than 0.1μg/L measured within 4h of injury, consideration could be given to not performing a CT (Jagoda et al., 2008). However, other investigators have failed to detect associations between S100B with CT abnormalities (Piazza et al., 2007). Additionally, it has limited utility in multiple trauma setting as it is not brain-specific. S100B can be found in non-neural cells, such as adipocytes, chondrocytes, and melanocytes (Chmielewska et al., 2018; Papa et al., 2014), and its levels are also elevated in trauma without head injury (Anderson, Hansson, Nilsson, Dijlai-Merzoug, & Settergren, 2001). However, recent data highlight the inclusion of S100B in sets of markers that in combination could contribute to better diagnosis, monitoring, and treatment of CNS conditions (Chmielewska et al., 2018).

**Glial Fibrillary Acidic Protein (GFAP)** is a filament protein that maintains cell shape and structure, coordinates cells’ mobility and contributes to the transduction of molecular signals in astrocytes. It is released upon cellular disintegration and degradation of the astrocyte. Concentration of serum GFAP increases after neural trauma and TBI (Chmielewska et al., 2018). GFAP measurements have provided promising data on injury pathway indication, focal versus diffuse injuries, and prediction of morbidity and mortality (Strathmann et al., 2014). GFAP level was increased in patients with CT-positive scans for intracranial lesions compared to CT-negative scans after mild TBI (Lei et al., 2015). Sensitivities have been reported between 67% and 100% while the specificities ranged from 0% and 89% (Mondello et al., 2017).

McMahon et al (2015) performed a multicenter trial to evaluate GFAP and its breakdown product GFAP-BDP in the diagnosis of intracranial injury. They found that “GFAP-BDP demonstrated very good predictive ability (area under the curve=0.87) and demonstrated significant discrimination of injury severity (odds ratio, 1.45; 95% confidence interval, 1.29-1.64)”. The authors concluded that “use of GFAP-BDP yielded a net benefit above clinical screening alone and a net reduction in unnecessary scans by 12-30% (McMahon et al., 2015).”

**Ubiquitin C-terminal Hydrolase-L1 protein (UCH-L1)**, is a cytoplasmic enzyme, highly enriched and specifically expressed in neurons, involved in the ubiquitinoylation of abnormal proteins destined for proteasomal degradation (Halford et al., 2017). It is also an important element of axonal transport and, by a strong interaction with cytoskeleton proteins, plays an important role in the axon’s integrity (Chmielewska et al., 2018). UCH-L1 has been shown to increase after TBI as well as correlate with TBI severity and abnormal CT findings (Diaz-Arrastia et al., 2014). High prognostic value of poor outcome was found at both 3-months (Diaz-Arrastia et al., 2014) and 6-months intervals (Mondello, Akinyi, et al., 2012). Two recent studies report the same sensitivity of 100% and specificities of 21% and 39% (Mondello et al., 2017).

Welch et al (2016) evaluated three serum biomarkers’ (glial fibrillary acidic protein [GFAP], ubiquitin C-terminal hydrolase-L1 [UCH-L1] and S100B measured within 6h of injury) ability to differentiate CT-negative and CT-positive findings. They found that “UCH-L1 was 100%
sensitive and 39% specific at a cutoff value >40 pg/mL. To retain 100% sensitivity, GFAP was 0% specific (cutoff value 0 pg/mL) and S100B had a specificity of only 2% (cutoff value 30 pg/mL). All three biomarkers had similar values for areas under the receiver operator characteristic curve: 0.79 for GFAP, 0.80 for UCH-L1, and 0.75 for S100B. Neither GFAP nor UCH-L1 curve values differed significantly from S100B. In our patient cohort, UCH-L1 outperformed GFAP and S100B when the goal was to reduce CT use without sacrificing sensitivity. UCH-L1 values <40 pg/mL could potentially have aided in eliminating 83 of the 215 negative CT scans (Welch et al., 2016).” However, the authors note that further research is needed.

Banyan BTITM (Brain Trauma Indicator BTI) from Banyan Biomarkers, Inc. is a proprietary blood test available for clinical measurement of mild TBI. The Banyan BTI is an in vitro diagnostic chemiluminescent enzyme-linked immunosorbent assay (ELISA). The test consists of two kits which provide a semi-quantitative measurement of the concentrations of UCH-L1 and GFAP from serum collected within 12 hours of suspected head injury. Results from the test should be interpreted according to the table provided by the manufacturer. The cut-offs for UCH-L1 and GFAP are 327 pg/mL and 22 pg/mL respectively (Banyan, 2016).

The Banyan BTI test was validated with a sample of 1947 patients. Of these 1947 patients, 120 had positive CT scans, and 117 of these 120 patients tested positive by Banyan BTI (97.5% sensitivity). Of the remaining 1827 patients that tested negative, 666 tested negative by Banyan for a specificity of 36.5%. A total of 669 patients had negative Banyan results, so the negative predictive value was 99.6% (Banyan, 2016).

Another proprietary test for TBI has been designated as a “Breakthrough Device” by the FDA. The Tbit platform by BioDirection uses nanowires to detect specific protein molecules that are characteristic of TBI. This platform measures S100B and GFAP in the bloodstream. The manufacturer claimed a sensitivity of 100% and specificity of 41% on a sample of 100 patients (BioDirection, 2015, 2017). They claim, “The Tbit System is designed to measure the body’s response to trauma and provide a rapid point-of-care test result in less than 2 minutes from a single drop of blood, while current technology may run 3-4 hours or more and require serum testing in a central laboratory (Densford, 2019).”

**Guidelines and Recommendations**

**American College of Emergency Physicians** (Jagoda et al., 2008) recommended in mild TBI patients without significant extracranial injuries and a serum S100β of level less than 0.1μg/L measured within 4 h of injury, consideration could be given to not performing a CT.

**Centers for Disease Control** (CDC, 2016) reaffirmed the 2008 ACEP recommendation in 2016.

**The Veterans Administration and Department of Defense (VA/DoD, 2016)** Practice Guideline for the Management of Concussion – mild Traumatic Brain Injury states that:

“Excluding patients with indicators for immediate referral, for patients identified by post-deployment screening or who present to care with symptoms or complaints potentially related to brain injury, we suggest against using the following tests to establish the diagnosis of mTBI or direct the care of patients with a history of mTBI:

a. Neuroimaging

b. Serum biomarkers, including S100 calcium-binding protein B (S100-B), glial fibrillary acidic protein (GFAP), ubiquitin carboxyl-terminal esterase L1 (UCH-L1), neuron specific enolase (NSE), and α-amino-3-hydroxy-5- methyl-4-isoxazolepropionic acid receptor (AMPAR) peptide

c. Electroencephalogram (EEG)”
Eastern Association for the Surgery of Trauma (Barbosa et al., 2012) state that “Biochemical markers such as S-100, neuron-specific enolase, and serum tau should not be routinely used in the clinical management of patients with MTBI except in the context of a research protocol.”

The consensus statement from American College of Sports Medicine (ACSM), American Academy of Family Physicians (AAFP), American Academy of Orthopedic Surgeons (AAOS), American Medical Society for Sports Medicine (AMSSM), American Orthopedic Society for Sports Medicine (AOSSM), and the American Osteopathic Academy of Sports Medicine (AOASM) (Herring et al., 2011) states that: “Investigation in the area of biomarkers (e.g., S-100 proteins, neuron specific enolase, tau protein) is inconclusive for identifying individuals with concussion and represents research that may one day be clinically applicable.”

Guidelines from The Brain Trauma Foundation (Carney et al., 2016), and the American Academy of Neurology (Giza et al., 2013) make no recommendation for or against any serum biomarkers of traumatic brain injury.

Concussion in Sport Group (CISG, 2017)

The Group states that fluid biomarkers are “important research tools” but need further validation and research to determine their clinical utility (CISG, 2017).

Brain Trauma Foundation (2014)

The Foundation states that, although biomarkers are promising, there is not enough conclusive evidence to support their use (Foundation, 2014).

American Academy of Pediatrics (AAP, 2018)

The AAP acknowledges that biomarkers such as "S100β, glial fibrillary acidic protein, neuron-specific enolase, τ, neurofilament light protein, amyloid β, brain-derived neurotrophic factor, creatine kinase and heart-type fatty acid binding protein, prolactin, cortisol, and albumin” have all been investigated in concussion evaluation, but none of these biomarkers have been used in clinical settings (AAP, 2018).

State and Federal Regulations, as applicable

On Feb 14, 2018 the U.S. Food and Drug Administration approved marketing of the first blood test, Banyan BTI™ (Brain Trauma Indicator BTI) from Banyan Biomarkers, Inc. as part of its Breakthrough Devices Program. This test’s purpose is to evaluate mild traumatic brain injury (mTBI), commonly referred to as concussion, in adults. The test is approved to be used, along with other available clinical information, as an aid in the evaluation of patients 18 years of age and older with suspected traumatic brain injury (Glasgow Coma Scale score 13-15). A result from this test is associated with absence or presence of acute intracranial lesions visualized on a head CT (computed tomography) scan (FDA, 2018).

Applicable CPT/HCPCS Procedure Codes

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<td>81479</td>
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Evidence-based Scientific References


doi:10.1177/0271678x17724681

doi:10.1249/MSS.0b013e3182342e64


doi:10.1016/j.annemergmed.2008.08.021


doi:10.1016/s1474-4422(17)30371-x

doi:10.1089/neu.2013.3265

doi:10.1227/NEU.0b013e318236a809


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