



## **The Role of the Pathologist in the Care of the Head & Neck Cancer Patient: Understanding the Pathology Report**

JOHN E. FANTASIA, D.D.S.

Anatomic (surgical) pathologists have protocol guidelines for the examination of surgical specimens removed from patients with head and neck cancer. These protocols may differ somewhat based on the site and type of tumor. The most important communication in surgical pathology is the specimen report. Often templates, checklists, and tabular data reporting in the form of so-called synoptic or summary reports are the mechanism by which this information is transmitted to the clinicians directing the patient's treatment. The goal of the synoptic pathology report is to have uniformity and consistency of data that is relevant to the clinical management of the patient. In addition, such information may assist in forming a basis for various research protocols that may be offered to the patient.

Head and neck cancers may be diagnosed by way of a small sample of tissue (a biopsy) or by obtaining individual cells by placement of a needle into a suspected tumor and drawing out a small sample of cells or tissue (fine-needle aspiration cytology). Not all head and neck malignant tumors are treated with surgery. The appropriate type of treatment depends on the location and tumor type, and the clinical or radiographic findings, as well as the overall medical condition of the patient. The proposed treatment will be determined by the physician often after discussion of the case at a tumor board or conference. The tumor board consists of doctors from various disciplines, including surgeons, radiation oncologists, medical oncologists, radiologists, pathologists, and dentists that specialize in the care of the head and neck cancer patient. The findings and recommendations of the group are then presented to the patient by the physician who is overseeing their cancer care, and a course of treatment is determined. The discussion that follows will focus on

the most common head and neck malignancy, squamous cell carcinoma. The important aspects of the pathology report, how this report is developed, and how this report may influence treatment decisions is presented.

The pathology report documents the adequate examination of the surgical specimen, the anatomic extent of the tissues removed, extent of the tumor, histologic (microscopic) type, and histologic grade. The report also includes lymph node status and any other pertinent information needed by the referring physician to select other therapies such as radiation, chemotherapy or both. The pathology report also allows your doctor to evaluate the planned therapy, estimate prognosis, and analyze the outcome. Currently, the most important features determining the prognosis are size and extent of local spread of the primary carcinoma and extent of involvement of regional lymph nodes. These features determine the "stage" of the cancer. In the not too distant future, molecular analysis of the tumor likely will give additional information that will direct treatment decisions.

When the surgical specimen is received by the pathologist, a summary of the relevant history which includes clinical findings, previous diagnosis and any previous treatments such as radiation therapy or chemotherapy are listed on the pathology requisition form. The type of surgical procedure is listed, such as excision of the right side of the tongue, and dissection of the lymph nodes in the right neck. The tissues removed are tagged with sutures by the surgeon, as this allows for the appropriate orientation of the tissues that have been removed, and then described by the pathologist.

### **GROSS (MACROSCOPIC) DESCRIPTION**

Once in the pathology laboratory, the pathologist will then describe the external aspects of the specimen, the size of the overall specimen in three dimensions, and the location of the tumor with tumor dimensions. Also, the location of the tumor with respect to the edges (margins) of the overall specimen is noted. In cases where the lymph nodes of the neck are removed, there will be a notation made if the lymph nodes have been removed in continuity or separate from the primary tumor.

The specimen is then further dissected by the pathologist and the depth of invasion of the tumor can be better defined once the microscopic assessment is performed. Some tumors grow in an outward direction (exophytic growth pattern), while most head and neck carcinomas grow inwardly (endophytic growth pattern). With the dissection of the specimen a more detailed macroscopic assessment of the tumor growth and the relation to the margins of the specimen can be made. The pathologist may comment on the appearance of the adjacent tissue as being normal or ulcerated or involved by tumor. For example, tumors that occur on or adjacent to the jawbone may penetrate the bone. Thus the pathologist would describe this bony invasion if identified.

See PATHOLOGIST on next page



SUPPORT FOR PEOPLE WITH  
ORAL AND HEAD AND NECK CANCER  
**S•P•O•H•N•C, INC.**  
P. O. BOX 53

**BOARD OF DIRECTORS**

**Nancy E. Leupold, MS, President**  
**James J. Sciubba, D.M.D, Ph.D., Vice President**  
**Jean O. Cashin, Secretary**  
**Walter E. Boehmler, Treasurer**  
**Louis Frillmann**  
**Karrie Zampini, CSW**

**MEDICAL ADVISORY BOARD**

<b>David M. Brizel, M.D.</b> Duke University Medical Center	<b>Herman Oliver, M.D., F.A.P.A.</b> North Shore-LIJ Health System
<b>Linda K. Clarke, MS, RN, CORLN</b> Greater Baltimore Medical Center	<b>David G. Pfister, M.D.</b> Memorial Sloan-Kettering Cancer Center
<b>David W. Eisele, M.D.</b> University of California San Francisco	<b>Jed Pollack, M.D.</b> North Shore-LIJ Health System
<b>Keith Heller, M.D., F.A.C.S.</b> North Shore-LIJ Health System	<b>James J. Sciubba, D.M.D., Ph.D.</b> Johns Hopkins Medicine
<b>Alex Keller, M.D., F.A.C.S.</b> North Shore-LIJ Health System	<b>Elliot W. Strong, M.D., F.A.C.S., Emeritus</b> Memorial Sloan-Kettering Cancer Center
<b>Jesus E. Medina, MD</b> University of Oklahoma Health Sciences	<b>Denise M. Vey Voda, M.A., D.D.S</b> North Shore-LIJ Health System
<b>Eugene N. Myers, M.D., F.A.C.S.</b> University of Pittsburgh School of Medicine	<b>Everett E. Vokes, M.D.</b> University of Chicago Medical Center
<b>David Myssiorek, M.D.</b> North Shore-LIJ Health System	<b>David P. Wolk, M.D., F.A.C.S.</b> North Shore-LIJ Health System

**Karrie Zampini, CSW**

**NEWSLETTER EDITOR**

**Nancy E. Leupold, MS**

**WEBMASTER**

**Barry Sebastian**

*News From SPOHNC* is a publication of  
Support for People with Oral and Head and Neck Cancer, Inc.  
Copyright ©2004–2005

DISCLAIMER: Support for People with Oral and Head and Neck Cancer, Inc. does not endorse any treatments or products mentioned in this newsletter. Please consult your physician before using any treatments or products.

**IN THIS ISSUE**

A Time for Sharing.....4  
How to Get Your Medical Plan to Work for You.....6

COMING IN MAY 2005  
“Carcinoma of the Palate”  
Mark Persky, MD

**PATHOLOGIST continued from page 1**

Removal of the lymph nodes of the neck would be determined if there was suspicion of the nodes being involved, based on a clinical examination of the neck or if a radiologist determines there is a likelihood of involved lymph nodes in this area. The physician responsible for the patient knows when additional studies such as computerized tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET) are needed. Also, if the primary tumor is of sufficient size a lymph node dissection of the neck will be recommended even in the absence of clinical or radiographic suspicion of lymph node involvement by the tumor.

The pathologist will assess the submitted lymph node dissection describing the various levels, the number of lymph nodes identified in each level and whether there is visible evidence of tumor in the lymph nodes. If tumor is grossly visible, the size of the largest lymph node that contains tumor is recorded. The pathologist will also comment on the presence of tumor in associated muscle, fat, or blood vessels that are removed with the lymph nodes.

**MICROSCOPIC DESCRIPTION**

The tissues that have been dissected by the pathologist are then submitted for microscopic analysis. The histologic type of tumor is then reported, for example, squamous cell carcinoma. The histologic grade will be defined as being either, well differentiated, moderately differentiated or poorly differentiated. The degree of differentiation or cell maturity reflects how closely the tumor resembles the normal tissue from which the tumor originated. Thus, a well differentiated squamous cell carcinoma closely resembles the tissue from which it arose, while a poorly differentiated tumor remotely or minimally resembles the tissue from which it arose. The extent of invasion of the cancer is described. Some tumors may invade the tissue only superficially, while others may involve the muscle, fat or bony tissues that have been removed with the tumor. The depth of invasion (tumor thickness) is measured in millimeters and reported. The pathologist examines all the submitted tissue for the presence or absence of tumor invading the blood vessels or lymphatic channels. Identification of tumor within blood vessels or lymphatic channels would indicate a greater likelihood that the tumor has spread to a regional or distant site. Also nerve fibers that are present in the tissues are evaluated for the presence or absence of nerve invasion. The presence of nerve invasion is often reported as perineural invasion. This indicates that the tumor wraps around nerve fibers, and would extend along the nerve fiber peripherally.

Additional findings that may be reported include evidence, if any, of the tumor being multifocal, whether or not the tissues adjacent to the tumor exhibit evidence of dysplasia (precancerous change) or carcinoma-in-situ (the earliest form of cancer, before invasion of surrounding tissues occur). The degree of inflammation around the tumor or in the adjacent tissue similarly may be commented on.

The lymph nodes are analyzed and reported as the number of lymph nodes positive for metastatic disease in relation to the total number of lymph nodes examined. For example, in a patient with squamous cell carcinoma of the right side of the tongue treated with partial removal of the tongue (hemiglossectomy) and removal of the lymph nodes of the right neck, the pathology report might read as follows: forty-two lymph nodes were identified and examined

PATHOLOGIST continued on page 3

PATHOLOGIST continued from page 2  
microscopically and three of the lymph nodes contained cells of squamous cell carcinoma. That is, 3 of a total of 42 lymph nodes were positive for metastatic squamous cell carcinoma that originated at the tongue site. The lymph node status is further subdivided to detail the level in the neck the positive nodes were identified. Another important feature of the lymph node examination is the size of the largest node involved and whether or not the tumor in the lymph node extends into or beyond the tissue that surrounds the lymph node. Extension of tumor beyond the confines of a lymph node is referred to as extracapsular spread (extranodal extension). Identification of extracapsular spread of tumor in the lymph nodes may modify subsequent treatment recommendations.

As stated in the introductory comments, the head and neck cancer patient is placed in a "stage" based on the physical findings, possibly aided by various imaging studies. The **TNM** staging system reflects primary Tumor size, status of regional lymph Nodes and whether or not there is radiographic or clinical evidence of distant Metastasis. This will influence the initial course of treatment. The tissue examination will result in an assessment of the primary Tumor, and the regional lymph Nodes, resulting in a **pTNM** pathologic classification based on the findings detailed in the surgical specimen pathology report. The pathology report will be read by the surgeon, and if further therapy is required based on the clinical circumstances and the findings indicated in the pathology report subsequent referral to a radiation oncologist, medical oncologist or both may follow. The radiation oncologist and medical oncologist likewise will scrutinize the pathology report as it will influence their treatment recommendations and planning.

The extent of the disease may be greater than initially determined after pathologic examination of the tumor, the adjacent tissues and lymph nodes; conversely, it is also recognized that sometimes tissue changes adjacent to the tumor and lymph nodes suspicious for tumor may reflect only inflammatory changes. Thus the examination of the surgical specimen both grossly and microscopically by the pathologist is of vital importance in formulating the best treatment options for the patient with head and neck cancer.

#### FROZEN SECTION ANALYSIS

Intraoperative frozen section analysis is widely used in head and neck cancer surgery. This procedure, if requested, is done prior to any of the pathologist's activities explained above. This is often one of the most important and difficult procedures performed by the pathologist. This procedure requires experience, knowledge of the clinical situation, dialogue with the surgeon, and an awareness of the limitations of this technique. Intraoperative frozen sections are a costly procedure. This technique consists of giving tissue during the course of the operation to the pathologist. The tissue is examined grossly and the tissue is then frozen so that sections can be prepared and stained for immediate interpretation by the pathologist.

Generally, intraoperative frozen sections are indicated only if the pathological findings would change the surgical procedure. The purpose of the frozen section may be to: 1) recognize the presence and nature of a tumor; 2) determine if the tumor involves the surgical margin; 3) establish if the tissue sampled contains diagnosable material.

The request for frozen section analysis, in head and neck cancer surgery for squamous cell carcinoma, is most widely used to assess the presence or absence of tumor at the surgical margin. Sometimes frozen sections are used to assess the status of specific lymph nodes in the neck (sentinel lymph node biopsy), which are negative clinically and negative using various imaging modalities. A scientific rationale for the potential indication of sentinel lymph node biopsy in head and neck cancer is being evaluated in several ongoing studies. The subject of sentinel lymph node biopsy for squamous cell carcinoma of the oral cavity was presented by Dr. Loree in the February 2005 SPOHNC newsletter.

Frozen section analysis of margins is highly accurate; however this procedure does not eradicate the potential for positive margins being identified in the final pathology. This procedure is most valuable in patients with early-stage lesions and those undergoing re-resection for recurrence or salvage surgery after radiation failure.

#### SUMMARY

An attempt has been made to familiarize the head and neck cancer patient with the pathologist role in the diagnosis of the disease;

and how the diagnosis and additional findings of the pathologist are communicated to the surgeon, radiation oncologist, medical oncologist and other members of the treatment team. Also, how the pathology findings influence treatment decisions is addressed. All involved in the care of the head and neck cancer patient look with hope to the future that a greater understanding of the molecular aspects of cancer biology will lead to improvements in treatments and possible cure and even prevention.

*Editor's Note: John E. Fantasia, D.D.S. is Chief, Division of Oral and Maxillofacial Pathology, Department of Dental Medicine and Department of Pathology, Long Island Jewish Medical Center, North Shore – Long Island Jewish, Health System. Dr. Fantasia is currently a Director of the American Board of Oral and Maxillofacial Pathology. He is a former recipient of training grants from the American Cancer Society, and the National Cancer Institute.*

#### Bibliography

- Strobel SL, Tatchell T. The surgical pathology report as an educational tool for cancer patients. *Ann Clin & Lab Science.* 32(4):363-368,2002.
- DiNardo LJ, Lin J, Karageorge LS, Powers CN. Accuracy, utility and cost of frozen section margins in head and neck cancer surgery. *Laryngoscope.* 110(10Pt1):1773-1776,2000.
- Min KW, Houck JR Jr. Protocol for the examination of specimens removed from patients with carcinomas of the upper aerodigestive tract: carcinomas of the oral cavity including the lip and tongue, nasal and paranasal sinuses, pharynx, larynx, salivary glands, hypopharynx, oropharynx, and nasopharynx. Cancer Committee, College of American Pathologists. *Arch Pathol Lab Med.* 122(3):222-230,1998.
- Ord RA, Aisner S. Accuracy of frozen sections in assessing margins in oral cancer resection. *J Oral & Maxillofac Surgery.* 55(7):663-669; discussion 669-671,1997.
- Tschopp L, Nuyens M, Stauffer E, Krause T, Zbaren P. The value of frozen section analysis of the sentinel lymph node in clinically N0 squamous cell carcinoma of the oral cavity and oropharynx. *Otolaryngology – Head & Neck Surgery.* 132(1):99-102,2005.
- Leslie KO, Rosai J. Standardization of the surgical pathology report: formats, templates, and synoptic reports. *Seminars in Diagnostic Pathology.* 11(4):253-257,1994.
- Jose J, Coatesworth AP, MacLennan K. Cervical metastasis in upper aerodigestive tract squamous cell carcinoma: histopathologic analysis and reporting. *Head & Neck.* 25(3):194-197,2003.

Rosai J. *Ackerman's Surgical Pathology.* 8<sup>th</sup> ed. St Louis, Mo: Mosby; pp. 8-9. 1996.

\*\*\*\*\*

## A TIME FOR SHARING

January 2000 dawned with a great deal of promise. The Y2K computer disaster didn't materialize, the stock market continued its seemingly endless rise, and my daughter Olivia was fast approaching her second birthday. I was 44, very fit, and despite the endless number of colds Olivia brought home to me from daycare, apparently healthy.

In mid-January, I noticed a small lump on the left side of my neck. Initially I ignored it, but about a week later noticed it had grown. After a brief course of antibiotics failed to eliminate the lump, my physician referred me to the ENT practice at the neighboring hospital. I tried calling from his office for an appointment but the busy signal was endless. Since the hospital was just across the street, I decided to walk over to the ENT center to schedule an appointment. I have wondered many times since whether I owe my life to that busy signal.

The wait for an appointment was 6-8 weeks. As I discussed my waiting list prospects with the admin, a nurse practitioner approached me. She was new to the office. Would I mind if she got some practice working me up? Within an hour a needle biopsy was conducted, and late the next day I received a phone call at work with the diagnosis of cancer. Stunned and terrified, I returned home feeling lost and utterly ignorant of what was before me.

My surgeon quickly ordered an MRI and a tonsillectomy was then scheduled to confirm the MRI. Despite the tense situation, I recall a moment of humor. My surgeon, a very accomplished head and neck surgeon, approached me while I was in pre-op. Suddenly overcome with fear, I needed to test his credentials. "How many tonsillectomies have you done?" I gravely asked him. I recall with great amusement his struggle to stifle his laughter at my rather desperate and untimely query.

The tonsillectomy confirmed the diagnosis: Stage IV squamous cell cancer, left tonsil primary with clean margins with metastasis to two lymph nodes, survivability

prospects between 30 and 50%. At this point anger and self-pity set in. How about 100% survivability, doc? Why me? Why Olivia's daddy?

Treatment planning came next which turned out to be a difficult process. The Tumor Board recommended a neck resection followed by radiation, but then referred me to a medical oncologist who was leading two clinical trials. Neither of the trials held any prospect of increasing my survivability so I declined. Unfortunately, the trial doctor went to great lengths to convince me to participate, including repeatedly emphasizing to my frightened wife what a dangerous a state I was in, and even telling me that if I did not participate in the trials then I would have to seek

*Cancer gives some of us a second chance at life, and like so many cancer survivors I'm doing my best to make the most of it. I hope and pray that all who face cancer will find renewed strength and faith through the experience.*

treatment elsewhere. My wife, herself a former heart failure trial coordinator, and I were shocked and saddened at this behavior. Hopefully that doctor has since found more appropriate and sensitive means of engaging patients in his trial work. To further complicate matters, a second opinion I'd sought recommended a different treatment plan than that of the Tumor Board.

Recognizing my frustrated and frightened state, my radiation oncologist referred me a doctor I will refer to here as Dr. J, the finest medical oncologist in the galaxy, a doctor who enters the room on the wing beats of angels. Dr. J's patient and caring manner helped me calm down, sort through the options, and decide upon a treatment plan: neck resection surgery followed by radiation and, possibly, chemo.

I had decided that I didn't want to go

through this battle alone and called SPOHNC, which put me in touch with George, a throat cancer survivor in Virginia. Being able to communicate with a survivor was a wellspring of solace. George was a font of advice for how to deal with the many side effects of treatment and he was incredibly generous with his time. Especially so, since he was himself dealing at that time with very difficult after effects of treatment, something he and his wife shielded from me so as to not cause concern. At any time they could have referred me to someone else for support, and with good reason, but did not. In fact, I did not discover George's difficulties until this past spring when I met he and his wife for dinner while visiting the East Coast. They are both heroes to me.

I shared with family and friends my situation and asked for help, something most difficult for me. The support I received humbles me to this day. Cards, calls, visits from friends and family, meals from neighbors, and prayers all came in abundance. A group of my friends even showed up every weekend for four months to mow my lawn when I grew too weak to do so! I realize that it is in some peoples' nature to face life's difficulties privately but, in retrospect, I feel that had I done so I would have missed some of cancer's gifts, the gifts of love and community.

Treatment commenced with the neck resection and a radical tonsillectomy. A lesson in the need to stay engaged in one's treatment came next. While reviewing the results of the resection pathology report with my doctors, my wife alertly noticed that they'd not checked for extra-capsular spread around the lymph nodes as they'd promised to do. The nodes were re-examined and spread was detected. On the basis of that finding, chemo was added to my treatment plan. My wife may well have saved my life that day by catching that error.

The surgery went well and, to my relief, the nerve bruising quickly abated and I regained complete motor control of my arm

and facial muscles. Three weeks post-op, we began the heavy lifting: 28 radiation treatments with concurrent chemo. I breezed through the first couple of weeks but kept in mind an old marathon dictum: the second half begins at the 22<sup>nd</sup> mile. By the third week the cumulative effects of dry mouth, mucositis, mouth sores, and painful swallowing brought on a growing psychological burden: forget about the cancer, will I survive the treatment?

I'd lost my sense of smell and taste and eating became a joyless, painful process conducted only to forestall the prospect of a feeding tube. For someone who greatly enjoys food it was distressing to have everything that entered my mouth, including water, taste like I was licking a piece of galvanized pipe. Knowing that sleep was essential, I took a sleeping pill each night and this ensured me at least one solid period of rest each day.

I required Lortab to numb the throat pain in order to eat. Unfortunately, the Lortab itself burned a great deal when it was going down. My technique for dealing with that was to first eat a few mouthfuls of vanilla ice cream to coat my throat (if only I could have tasted it!), and then quickly drink Lortab diluted with water. It was the best defense against the pain that I could devise, and it enabled me to keep enough weight on to fend off the feeding tube. I also gargled with aloe vera juice, available in most health food stores, and rubbed it on my skin, which greatly aided healing.

I maintained an exercise regimen while undergoing treatment until the effects of treatment left me too weak to do so. I over did it a couple of times, failed to re-hydrate sufficiently, and ended up in the hospital twice with fever. In retrospect I wish I had taken it a bit easier, but believe maintaining some semblance of an exercise routine helped my mental outlook. One of the nights in the cancer ward bought a moment of true beauty: a volunteer moved from room to room, softly playing gentle Spanish themes on his guitar. These were among the sweetest and most reassuring sounds I have ever heard and they reminded me of the need, even in difficult times, to always make room for gratitude in one's life.

Although I'd worked during treatment,

taking a few days off only around the chemo drips, I found myself growing increasingly tired towards the end of radiation. When I got to the point of needing to nap several hours midday, every day, I decided to listen to my body and take a medical leave. This proved to be a good decision, since I did not hit my nadir until a couple of months later and the rest time was necessary for healing.

Although my company offered great benefits, I had to give up my position to take the leave and this distressed me. Would there be a job for me when I returned? If so, would I find it challenging and enjoyable? Not having the luxury of choice at that point, I decided to just hope for the best and trust in the future.

I believe that post-treatment exercise was a key factor in my recovery. Slowly my strength started to return and my shuffles to the end of the driveway and back turned into walks, and walks into hikes. I also worked out in a gym, slowly building back muscle strength and endurance, and acupuncture treatments helped increase saliva flow.

As my throat slowly healed eating became easier. Then, about four months post treatment, I walked into my kitchen and, for the first time in about six months, I could actually smell something: cinnamon! This was a joyous experience I can only compare to witnessing the birth of one's child. With my sense of taste and smell returning my appetite grew, I regained weight, and my mental outlook improved.

As I moved through the early stages of recovery I found my mental focus shifting from surviving treatment to living life. OK, looks like I survived treatment, now what? How will I live with the threat of recurrence? What has cancer taught me about myself and how do I want to live my life?

For starters, I decided that climbing the corporate ladder wasn't my top priority in life, that my health and family were. I lucked into a wonderful job upon my return to work, which allowed me to focus on the fun stuff and less upon budgets and managing teams, things I found uninteresting and rather stressful. I also lucked into a fantastic manager, herself a cancer survivor, who was very supportive of my need to balance work and life. I suppose it is for others to say

whether or not I'm a better person as a result of cancer, but I do feel that I have become more trustful and patient person, more willing to face the tough choices in life, and more readily see the gifts that are in those around me.

With my newfound sense of the fragility of life, I came to savor every moment with my family. At one point during treatment planning I recall throwing up my arms and telling my docs, "I don't care what you do, just get me to my daughter's high school graduation." As the words came out they sounded rather greedy, given my condition, so I quickly amended them, "No, just get me to her first day of kindergarten." I am eternally grateful to have Olivia's kindergarten photo in my wallet today, and to have escorted her to her first day of first grade this morning.

I also try to make time for my passions, one of which is mountain climbing. Almost a year to the day following my last chemo drip, I climbed Mt. Shasta with the same friends who mowed my lawn during treatment. High winds and whiteout turned us back at 13,000 ft., but not without giving us a majestic, humbling sunrise of unforgettable force and color. The following summer I celebrated my two-year anniversary by summiting Mt. Rainier and found great joy upon its flanks in my recovered strength.

There were times during this ordeal that I doubted whether I'd survive. I tried to keep a positive attitude and, in the dark moments, sometimes had to take it one day at a time, one hour at a time, even one minute at a time. But now, as I approach the five-year mark, I look back on it all and am reminded of what a young soldier, in a private moment of support, told Lance Armstrong early in his fight with cancer, "You don't know it yet, but we're the lucky ones."

Cancer gives some of us a second chance at life, and like so many cancer survivors I'm doing my best to make the most of it. I hope and pray that all who face cancer will find renewed strength and faith through the experience.

*Richard Boucher*  
Jacksonville, Oregon  
richard.boucher@hp.com

## How to Get Your Medical Plan to Work for You

Myrna L. Cortez, MSIR

**G**etting your health insurance plan to pay your medical bills can be a challenge at any time. Plans are increasingly complex, with specialized language and procedures. If you happen to be coping with a serious illness, dealing with medical claims problems is the last thing you need. The following suggestions will help you make your medical insurance plan work for you when you need it most.

### Advocate For Yourself

Gather information, resources, and support. Educate yourself, read related materials, look at Medicare and insurance company websites, and ask for help from someone you trust. Be patient and persistent. Don't try to do everything yourself.

Learn everything you can about your insurance plan. Read your plan booklet, especially the section on exclusions. If you don't understand something, call your insurance company, your employer's benefits representative, your doctor, your hospital or whoever sent the material and ask questions. Ask for a supervisor if the person you're talking to can't help you. Don't feel intimidated by what you don't know.

Keep copies of anything you send or receive and document all phone conversations. Keeping good records makes follow-up calls easier. This is also important if providers file claims beyond the time limits set by your insurance company. You may be able to have late bills written off if you gave your provider your insurance information and they failed to file with your insurance company on time.

If your insurance doesn't cover or only partly covers certain services and items you need, call and ask why. Mistakes are common. For example, your plan may state that teeth problems should be considered under dental insurance. But if you needed to have teeth removed because you received radiation therapy, your plan may not understand the medical issues involved in these treatments. Ask your insurance representative how to re-process or appeal your claim.

Don't give up if your claim is denied repeatedly. You may need to get a letter of medical necessity from your physician to have the claim reconsidered. Read your plan booklet regarding the appeal process and call your plan administrator for information.

### Use Your Plan Well

To save money, use your "in-network" benefits as much as possible. If you have Medicare, select physicians that accept Medicare assignment. If you're in an HMO (health maintenance organization) or POS (point of service) plan, use your primary care physician to get referrals to specialists. If you're in a PPO (preferred provider organization), use network hospitals and network physicians. Your hospital may be in-network, but individual physicians may not. If your claims for radiology, pathology, or anesthesiology are denied as out of network, call your plan and ask about a wraparound benefit. This means that because you didn't choose an out-of-network physician, you shouldn't be penalized, and your claims may be recalculated at the higher in-network level.

### Pay Only the Bills You Really Owe

Review all medical bills for accuracy. Understand what you are being asked to pay for. Request an itemized bill for all hospital stays. Check for duplicate charges, procedures or items not provided, or miscellaneous charges without explanation. Mistakes happen. Some insurance plans offer cash incentives to you for finding errors in your hospital bills. An experienced professional can also audit your hospital bills.

Don't pay your bills as soon as you get them. Review the Explanation of Benefits statements your insurance company sends you and compare them to your medical bills. Do the amounts match? Do you understand the charges? If not, call your insurance company or healthcare provider and ask questions. Their errors can be costly to you.

Don't pay for office visits with cash or a credit card if you expect your insurance will cover them. Wait until your insurance pays and then pay the difference. You may pay less because providers are required to apply discounts when they bill your insurance company. Many providers are slow to issue refunds if they have been overpaid.

If you get a collection notice, don't panic or be scared into writing a check for amounts you may not owe. Many notices are sent in error. Call the collection agency and request that your account be placed on hold for 60 days and ask for an itemized bill. When you receive it, call your insurance company and ask if they've paid it. If not, send the bill to your insurance company and notify the collection agency. If you actually owe the amount, negotiate for a payment schedule you can afford.

### Save Money on Your Prescription Drugs

Ask your doctor for free samples. Take only the drugs you really need. Save by buying a 90 vs. 30 day supply. Get only a 7-day supply of new medication. See if you qualify for Veteran's Administration benefits. You may be eligible for a free drug program. Contact your drug manufacturer for further information.

### If You Don't Have Coverage for Certain Procedures

Tell your doctor that you are paying out of your pocket. Ask if you can be charged for a less expensive visit or procedure. For expensive procedures that are not covered by your insurance plan, negotiate with the doctor or hospital beforehand. Your providers have probably contracted to accept discounted rates from insurance companies, so why not from you? Request write offs of amounts over usual and customary not covered by your insurance plans. Contact your hospital's financial aid office for help with discounts or information on eligibility for Medicaid in your state.

PLAN continued on page 7

PLAN continued from page 6

**How to Cover Your Pre-existing Condition If You Lose or Change Your Job and/or Insurance**

The federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act) offers continuation of group health coverage under certain situations. If you are covered by a group health plan at your job and lose coverage due to termination of employment, you and your covered family members may be able to continue coverage for 18 months. Other COBRA qualifying events allow continuation for 36 months and are explained in your group insurance plan. Contact your employee benefits representative for more information.

If you change jobs and have a new insurance plan, or switch to coverage under your spouse's group plan, the federal law known as HIPAA (Health Insurance Portability and Accessibility Act of 1996) may help. Your new group health plan must reduce the length of any pre-existing condition exclusion period by the amount of time you had prior medical coverage. When your insurance ends, ask your old plan, whether it is a group or individual plan, for a certificate of creditable coverage. With this certificate, your new plan's pre-existing exclusion period may shrink to zero.

If you become disabled under Social Security rules within 60 days of losing your job, you can request an extension in COBRA coverage from 18 to 29 months. When your COBRA coverage ends, you may be able to convert to an individual plan with the same insurance company, where your pre-existing condition would be covered. Review your plan document or ask

your employee benefits representative if your group plan has a conversion option..

If you're not eligible for a group plan, many states have insurance plans for individuals not able to get coverage due to pre-existing conditions. Contact your state's department of insurance for further information.

**Eligibility for Medicare Disability Coverage**

If you become totally disabled and unable to work, after 5 months you may be eligible for Social Security Disability payments. After 29 months of total disability, you may be eligible for Medicare disability insurance coverage, even if you are younger than 65. Contact the Social Security Administration at (800) 772-1213, or [www.ssa.gov](http://www.ssa.gov) for more information.

**Remember You're the Customer**

Making your insurance plan work for you can be a challenge. But remember, as the customer, you have the right to understand and receive good service. You deserve satisfaction. If you feel unable to proceed, seek the help of a professional. You can succeed with persistence, patience, and assistance.

*Editor's Note: Myrna L. Cortez, MSIR, is a medical claims advocate and president of Evanston, Illinois-based ProMediClaim, Inc. She has over 20 years of experience helping people, on a national basis, navigate and resolve medical claims issues. She works with individuals, families, providers, employers, and attorneys. Call toll free (888) 777-8092 or visit [www.promediclaim.com](http://www.promediclaim.com) for more information.*



Helping to Raise Awareness of Oral and Head and Neck Cancer

1-9 pins: \$6.50 each  
10 or more pins: \$6.00 each including shipping and handling



"We Have Walked In Your Shoes," a three-part resource for Oral and Head and Neck Cancer Patients and their families

To order in English or Spanish Call 1-800-377-0928

Visa, Mastercard and American Express accepted by phone and mail  
Visa and Mastercard online

**MEMBERSHIP APPLICATION**  
**SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.**  
Membership includes subscription to nine issues of *News From SPOHNC*

Name \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please Check: Survivor  Friend  Health Professional (Specialty) \_\_\_\_\_

- ANNUAL MEMBERSHIP**  
 \$25.00 individual     \$30.00 family  
 \$30.00 Foreign (US Currency)

- CONTRIBUTIONS**  
 Booster, \$10+     Donor, \$50+     Sponsor, \$100+  
 Patron, \$500+     Benefactor, \$1,000+     Founder, \$5,000+  
 Leaders Circle, \$10,000+

Call 1-800-377-0928

to become a member and make a contribution by credit card or order on line at [www.spoync.org](http://www.spoync.org)

**SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER (SPOHNC)**

SPONHC CHAPTER

COORDINATOR/FACILITATOR

PHONE

480-832-5436  
480-838-5194  
310-825-5707  
714-456-5235  
760-751-2109  
415-353-7982  
303-798-3041  
202-444-3755  
561-395-7100  
352-265-0680  
786-596-6951  
305-243-4952  
561-737-3699  
404-284-8045  
404-778-2369  
708-327-2042  
773-834-2470  
617-731-1703  
313-916-7578  
586-228-2309  
314-569-6569  
704-355-7283  
402-559-4676  
973-586-3522  
856-722-574  
732-557-8270  
505-681-1971  
631-444-7678  
212-844-8775  
516-759-5333  
614-293-7042  
412-647-9127  
972-373-9599  
214-820-2608  
281-401-5900  
434-982-4091  
703-776-2813

Keri Winchester  
Bette Denlinger  
Sabah Gasim, MSW  
Jennifer Higgins, MSW  
Valerie D. Targia  
Michelle Francis, LCSW  
Henry V. Holdridge  
Joanne Assarson, MSW  
Darci Lipson-McNally  
Gail Adomo, LCSW  
Annie Garcia-Montes  
Penny Fisher, RN  
Carmine Puleo  
Harmon Grotsky  
Arlene Kehir, RN  
Jenny Abrams, LSW  
Robyn Eagan  
Valerie Goldstein  
Amy Orwig, MSW  
Suzanne Frantz  
Carol Murphy, SW  
Meg Turner  
Susan Stensland  
Howard Sakolsky  
Micki Naimoli  
Sherry Laniedo, SW  
Anita Bryan  
Fran Tanzeila  
Jackie Mojica  
Nancy Leupold  
Vicki Heinke, MSW  
Marilyn Hudak, RN  
Dan Stack  
Tavis Maxwell  
Mart Hosford, RN  
Vikko Bravo  
Corinne Cook, CSW

ARIZONA--PHOENIX  
ARIZONA--SCOTTSDALE (new)  
CALIFORNIA--LOS ANGELES-UCLA  
CALIFORNIA--ORANGE-UCI  
CALIFORNIA--SAN DIEGO  
CALIFORNIA--SAN FRANCISCO-UCSF  
COLORADO--DENVER  
DC--WASHINGTON-LCC  
FLORIDA--BOCA RATON  
FLORIDA--GAINESVILLE (new)  
FLORIDA--MIAMI  
FLORIDA--MIAMI-Mort Silverblatt Head and Neck  
FLORIDA--PALM BEACH (new)  
GEORGIA--ATLANTA-GA  
GEORGIA--ATLANTA-Emory  
ILLINOIS--MAYWOOD  
ILLINOIS--CHICAGO (new)  
MASSACHUSETTS--BOSTON  
MICHIGAN--DETROIT-HFHS  
MICHIGAN--TROY  
MISSOURI--ST LOUIS (new)  
NORTH CAROLINA--CHARLOTTE  
NEBRASKA--OMAHA  
NEW JERSEY--MORRISTOWN  
NEW JERSEY--PENNSYLVANIA  
NEW JERSEY--TOMS RIVER  
NEW MEXICO--ALBUQUERQUE, (new)  
NEW YORK--LONG ISLAND EAST  
NEW YORK--LONG ISLAND WEST  
NEW YORK--MANHATTAN, NY Beth Israel  
NEW YORK--SYOSSET  
OHIO--COLUMBUS  
PENNSYLVANIA--PITTSBURGH-UPMC  
TEXAS--DALLAS-Irving  
TEXAS--DALLAS-Baylor/Sammons  
TEXAS--HOUSTON/TOMBALL  
VIRGINIA--CHARLOTTESVILLE (new)  
VIRGINIA--FAIRFAX-Heads Up!



SUPPORT FOR PEOPLE WITH  
ORAL AND HEAD AND NECK CANCER  
**S•P•O•H•N•C, Inc.**  
P. O. Box 53  
LOCUST VALLEY, NY 11560-0053

NON-PROFIT  
ORGANIZATION  
U.S. POSTAGE  
PAID  
LOCUST VALLEY, NY  
PERMIT NO. 28



ORAL, HEAD AND NECK  
CANCER  
AWARENESS WEEK

APRIL 11 - APRIL 17, 2005