

NEWSLETTER



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A MESSAGE FROM THE PRESIDENT

ADITYA PANDEY, MD

Dear Colleagues,

I am thrilled to share exciting updates from the Michigan Association of Neuro Surgeons (MANS) as we continue to grow and enhance our educational and networking opportunities for the neurosurgical community.

Our 3rd Annual Surgical Techniques and Career Development (STCD) Meeting on May 10, 2025, was a huge success. This is a FREE event and open to all neurosurgery residents, advanced practitioners, and medical students. Attendees had the opportunity to learn from leading faculty experts and MANS board members while engaging in hands-on lab demonstrations featuring the latest neurosurgical technology. Mark your calendar for this 2026 event – May 9, 2026, Novi, MI.

We are excited to invite you to the 43rd Annual MANS Summer Meeting, taking place August 8-10, 2025, at the Grand Hotel on Mackinac Island. This event will feature discussions, networking, and professional development opportunities.

Highlights include:

- **Sip N Sail Sunset Cruise** – A scenic networking event to connect with colleagues in a relaxed atmosphere.
- **Interactive Exhibit Hall** – Filled with engaging opportunities and industry insights.
- **Controversial Panel Discussions** – Addressing the latest and most debated topics in neurosurgery.
- **Honored Guest Speakers** – Dr. Elad Levy, Dr. Kevin Foley and Dr. Paul Park, three distinguished figures in our field.
- **Welcome Reception, Dinner, and Motivational Presentation** – A special evening to kick off the conference with inspiration and camaraderie.

To further enhance our educational offerings, we are hosting two specialized breakout sessions:

- **Advanced Practitioner Session** – Focused on critical topics relevant to our Advanced Practitioner colleagues.
- **Resident Board Prep & Employment Readiness** – A session dedicated to preparing residents for the board exams and next steps in their careers.

We encourage you to invite your residents and APs to participate in these exciting events and opportunities. Your engagement is what makes MANS a thriving association.

Register Now!

The Grand Hotel and the Entire Mackinac Island has limited Hotel Rooms. Hotels are selling out fast!



Aditya Pandey, MD

MICHIGAN ASSOCIATION OF NEURO SURGEONS

A BASIS FOR HOPE AND OPTIMISM IN GLIOMA THERAPY

BY ARUSHI TRIPATHY MD, CYLAINA BIRD MD, ARMIN MORTAZAVI MD,
EDWIN NIEBLAS-BEDOLLA MD, WAJD N AL-HOLOU, MD

As Neurosurgeons, we have seen significant advancements in surgical resection techniques, yet despite maximal resection these tumors rapidly recur after surgery. Our current standard of care treatment is a combination of temozolomide and radiation, which is based on the Stupp protocol published in 2005. Yet, since 2005 very little has changed, and most other drug therapies studied in clinical trials have failed. Thankfully this past year a new drug was finally approved for gliomas.

In August of 2024, the FDA approved the IDH-mutant inhibitor, vorasidenib, for adults and children aged 12 and older with grade 2 IDH mutant astrocytomas or oligodendrogliomas, following surgery, based on results of the INDIGO trial. Patients treated with vorasidenib had a median progression-free survival of 27.7 months, compared to 11.1 months for those receiving a placebo. This approval highlights the clinical significance of IDH-mutant inhibitors for managing patients with tumors that have undergone complete resection or have residual or recurrent disease.

GLIOMAS ARE
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DIPG/DMG Tumors

Historically, diffuse intrinsic pontine gliomas (DIPG), now known as diffuse midline gliomas (DMG), had a dismal prognosis of 12 months or less. However, a recent published analysis of a Phase 1 study of patients with H3K27mutated DMG tumors receiving the drug ONC201 has given the field of Neuro-Oncology new hope. In this study led by the University of Michigan team, they found that patients receiving ONC201 immediately after radiation had a median overall survival of 21.7 months as compared to the poor survival of less than 12 months for historical controls. As a result of these exciting results, the Phase 3 ACTION Clinical trial is now enrolling.

Can we Target Tumor Metabolism

A common question that patients often ask is whether they can alter their diet to “starve the tumor.” Well now, thanks to work being done intra-operatively at the University of Michigan led by Wajd Al-Holou, Daniel Wahl, and Deepak Nagraath, we can now precisely determine what metabolites brain tumors require to grow and survive. This team established the first in human brain cancer isotope tracing program. This work has identified metabolic pathways that are vulnerable in high grade gliomas that can be specifically targeted to create novel therapeutic treatments for these lesions. Specifically, the team identified that minimizing serine in the diet actually causes tumors to shrink. As a result, they are developing a clinical trial to target serine metabolism in gliomas.

New Advances in Intraoperative Decision Making

Based on work done at the University of Michigan in collaboration with the University of California San Francisco, Todd Hollon’s team recently introduced FastGlioma, a cutting-edge artificial intelligence driven visual foundation model that enables rapid and accurate detection of glioma infiltration in fresh, unprocessed surgical tissue within minutes. This work, published in the prestigious journal Nature. Trained on millions of label-free optical microscopy images, this model demonstrated exceptional performance and offers promising potential for artificial intelligence in enhancing neurosurgical care.



MICHIGAN ASSOCIATION OF NEURO SURGEONS

MEDIUM VESSEL OCCLUSION (MEVO) THROMBECTOMY: END OF THE ROAD, OR START OF AN ERA BY DR. GARY RAJAH (MUNSON MEDICAL), DR. FAZEEL SIDDIQUI & DR. SRAVANTHI KODURI (UNIV. OF MICHIGAN)

What if I told you that one of the most beneficial modern surgical procedures, perhaps ever, was almost disregarded after several randomized trials failed to demonstrate safety and efficacy in the interventional arm...would you believe me? Had it not been for a few proceduralists and surgeons willing to re-evaluate the technique, revisit the tools, reconsider the indications, engage in difficult conversations with patients and families during informed consent about what we can do, what our beliefs or experiences suggest, while also contrasting that with current data, and ultimately taking a professional risk on behalf of the patient, not the statistic...perhaps mechanical thrombectomy for large vessel occlusions would have never existed.

We all know that no randomized controlled trial (RCT) is perfect. However, when they fail to demonstrate a benefit, they can have severe consequences. Most neurosurgeons and interventionalists remember the fallout from the ARUBA trial for AVMs.

Doctors can agree that if a therapy doesn't help and causes risk or injury, it should not be performed or offered. However, we rarely have such a clear answer. What if the procedure may help, but there are risks? What if studies say there is equipoise with medical management; does "no better" than medical management mean: it did not help anyone? Or that it didn't help more than the medical treatment group on average out of hundreds of people....which still means maybe it did help selective individual patients. This is, of course, a difficult way to look at randomized data, as for anyone who has gone to medical school, it's all or nothing, significant or not.

MEVO occlusion thrombectomy is at a crossroads. This comes only 10 years after the pivotal trials, which included no fewer than 7 RCTs, confirmed starting in 2015 that mechanical thrombectomy for large vessel occlusions (LVO) was safe and effective for proximal anterior circulation occlusions (MCA M1, ICA terminus) within 6 hours. These trials paved the way for extending intervention windows of up to 24 hours in 2018, with the Dawn and Defuse 3 trials. The NNT for LVO thrombectomy improvement is typically between 2.8 and 8, depending on the study and parameters. One of the lowest NNTs in procedural history; yet, in 2013, three RCTs found no benefit in outcomes over medical management for LVO treated with thrombectomy. 2013 possibly spelled an early death for this new therapy, which, only 2 years later, went on to become the standard of care as we know it. In 2013, IMS-III, SYNTHESIS, and MR RESCUE trials failed to show a benefit for mechanical thrombectomy over medical care. This was coupled with the fact that IV-TPA was already hailed as the holy grail of stroke treatment since the 1990s, despite the widely ignored fact that it only reduced death and disability by 13% in those studies.

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A NIGHT TO REMEMBER ON MACKINAC ISLAND

Join us for an unforgettable evening on the water. Set sail aboard a private charter and experience the magic of a Mackinac Island sunset while enjoying drinks, live music, hors d'oeuvres, and great company.

Relax and unwind as you take in breathtaking views of the historic landmarks and the iconic Mackinac Bridge, all bathed in the warm glow of the setting sun. Whether you're catching up with colleagues, networking with peers, or simply soaking in the beauty of Northern Michigan, this cruise promises to be a highlight of the weekend. Registration to the meeting is required to add this event option on.

Limited seating is available so register you and your guest(s) now.

Scan the QR Code to Register now to secure your spot at this exclusive add on event to your meeting registration.

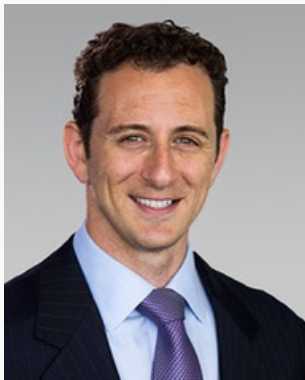


MICHIGAN ASSOCIATION OF NEURO SURGEONS

MEET OUR KEYNOTE SPEAKERS
2025 SUMMER MEETING

Kevin Foley, MD a professor in the Departments of Neurosurgery and Orthopaedic Surgery & Biomedical Engineering at the University of Tennessee Health Science Center in Memphis, TN. He received his medical and neurosurgical training at the UCLA School of Medicine, after which he served in the United States Army Medical Corps. Since leaving the military, Dr. Foley has been a full-time practicing neurosurgeon at Semmes Murphey Clinic, where he is chairman of the board, and has been actively involved in teaching, research and product development. His areas of interest include minimally invasive surgery, image-guided navigation, robotics, biomechanics, disc regeneration, and clinical outcomes.

Paul Park, MD is presently at the Semmes-Murphey Clinic in Memphis and is a Professor of Neurosurgery as well as the Director of Spinal Surgery at the University of Tennessee Health Science Center. He was born in Los Angeles, CA and attended UCLA for college where he earned his bachelor's and master's degrees in biology. Dr. Park subsequently obtained a MD degree from the UofM and completed a neurosurgical residency at the UofM. He completed an enrolled fellowship at the Cleveland Clinic Spine Institute as well as a post-residency fellowship in minimally invasive spinal surgery at the Semmes-Murphey Clinic. Until recently, he was Professor of Neurosurgery as well as the Director of the Spine Program and Spine Fellowship Director at the UofM in Ann Arbor, where he practiced for 17 years.



Elad Levy, MD, MBA Professor and Chair of Neurosurgery and the L. Nelson Hopkins Endowed Chair of the Department of Neurosurgery at the State University of New York Buffalo and awarded Distinguished Professor. He has served on the Congress of Neurological Surgeons Executive Committee since 2007 and is the past president of the CNS Foundation; he has helped develop multiple global philanthropic initiatives. He currently serves as President of the CNS and Vice Chair of the American Board of Neurological Surgery and as the Endovascular Section Editor for Neurosurgery. His clinical and research interests are focused on treatment of cerebrovascular diseases, specifically aneurysm and stroke. He received the Drake Lectureship Award in 2024, and received the Dacey Medal for Outstanding Cerebrovascular Research and the Duke Samson Award for his groundbreaking work on the COMMAND trial.

Invite Your Residents & APPs

Discounted Registration for Advanced Practitioners.

We have breakout sessions planned specifically for APPs, focused on critical topics relevant to the APP community.

Resident Board Prep & Employment Readiness.

Breakout sessions dedicated to preparing residents for oral board exams and next steps in their careers.

HANDS-ON LEARNING AT THE MAY 10, 2025 SURGICAL TECHNIQUES & CAREER DEVELOPMENT EVENT

Date: May 10, 2025

Location: Henry Ford Providence Hospital, Van Elslander Surgical Center, Novi, MI

The Michigan Association of Neurosurgeons (MANS) hosted its annual Surgical Techniques & Career Development event on May 10, 2025, bringing together neurosurgery residents, faculty, and industry leaders for a dynamic day of hands-on learning.

The event featured concise, high-impact lectures followed by an immersive cadaver lab where attendees rotated through stations focused on Tumors, Spine, Trauma, Endovascular, and Endoscopic procedures. This format allowed participants to practice real-world techniques in a collaborative, low-pressure environment.

A HUGE THANK YOU

A huge thank you goes out to Joe, Vanessa, and the entire team at Henry Ford Health – Providence VESIC Lab, whose outstanding support and coordination made the lab experience possible. We're also grateful to our vendor partners for their exceptional engagement—many went beyond exhibiting and assisted directly at the lab stations, offering equipment, tools, and hands-on guidance.

With high participation and enthusiastic feedback, this year's event marked another step forward in our commitment to supporting neurosurgical education and professional development in Michigan.

Our 2025 Vendor Support

- Aesculap, Inc
- Globus Medical
- J&J Med Tech
- KLS Martin
- LivaNova
- Medtronic
- Raumedic
- Rosman Search
- SI-Bone
- Stryker
- Synergy Surgical



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MEDIUM VESSEL OCCLUSION (MEVO) THROMBECTOMY: END OF THE ROAD, OR START OF AN ERA BY DR. GARY RAJAH (MUNSON MEDICAL), DR. FAZEEL SIDDIQUI & DR. SRAVANTHI KODURI (UNIV. OF MICHIGAN)

In just two short years, LVO thrombectomy has gone from being no better than medical care to the new standard of care. This was due to surgeons and proceduralists who had achieved good outcomes with patients, worked towards better patient selection, utilized improved catheter technology, paid careful attention to time parameters, and employed new devices to drive this change.

Medium vessel occlusions, such as MCA M2/3, PCA P1-3, and ACA A1-3, currently remain a hot topic in the field. Prospective and retrospective data have shown benefits, particularly in terms of excellent functional outcomes (mRS 0-1). Currently, MEVO thrombectomy is experiencing its own 2013. ESCAPE-MEVO, DISCOUNT, and DISTAL RCTs, all published in 2024-2025, found MEVO thrombectomy to be no better than current medical management. No additional clinical benefit was seen over medical management. ESCAPE-MEVO had higher mortality in the thrombectomy arm compared to medical management (13.3% vs 8.4%). DISTAL showed no significant difference in mortality (15.5% vs 14%) compared to the medical arm. And although DISCOUNT showed lower mortality in the thrombectomy group (3%) vs the medical arm (7%), this was despite higher rates of hemorrhage. This suggests hemorrhage is not the driver of mortality in this MEVO study.

Unfortunately, MEVO occlusions are very common, making up 25-40% of acute strokes. Despite typically having less severe symptoms and lower NIHSS, MEVO strokes still result in 1/3 of patients not achieving functional independence at 90 days. Mortality remains high, even with the best medical management, at around 8-13%. If the MEVO studies of 2024-2025 taught us anything, it would be that medical management arms still have high mortality, up to 15%. Many patients may not be candidates for IV-TNK or TPA due to the concurrent use of anticoagulation. IV lytics (TNK/TPA) alone fail to recanalize MEVOs 50-60% of the time.

Thus, MEVOs are not a benign process; should be given every bit of attention and thought as LVOs, and deserve further study. Critics and supporters alike would point to several limitations of the recent MEVO thrombectomy RCTs.

“MANY OF LIFE’S FAILURES ARE PEOPLE WHO DID NOT REALIZE HOW CLOSE THEY WERE WHEN THEY GAVE UP, THOMAS EDISON”

High-quality data currently exist for M2 occlusion MCA thrombectomy, based on post-hoc analysis of previous LVO studies. A clear benefit for M2 MCA thrombectomy exists, despite its lack of a dedicated randomized controlled trial (RCT). This has led some investigators to believe there may not be true equipoise in MEVO care, depending on location. This, coupled with the advent of numerous catheters and devices tailored for medium vessels, could have created bias, in that some centers took patients with more severe deficits for thrombectomy outside of the trials instead of randomizing them, potentially risking the medical management arm. Thus, more mild MEVO strokes were included in the recent studies. NIHSS scores included in the studies were greater than 4-5, with an average of around 8. Real-world MEVO registries have reported NIHSS scores ranging from 10 to 18. Aspiration thrombectomy, also known as contact aspiration, was underrepresented in these studies, while stent retrievers were more frequently used. This could have resulted in slightly higher symptomatic ICH rates than previously seen. Distal vessels are 1: small, thin, tortuous, and 2: in the subarachnoid space with small parenchymal perforators which can be pulled from the pia. This differs from the thicker, larger proximal vessels, making the procedure more fragile. Close to half of the included patients in these studies had pre-morbid disability, which was in stark contrast to the original LVO studies in 2015. When dealing with lower NIHSS scores, pre-existing deficits can significantly complicate the picture. IV lytic administration appeared to outperform real-world studies in terms of administration rates in the recent MEVO studies. The three studies for MEVO had roughly a 60-70% administration rate, while real-world data suggest rates of 20-40% for IV lytics. The median age was also 74-77 for these recent studies, which, compared to MEVO registries (67-71), was older. Lower revascularization rates were also noted compared to real-world data (70-75% vs 85%). Recanalization of the occlusion is paramount to see the clinical benefit. Lastly, the outcome measure itself, the mRS score, is clumsy and better suited to LVO studies.

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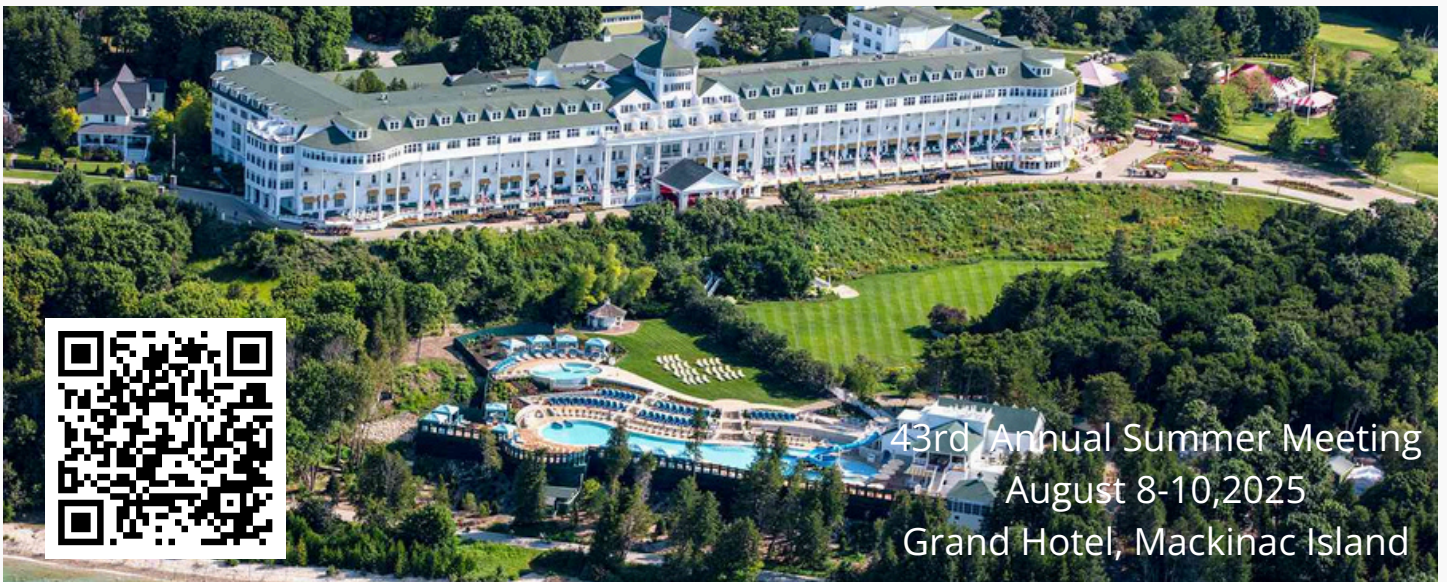
MEDIUM VESSEL OCCLUSION (MEVO) THROMBECTOMY: END OF THE ROAD, OR START OF AN ERA BY DR. GARY RAJAH (MUNSON MEDICAL), DR. FAZEEL SIDDIQUI & DR. SRAVANTHI KODURI (UNIV. OF MICHIGAN)

MEVOs typically have more focal deficits, which scoring systems like NIHSS and mRS struggle to capture. Thus, better outcome measures for specific vessel territories are necessary for MEVO care assessment, much like focused cognitive tests.

More MEVO studies are forthcoming, but many of the issues we discussed above will be challenging to rectify, particularly bias, if the proceduralist or surgeon does not genuinely believe there is true equipoise. Consider a patient with a high NIHSS, such as 10–20, in a retrievable location based on anatomy, as determined by CTA and surgeon experience, in the setting of atrial fibrillation (ICAD is a separate topic), in a patient who can't receive IV TNK, and is young. This maybe a patient most could agree would benefit from MEVO thrombectomy. Currently, guidelines from AHA/Stroke suggest level 2b evidence for MEVO thrombectomy, saying it may be reasonable for M2/3 location MEVO/DVO. MEVO can be difficult to visualize on CTA alone, especially with anatomic variations, such as MCA trifurcations, which can add complexity to the decision-making and diagnosis. CTP can be helpful in this regard, as it will not miss a perfusion deficit of 30–50 cc or greater.

In summary, MEVO thrombectomy is becoming more common, but at a tipping point similar to that of 2013 for LVO thrombectomy. There must be careful consideration of the facts, personal experience of experts, and all the factors we have discussed above to ensure patients are given fair and informed consideration of thrombectomy, especially with higher NIHSS or functional deficits, while also being protected from unnecessary procedural risk. MEVO thrombectomy remains a very tailored, personalized decision between specialists and patients that should be used cautiously.

REGISTER NOW



43rd Annual Summer Meeting
August 8-10, 2025
Grand Hotel, Mackinac Island

THE GRAND HOTEL ROOMS ARE ALMOST SOLD OUT

Once you register for the summer meeting, you will get a confirmation email with the discounted hotel room options on the island.

We look forward to seeing you this summer!

MICHIGAN ASSOCIATION OF NEURO SURGEONS

MIDDLE MENINGEAL ARTERY EMBOLIZATION IS REVOLUTIONIZING CHRONIC SUBDURAL HEMATOMA MANAGEMENT

BY JEFFREY TURNBULL, DO AND BOYD RICHARDS, DO

A revolution is transforming one of neurosurgery's most familiar battlegrounds. Chronic subdural hematoma (cSDH)—a condition every neurosurgeon encounters—have long been difficult to manage thanks to the patient population and the high incidence of recurrence.

However, middle meningeal artery embolization is transforming the way we care for these patients. What was once an experimental adjunct is also becoming a front-line therapy for some patients, and its implications are profound. With an aging population and an incidence as high as 79.6 cases per 100,000 in some demographics, cSDH poses a growing challenge. Estimates project that by 2030, over 60,000 Americans annually will face this diagnosis. Traditionally, surgical evacuation—via burr holes, craniotomies, or twist-drill techniques—has been the mainstay of treatment. However, recurrence rates and repeat surgeries have long plagued neurosurgeons. Enter MMA embolization: a minimally invasive, endovascular strategy that directly targets the fragile neovasculature driving hematoma persistence and recurrence.

By occluding the vascular supply feeding the pathological membranes, MMAe interrupts the inflammatory cycle and facilitates natural resorption. What's more, it does so with a favorable safety profile, and without the need to interrupt antiplatelet or anticoagulant therapy—making it a compelling option for elderly or high-risk patients.

At our center, MMAe is no longer a rare consideration—it's part of the standard cSDH protocol. Whether following surgical drainage or as a stand-alone treatment, MMA embolization is proving to be a game changer. We tailor our embolization approach based on operator preference

“AT OUR CENTER, MMAE IS NO LONGER A RARE CONSIDERATION—IT'S PART OF THE STANDARD CSDH PROTOCOL”

and patient anatomy, employing particle embolics like Embospheres® or PVA particles, as well as glue and coil combinations for more durable occlusion. While the ideal embolic strategy remains an open question, they have all proven to be very effective in treating cSDH.

And this shift is more than anecdotal. A growing body of evidence—ranging from single-center series to meta-analyses—is highlighting MMAe's ability to reduce recurrence rates, shorten hospital stays, and minimize surgical morbidity.

As multicenter, randomized trials begin to take shape, the neurosurgical community stands at the threshold of a major treatment paradigm shift. MMA embolization isn't just here to stay—it's poised to become a part of standard in cSDH management.

For neurosurgeons navigating the complexities of an aging population and recurrent subdurals, this technique offers something truly rare: the promise of a simpler, safer, and more effective way forward.

The 2025 Congress of Neurological Surgeons 75th Annual Meeting



Member Milestones & Legacy

Karin M. Muraszko, MD Honor Your Mentor Fund

Lynda Yang, MD, PhD Fund

Jack P. Rock Fund

Justin A. Singer, MD Memorial Fund

Transitions & Tributes

These esteemed professionals exemplify the growth and excellence within Michigan's neurosurgical community.

Dr. Michael Karsy joins University of Michigan Sparrow/Ann Arbor in July 2024

Dr. Nasser Yaghi joins University of Michigan Sparrow/Ann Arbor in July 2024

Dr. Badih Daou joins University of Michigan Sparrow/Ann Arbor in July 2024

Dr. Christian Bowers joins Hurley Medical Center in 2024

Dr. Meic Schmidt joins MyMichigan Medical Center Saginaw in March 2025

Dr. Dylan Goodrich joins MyMichigan Health Midland in July 2024

Dr. Neil Klinger joins Munson Neurosurgery in August 2024

Dr. Elizabeth Hogan joins Marquette's Brain and Spine Center in 2023

Dr. Brian Fiani returns to Michigan and joins Mendelson Kornblum Orthopedics and Spine Specialists in 2023

Dr. Chad Claus joined Michigan Spine and Brain Surgeons in 2024

Dr. Jake Jasinski will be joining Michigan Spine and Brain Surgeons in July 2025

Dr. Ryan Urbonas joined Munson Neurosurgery in April 2025

Dr. Timothy Yee joined University of Michigan in August 2024

Dr. Michael Cloney joined University of Michigan in August 2024

Dr. Noojan Kazemi joined University of Michigan in August 2024

Email [MANSA Admin](mailto:MANSA@MANSNEUROSURGERY.ORG) to submit any Michigan neurosurgeons, residents, fellows, and students who has made headlines or notable contributions in their field.

CALLING ALL OUR MEMBER EXPERTS



CALL FOR SPEAKERS

We extend an invitation to our knowledgeable members to submit presentation proposals for future meetings.

2026 – Surgical Techniques, Novi, MI

2026 – Crystal Mountain, Thompsonville, MI

2027 – The Grand Hotel, Mackinac Island

2028 – Grand Traverse Resort or Boyne Mountain

JOIN OUR PLANNING COMMITTEE

We invite you to consider joining our planning committee for the organization's annual meetings. Your active involvement is crucial to our success. We value your expertise and input, and your involvement will ensure that our annual meeting is engaging and impactful for all attendees.



NEWSLETTER ARTICLES

FREE Advertisement for members.

Share interesting news for our upcoming newsletters. This could include employee promotions, surgeon recognitions, welcoming new surgeons to your practice, graduating residents, new surgical procedures, controversial topics, job postings within your institution, and any noteworthy information relevant to Michigan neurosurgeons.

FACULTY MEMBERS NEEDED

We are in need of faculty members to participate on-site at a lab station at our Surgical Technique & Career Development course in Novi, scheduled for May 9, 2026.

We are asking for your assistance to express to the importance to your residents, fellows and students on how important it is to attend and support this event. It is FREE Registration for all MANS members.



CONTACT MANS OFFICE WITH QUESTIONS OR TO EXPRESS YOUR INTEREST

Call or Email the MANS office: 517-580-5701 or admin@mansneurosurgery.org

STATE AND FEDERAL HEALTH POLICY UPDATE

BY JAY K. NATHAN, MD

To call this a period of rapid and unpredictable change in the politics and policy of health care would be an understatement. For the practicing neurosurgeon, here we summarize recent key federal and State of Michigan developments that have come to fruition or are under active consideration as of April 2025. In the interest of saving face more so than preserving objectivity, no predictions shall be made!



CONTACT YOUR
REPRESENTATIVE AND
TAKE ACTION

Top of mind for national physician organizations such as the AMA and the CNS/AANS Washington Committee is seeking legislation to reverse the 2.83% cut in the Medicare Physician Fee Schedule Conversion Factor that the Centers for Medicare and Medicaid Services (CMS) announced in its 2025 Final Rule on November 1, 2024. A long-sought alternative has been to index fee schedule payments to measures of inflation of practice expenses, particularly since Medicare reimbursement rates have declined more than 20% in real dollar terms in the 21st century. This advocacy was recently bolstered by the Medicare Payment Advisory Commission's March 2025 report to Congress, which recommended that fee-for-service rates be indexed to the Medicare Economic Index from 2026 onward. However, these recommendations are non-binding, and current legislation incorporating this is seen as unlikely to pass owing to the billions of dollars in additional government spending required, unless budgetary offsets are found. On the topic of budgeting, you are likely aware of the contentious discussions between House and Senate leadership regarding a House-passed budget proposal that would translate to \$880 million in cuts to the Medicaid program. The political ramifications of this alone are seen as anathema to many on both sides of the aisle facing 2026 midterms, to say nothing of the loss in medical and economic security that such a draconian cut would impose on patients requiring neurosurgical and other essential care.

"All readers of this newsletter will be impacted by such changes in some form, and are all encouraged to visit the state-run website and contact your state representatives to weigh in.", says Dr. Jay Nathan,

Many in practice have noticed the unyielding rise in prior authorization frequency and burden. Former cardiothoracic surgeon turned daytime television personality Dr. Mehmet Oz, no longer in need of advertising revenue from Medicare Advantage insurers, spoke during Senate hearings prior to his confirmation as CMS Administrator on the need for greater scrutiny of Medicare Advantage organizations, particularly regarding delays and denials of care. The neurosurgery Washington Committee has long fought prior auth burdens imposed by public and private coverage, and is part of a coalition supporting the mandatory adoption of electronic-only prior auth systems, rigid and faster review times, review by a board-certified physician of the same specialty, reliance on standardized evidence-based criteria, and exemptions for physicians who consistently prescribe appropriate and high-quality care. As Medicare Advantage, or Part C of Medicare, now constitutes over 50% of the Medicare program and is the source of the highest margins in the health insurance industry, reforming the program has become all the more challenging, but is a battle worth fighting on behalf of our patients. All this as the Department of Health and Human Services faces unprecedented layoffs/restructuring, device approvals by FDA are likely to be slowed as a result, and federal funding for research on brain tumors and cutting-edge neurosurgical treatments is threatened while NIH goes to court over the 15% cap in indirect costs for grant recipients it imposed on February 7, 2025.

As physicians navigate interactions with health insurers and seek to ensure adequate coverage for our patients' medical needs, it is critical to be aware of who sets the rules of the road for different plans. Perhaps the greatest difficulty in doing so comes in employer-provided coverage. Technically, these plans are known as employee "welfare benefit" plans and are regulated principally by the Employee Retirement Income Security Act of 1974, or ERISA. This law was passed after the McCarran-Ferguson Act of 1945, which preserves the ability of states to regulate insurance markets, and thus a balance between the two laws was struck.

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STATE AND FEDERAL HEALTH POLICY UPDATE

BY JAY K. NATHAN, MD

The key factor in ERISA, to determine whether a particular health plan is subject to state regulation, regards which entity is ultimately on the hook for the covered portion of the employee's medical bills. Larger employers tend to self-fund their plans, meaning they are writing checks for health care spend, and they purchase administrative services from the health insurers we have all heard of. These plans are subject to federal regulation under ERISA exclusively, perhaps surprisingly by the Department of Labor. Critically, ERISA imposes a fiduciary duty on employers to seek the best health care value possible for their employees (the subject of a variety of current class-action lawsuits). Smaller employers often purchase group health insurance plans, with the insurer at risk, into which their employees can enroll. Regulation of key details of these plans occurs at the state level, with some elements still subject to federal oversight. Looking at a patient's insurance card rarely adds clarity to this, but each of the 50 states holds significant power in health policy, and this is but one facet in the complexity of producing change. News of note in the State of Michigan primarily concerns preserving patient access to and insurance coverage of telemedicine services. Companion House Bills [4131](#) and [4213](#), signed into law on June 6, 2024, prioritize patient and physician choice of telemedicine services, while preventing insurers from mandating it over in-person care without specific contractual terms. Such a contract cannot override physician judgement regarding safety and clinical necessity. Physicians who provide telemedicine services to Michigan patients must be licensed in the state.



Covered Medicaid telemedicine services must be synchronous, but can be audio-only, while covered commercial services can also include store-and-forward messaging. Finally, payment must be equivalent whether an E&M service is in-person or via telemedicine, with the caveat in the Medicaid program that this is subject to adequate federal funding (see above). Regarding eligibility for Medicaid, [HB 4224](#) was signed into law on January 21, 2025, repealing work requirements in the Healthy Michigan Medicaid program

Regarding surgeon employment and the balance of negotiating between hospital systems and private practices, [HB 4040](#) was introduced this January, seeking to prohibit non-compete restrictions. It is opposed by the Michigan Hospital Association. MHA also opposes [Senate Bill 148](#), introduced on March 13 to repeal certificate of need requirements for outpatient imaging centers looking to install CT, MRI, or PET scanners. House Bills 4101-4 seek to increase the number of physical and occupational therapists in the state by entering into multi-state licensure compact arrangements. [HB 4246](#) and [HB 4309](#) seek the same for nurses and PAs, respectively. All readers of this newsletter will be impacted by such changes in some form, and all are encouraged to visit the state-run [Michigan Voter Information Center](#) website to find and contact your state representatives to weigh in. Though ours is not the only voice in the process, by building longitudinal, value-added, individual relationships with state lawmakers and regulators, we can improve the chances that the neurosurgery voice is a powerful one.

MICHIGAN ASSOCIATION OF NEURO SURGEONS



BRAIN WAVES: NEUROSURGERY RESIDENT UPDATES

LEVEL UP AT THE MANS SUMMER MEETING

TURN YOUR RESEARCH INTO **REWARD** WIN UP TO \$1,100!

**The 2025 Resident Abstracts have been selected for presentation at the MANS 2025 Summer Meeting:
GOOD LUCK TO OUR RESIDENT PRESENTERS!**

- Anisse Chaker, MD – Henry Ford Health
- Daniel Griep, DO – Henry Ford Health
- Geoff Kahn, MD – Henry Ford Health
- Jordan Lam, MD – University of Michigan
- Macy Mitchell, MD – Michigan State University
- Rushikesh Joshi, MD – University of Michigan
- Bryce Sarcar, DO – Henry Ford Providence
- Ayobani Ward, MD – University of Michigan

RESIDENT BOARD PREP **AND** EMPLOYMENT READINESS

Resident Board Prep & Employment Readiness

Take your neurosurgical training to the next level at the MANS Summer Meeting with our specialized Breakout Sessions.

This focused session will help residents prepare for board exams and navigate their career path, covering everything from study strategies to job search tactics and contract negotiations.

Join us this summer for invaluable insights, expert guidance, and the tools you need to excel in your exams and advance your neurosurgery career!

Secure your spot now to take advantage of limited discounted additional room nights and cost-sharing rooms with two beds—don't miss out on this opportunity to save while you learn!

NEW OPPORTUNITY FOR NEUROSURGERY RESIDENTS

MEET THE 2025-2027 BOD CANDIDATES

We have 5 open positions for a two-year term. There are three open (member at large/director) voting positions for neurosurgeon members. Additionally, we are electing one Resident Representative and one Advanced Practice Provider (APP) Representative to serve in non-voting advisory roles on the board. While the resident and APP representatives will not have voting rights, they will actively participate in board meetings and contribute to discussions and initiatives that shape the direction of the organization. Electronic ballots will be emailed out on July 21.

[CLICK HERE TO MEET THE CANDIDATES](#)

MANS BOARD **OF** DIRECTORS

President: Aditya Pandey, MD – Michigan Medicine

President-Elect: Marc Moisi, MD – Hurley Medical Center

Immediate Past: Jason Schwalb, MD – IU Health

Secretary: Justine Pearl, MD – Munson Medical Center

Treasurer: Adam Robin, MD – Henry Ford Health

Director/Members at Large

Partha Chamiraju, MD – Detroit Medical Center

Boyd Richards, DO – MI Spine and Brain Surgeons

Nick Szerlip, MD – Michigan Medicine

Interested in Joining our Board of Directors or Planning Committee? Email [MANS Admin](#) to get placed on the MANS ballot.