

<b>Statement of Deficiencies</b>	<b>(X1) Provider/Supplier/CLIA Identification Number</b>  03D0974359	<b>(X3) Date Survey Completed</b>  01/14/2025
<b>Name of Provider or Supplier</b>  Arizona Dermatology	<b>Street Address, City, State</b>  1500 S White Mountain Road, Suite 401, Show Low, AZ	
For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.		

<b>(X4) ID Prefix Tag</b>	<b>Summary Statement of Deficiencies</b>
<b>D5217</b>	<p><b>EVALUATION OF PROFICIENCY TESTING PERFORMANCE</b> CFR(s): 493.1236(c)(1)</p> <p>At least twice annually, the laboratory must verify the accuracy of any test or procedure it performs that is not included in subpart I of this part.</p> <p>This STANDARD is not met as evidenced by: Based on lack of accuracy verification documentation for Mohs and interview with the facility personnel, the laboratory failed to verify the accuracy of testing performed under the subspecialty of Histopathology at least twice annually during 2023 and 2024. Findings include: 1. No documentation was presented for review to indicate the laboratory verified the accuracy of dermatopathology testing (performed in conjunction with the Mohs procedure) at least twice annually during 2023 and 2024. 2. The facility personnel interviewed on 1/14/25 at 11:45 AM confirmed the laboratory failed to verify the accuracy of dermatopathology testing at least twice annually during 2023 and 2024. 3. The laboratory's reported annual test volume in the subspecialty of histopathology is 704.</p>
<b>D5891</b>	<p><b>POSTANALYTIC SYSTEMS QUALITY ASSESSMENT</b> CFR(s): 493.1299(a)</p> <p>(a) The laboratory must establish and follow written policies and procedures for an ongoing mechanism to monitor, assess and, when indicated, correct problems identified in the postanalytic systems specified in 493.1291.</p> <p>This STANDARD is not met as evidenced by: Based on lack of Quality Assessment (QA) documentation from 2023 and 2024 and interview with the facility personnel, the laboratory failed to follow established</p>

policies and procedures for an ongoing mechanism to monitor, assess and, when indicated, correct problems identified in the postanalytic systems specified in 493.1291. Findings include: 1. Patient-specific data and the final test result information for Mohs is manually transcribed by laboratory personnel into the patient's Electronic Health Record (EHR). 2. The facility personnel interviewed on January 14, 2025 at 12:00 PM stated that it is the practice of the laboratory to perform a "Quality Assurance Laboratory Mohs Audit" on at least 2 cases, twice annually, per Mohs physician. 3. No documentation from 2023 and 2024 was presented for review to indicate the laboratory followed the policy referenced above to ensure patient test results and patient-specific data were accurately and reliably transcribed into the patient's EHR. 4. The facility personnel interviewed on 1/14/25 at 12:00 PM confirmed the laboratory failed to perform a postanalytic QA audit for each physician on at least 2 cases twice annually during 2023 and 2024. 5. The laboratory performs a reported 704 tests annually under the subspecialty of Histopathology. The laboratory listed 3 physicians on the CMS-209, Laboratory Personnel Form presented for review during the survey who perform the Mohs procedure.