5) Powsner SM, *et al*. Clinicians are from Mars and pathologists are from Venus. Clinician interpretation of pathology reports. *Arch Pathol Lab Med.* 2000;124:104-1046
6) Department of Health and Human Services, Centers for Medicare and Medicaid Services. Clinical laboratory improvement amendments of 1988; final rule. *Fed Register*. 2023(Dec 28): [42CFR493.1273(e)].

ANP.12170 Report Review — Phase II

All reports are reviewed and signed by the pathologist or other qualified physician as defined in ANP.11660.

NOTE: The review of the report by the pathologist must include review of the gross examination, microscopic descriptions (if provided), and pathologic diagnosis.

A single signature on the final pathology report indicates that the responsible pathologist has reviewed all sections of that report. Signatures for each section of the report are not necessary.

The inspector must review a broad sampling of surgical pathology reports issued since the previous on-site inspection, representing at least the most common types of specimens seen in the laboratory. When diagnostic reports are generated by computer or telecommunications equipment, the actual signature or initials of the pathologist may not appear on the report. It is nevertheless essential that the laboratory have a procedure that ensures and records that the responsible pathologist has reviewed and approved the completed report before its release. In the occasional situation when the diagnosing pathologist is not available for timely review and approval of the completed report, the laboratory may have a procedure for review and approval of that report by another pathologist. In that circumstance, the names and responsibilities of both the pathologist who made the diagnosis and the pathologist who performs final verification must appear on the report.

REFERENCES

1) Department of Health and Human Services, Centers for Medicare and Medicaid Services. Clinical laboratory improvement amendments of 1988; final rule. *Fed Register*. 2023(Dec 28): [42CFR493.1273(c)(d)].

ANP.12173 Mohs Report — Phase I

A written report is generated for each Mohs surgical procedure.

NOTE: A written note, report, or diagram must be included in the patient's medical record or operative report. The report must include required elements such as gross description, accession number, designation of relationship of blocks to the slides, and clear diagnosis on each specimen.

ANP.12175 Significant and Unexpected Findings — Phase II

Significant and unexpected surgical pathology findings are communicated to the responsible clinician and records of those communications are retained.

NOTE: Certain surgical pathology diagnoses may be considered significant and unexpected warranting special communication to the responsible clinician(s). The pathology department determines diagnoses to be defined as "significant and unexpected," in cooperation with local clinical medical staff. Examples include: malignancy in an uncommon location or specimen type (eg, hernia sac, intervertebral disk material, tonsil, etc.), change of a frozen section diagnosis after review of permanent sections, amendments to reports that may significantly affect patient care, neoplasms causing paralysis, or fat in an endometrial curettage.

There must be a reasonable effort to ensure that clinicians receive the communications. The records must include the following:

- *Date of communication*
- *Time of communication (if required by laboratory policy)*
- *Responsible individual communicating the result*
- *Person notified using identifiers traceable to that person (a first name alone is inadequate)*