Iowa Department of INSPECTIONS, APPEALS, & LICENSING

The Pulse
Hospital Education

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DIAL committed to education about EMTALA requirements

The Department of Inspections, Appeals, and Licensing (DIAL) is committed to providing education to hospitals for compliance with requirements for dedicated emergency departments (ED). DIAL investigates Emergency Medical Treatment and Labor Act (EMTALA) complaints at hospitals. The term “hospital” includes critical access hospitals (CAHs). The factors written in this newsletter are intended to highlight certain aspects of the Medicare EMTALA requirements, but they are not a legal document.

The regulation defines a dedicated ED as any department or facility of the hospital that is licensed by the State as an ED. EMTALA requirements also apply when an emergency medical condition (EMC) occurs elsewhere on hospital property. The hospital property includes the main hospital campus, parking lot, sidewalk, driveway, hospital departments, and buildings owned by the hospital, as well as any facility of the hospital.

EMTALA requires hospitals to provide a medical screening examination (MSE) to any individual who comes to the ED and requests such an examination, and prohibits hospitals with EDs from refusing to examine or treat individuals with an EMC.

From May 1, 2023, to April 30, 2024, Iowa had approximately 176 complaint investigations for hospitals. EMTALA violations were cited about 67 percent of the time. An examination of recently cited violations showed deficiencies regarding MSEs were cited with more frequency.

Maintaining an ED central log

One instrumental component of EMTALA requires maintaining a central log for MSEs as defined in Section 489.24(b). Each individual who comes to the emergency department seeking assistance should be on the central log. The log should address the following:

- The patient refused treatment
- The patient was transferred
- The patient was admitted and treated
- The patient was stabilized and transferred, or discharged

DIAL recently cited a hospital for a patient who presented to the ED seeking medical care. Review of the hospital's ED log revealed no entry in the log for the patient. The hospital did not have evidence of documentation of a medical record for the patient. Failure to provide an appropriate MSE placed the patient at risk for an undiagnosed EMC, resulting in a deterioration in health.

The hospital failed to meet these requirements:

- 2400 - COMPLIANCE WITH 489.24 CFR(s): 489.20(l)
- 2405 - EMERGENCY ROOM LOG CFR(s): 489.20(r)(3)
- 2406 - MEDICAL SCREENING EXAM CFR(s): 489.24(a) and 489.24(c)

DIAL investigative findings summary

Based on a review of the hospital's policy, the hospital's ED log, and staff interviews, DIAL investigators found that the hospital's administrative staff failed to ensure its staff maintained a complete ED log per hospital policy. The hospital also failed to ensure that staff provided, within the hospital's capabilities, an appropriate MSE for this patient. The failure to provide an appropriate MSE for all patients who present to the ED seeking medical care places them at risk for an undetected EMC.

Patient registration staff reported family members came in and asked if they should “come to this hospital” or go to a larger one. Patient registration staff said they offered to register the patient in the ED.

The chief nursing officer stated that when this patient arrived at the ED, registration staff immediately asked for the patient's date of birth and entered the patient's name and chief complaint in the computer system which populated the patient in the ED log.

The registered nurse (RN) alleged the patient registration staff called the ED nurse’s station and asked if a surgeon was available. The RN reported they instructed patient registration staff that everyone who presented to the ED would be seen and to register the patient, so a provider could evaluate them. The RN stated they walked to the registration desk and instructed the family to bring the patient to the hospital to be registered and evaluated, but the patient never presented to the ED registration desk. The RN reported they instructed the family member that if the patient was out in the car, the family member should bring the patient in to be registered and evaluated. The RN stated the family never brought the patient in for registration.

Other staff interviews stated the patient came to the CAH and waited in the car on hospital property while their family went inside. ED staff said they informed the family that it did not have a surgeon on call and gave the patient’s family ice for treatment without explaining the medical risks of leaving prior to an MSE or determining the timing, nature, or extent of the patient's traumatic injury, including if they were actively bleeding or experiencing pain.

During the ED tour, it was reported that the hospital is a level IV trauma center. An interview with the ED coordinator revealed the hospital was staffed with physicians, mid-level providers, registered nurses, patient care technicians, equipment, and resources needed to stabilize serious patients while preparing patients for transfer if needed.

EMTALA information resources

For further EMTALA requirements, relevant laws, regulations, and rulings, see the resources below.

General EMTALA Information

Appendix V - EMTALA Interpretive Guidance

EMTALA “Know Your Rights” Fact Sheet

Civil Monetary Penalties Imposed by U.S. Department of Health and Human Services Office of Inspector General