

The Last Surprise Bill

Why ground ambulance rides remain the largest unprotected gap in U.S. patient billing — and what an automated audit can catch.

Jeseka Price | Founder & AI Developer, EMRVerify | August 2026
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Executive Summary

When Congress passed the No Surprises Act, it ended balance billing for emergency room care, out-of-network providers at in-network facilities, and air ambulance transport. It did not end balance billing for the vehicle that brings most patients to the emergency room.

Ground ambulance was deliberately excluded. Four years later, that exclusion remains, and roughly half of emergency ground ambulance rides still generate an out-of-network charge. Patients cannot choose their ambulance provider, cannot compare prices, cannot consent to terms, and in most states cannot contest the resulting bill under federal law.

This paper argues that ground ambulance billing represents a distinct and addressable category of patient harm: charges are non-standardized, error rates are structurally high, and the two most common errors — level-of-service upcoding and mileage inflation — are detectable through automated document analysis. EMRVerify's audit engine, built to parse Explanation of Benefits documents and itemized bills for coding irregularities, extends directly to this problem.

51%

of emergency ground ambulance rides for privately insured patients included an out-of-network charge, according to Peterson-KFF analysis. In seven states — including Texas — more than two-thirds of emergency rides resulted in an out-of-network charge.

1. The Carve-Out

The No Surprises Act took effect January 1, 2022, and represented the most significant federal consumer protection in medical billing in a generation. It prohibited balance billing in the circumstances where patients have no meaningful ability to choose a provider.

Ground ambulance was left out. The stated reasons were structural: ambulance services are delivered by an unusually varied mix of providers — municipal fire departments, county EMS districts, private companies (increasingly private-equity owned), and hospital-based services — operating under a patchwork of local and state regulation. Congress also cited a lack of reliable cost data.

The result is a protection gap of remarkable specificity. A patient transported by helicopter is protected. The same patient transported by van is not.

Federal action has stalled

The Act itself established the Ground Ambulance and Patient Billing (GAPB) Advisory Committee to study the problem. The Committee delivered its report to the Secretaries of Health and Human Services, Labor, and the Treasury on August 28, 2024. Its recommendations included tailored federal legislation modeled on the No Surprises Act, standardized definitions across provider types, a payment standard deferring first to state and locally established rates, and a cap on patient out-of-pocket costs for emergency and interfacility transports.

Congress has not acted on those recommendations. As of this writing, the federal gap remains open.

2. The State Patchwork — and Why It Isn't Enough

Roughly eighteen states have enacted their own ground ambulance balance billing protections. These laws share a critical limitation: state insurance regulators cannot reach self-funded employer health plans, which are governed by federal ERISA law. Approximately 99.5 million Americans are enrolled in self-funded plans.

Texas illustrates the problem precisely. After earlier attempts failed, Senate Bill 2476 took effect January 1, 2024, prohibiting ground ambulance balance billing. Senate Bill 916, signed in June 2025, extended those protections through September 1, 2027. But the law reaches only plans regulated by the Texas Department of Insurance. The Texas EMS Alliance has estimated this covers roughly one in five insured Texans.

The remaining four in five — plus every uninsured patient in the state — have no statutory protection against an ambulance balance bill.

3. How Ambulance Charges Are Constructed

An ambulance bill is not a single price. It is assembled from components, each of which can be misapplied.

Component	How it works	Where errors occur
Base rate	Set by level of service. Medicare's Ambulance Fee Schedule assigns Relative Value Units across seven ground levels, from BLS non-emergency (RVU 1.00) through ALS1, ALS2, and Specialty Care Transport.	Billing ALS when only BLS-level care was delivered.
Loaded mileage	Charged per mile with the patient onboard. Commercial rates commonly run \$10-\$30 per loaded mile.	Mileage that does not match the actual pickup-to-destination distance.
Supplies & interventions	Itemized consumables, medications, oxygen, and monitoring.	Charges for supplies not documented in the run report.
Geographic adjustment	Rural and super-rural pickups receive add-ons; Medicare applies a 22.6% super-rural bonus.	Misapplied designation.

Commercial charges are not standardized. Reported ranges commonly place Basic Life Support transports between roughly \$400 and \$1,200, and Advanced Life Support transports between roughly \$800 and \$2,500 or higher, with wide variation by provider and locality. Medicare's own data shows average submitted charges of approximately \$1,162 for BLS-emergency and \$1,536 for ALS1-emergency transports.

4. The Two Errors That Matter Most

Level-of-service upcoding

The difference between a Basic Life Support and an Advanced Life Support transport is clinical: ALS requires interventions such as intravenous access, cardiac monitoring, or administration of medications. When a transport is billed at ALS but the run report documents no such intervention, the charge is not supported.

This is the highest-value single correction available on an ambulance bill. Depending on the provider's rate structure, reclassifying an unsupported ALS charge to BLS commonly reduces the base rate by several hundred dollars — often \$300 to \$800 or more — before mileage is even examined.

Mileage inflation

Loaded mileage is charged from the point of patient pickup to the point of delivery. Because mileage is billed per unit and rates are high, small discrepancies compound. A bill claiming mileage inconsistent with the documented pickup address and receiving facility is verifiable against public routing data.

Both of these errors share a property that matters for automation: **they are detectable by comparing two documents to each other.** The itemized bill states what was charged. The run report states what was done and where. Discrepancies between them are machine-findable.

5. Who Is Auditing These Bills Today

Effectively, no one at scale. General-purpose medical bill negotiators will accept an ambulance bill as part of a broader engagement, but none specialize in it, and most operate on contingency models — commonly 10% to 35% of savings — that are uneconomic on the small-dollar balances typical of a single ambulance transport.

The result is a structural mismatch. The bills are numerous and individually modest. The available help is priced for large balances. Most patients simply pay, or default.

6. The Case for Automated Audit

EMRVerify's core engine parses Explanation of Benefits documents and itemized bills to detect upcoding, unbundling, duplicate charges, and same-day code stacking. Ground ambulance auditing is not a new capability — it is the same capability applied to a document set with the same failure modes.

Three factors make this a strong extension rather than a new venture:

- Shared error taxonomy.** Upcoding and unbundling are already the engine's primary detection targets. Ambulance-specific rules are additions to an existing rule set, not a replacement for it.
- Flat-fee economics fit the balance size.** A per-audit or subscription price serves bills too small for contingency-based negotiators

to accept.

- **The regulatory gap is documented and durable.** A federal advisory committee has formally recommended action that Congress has not taken. The problem is neither speculative nor about to be solved by legislation.

7. Conclusion

Ground ambulance billing sits at the intersection of three conditions that reliably produce patient harm: the consumer cannot choose the provider, cannot see the price in advance, and cannot appeal under federal law. Congress recognized this pattern clearly enough to legislate against it everywhere else it occurs.

Until that gap closes, the remedy available to patients is verification — establishing whether the bill in front of them reflects the care they actually received. That determination requires reading a clinical run report against an itemized charge sheet and knowing which combinations are unsupported. It is precise, rules-based, repetitive work.

It is exactly the kind of work that should be automated, and exactly the kind of work almost no one is doing on the patient's behalf.

Sources

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