InterPulse Global

COMPANY BROCHURE

Neutralize claim denials. Accelerate reimbursements.

Specialty-aware medical billing and revenue cycle management for healthcare practices across 30+ medical specialties.

Driving Digital Excellence

Free Practice Review / Audit Services · We follow up within one business day

www.interpulseglobal.com · contact@interpulseglobal.com · +1 (406) 505-8012

ABOUT US

Your partner in high-performance medical billing

InterPulse Global believes in complete transparency. Our team of highly skilled medical billing professionals is dedicated to maximizing revenue for healthcare providers by ensuring accurate coding, timely claim submission and efficient follow-up.

We remove administrative friction so clinicians can stay focused on care. Instead of chasing insurance companies, correcting rejected claims or managing billing paperwork, your team gets a clear, disciplined process behind every claim.

150+
Physicians trusting InterPulse Global

30+
Medical specialties served

End-to-end
Streamlined billing, from charge capture to payment

Up to 98%
First-pass clean claims rate

Our promise

Eliminate administrative friction. Neutralize claim denials. Accelerate clinical reimbursements. Every practice gets a billing workflow built around its own specialty, providers and payer mix.

Who we support

Solo practices, multi-provider clinics, specialty groups, surgery centers and growing healthcare organizations, with modular support from a single service to the full revenue cycle.

THE CHALLENGE

Where practices lose revenue

Most revenue loss is quiet. It hides in denials, underpayments and claims nobody follows up on.

01

Claim denials

A denied claim costs far more than the original unpaid amount: rework, appeals, delayed cash flow and staff time. A claim can even be accurately coded and submitted correctly and still be denied during complex payer decisions.

02

Revenue leakage

The difference between what a provider should receive and what is actually collected, often with no obvious rejected claim. Missed charges, underpayments and unresolved balances can all hide here.

03

Administrative overload

Staff spend hours correcting rejected claims and chasing insurers instead of supporting patients. The more time billing takes, the less time is left for care coordination.

Prevention, tracking and follow-up close the gap, and that is exactly what InterPulse Global is built to do.

OUR SERVICES

A modular service suite

Choose one service or combine them. Each module plugs into your existing workflow.

Medical Billing Services

End-to-end claim handling from charge capture through payer follow-up.

Medical Billing & Coding

Surface lost revenue, coding gaps and denial patterns.

Revenue Cycle Management

Every stage of the revenue cycle managed with discipline.

Medical Billing Audit

Audits that expose revenue leakage and convert findings into cleaner claims.

Laboratory Billing

Built for specimen complexity and test-level reimbursement.

Medical Credentialing

Provider enrollment and payer-panel setup with careful follow-through.

MIPS Reporting

Support for eligible Medicare providers documenting quality performance.

Free Practice Review / Audit Services

We map your specialty mix and denial patterns and outline a path to cleaner first-pass claims.

SERVICES IN DETAIL

Medical billing and coding

Medical Billing Services

End-to-end claim handling, from charge capture through payer follow-up, so your team spends less time chasing payments and more time caring for patients.

What is included: charge capture, claim submission, payment posting and payer follow-up.

What it means for you: your billing runs as a documented, disciplined process, with clear ownership at every step, instead of as a pile of tasks competing for your staff's attention.

Medical Billing & Coding Services

We surface lost revenue, coding gaps and denial patterns across your current workflow, without disrupting day-to-day operations. Our billing specialists review diagnoses, procedures, modifiers and documentation to help minimize avoidable billing errors.

What it means for you: claims that accurately describe the care you delivered, and fewer preventable denials.

SERVICES IN DETAIL

Revenue cycle management and audit

Revenue Cycle Management

Every stage of the revenue cycle managed with discipline, improving collections, shortening delays and strengthening financial outcomes.

From eligibility verification and coding through claim submission, payment posting, denial management and A/R follow-up, our services can support the complete revenue cycle.

What it means for you: one accountable partner following the money from the first eligibility check to the final payment.

Medical Billing Audit

Targeted audits that expose revenue leakage, coding weaknesses and denial trends, then convert the findings into cleaner claims and stronger recovery.

What it means for you: a clear picture of where money is being lost today, and a practical plan to fix it, whether or not you decide to outsource the whole billing function.

SPECIALIZED SERVICES

Laboratory billing and credentialing

Laboratory Billing Services

Specialty lab billing built to capture specimen complexity, payer nuances and compliance requirements while protecting test-level reimbursement.

Laboratories bill test by test, and each payer can apply its own rules. Careful, test-level billing helps ensure that the work your lab performs is reflected in the claim.

What it means for you: billing support that understands how laboratory reimbursement actually works.

Medical Credentialing Services

Provider enrollment and payer-panel setup handled with careful follow-through, so clinicians can practice without enrollment bottlenecks.

Credentialing is the approval process insurers require before a provider can be reimbursed for seeing their members. Delays here can delay revenue.

What it means for you: new and existing providers enrolled with careful follow-through, so enrollment does not hold up your schedule.

COMPLIANCE AND SYSTEMS

MIPS and EMR/EHR support

MIPS Reporting

Accurate MIPS support that helps eligible Medicare providers protect reimbursement and document quality performance with confidence.

MIPS is a Medicare quality program, and correct reporting matters to payment.

What it means for you: your quality performance is organized and documented, so eligible providers can protect their Medicare reimbursement.

EMR/EHR Support

Our medical billing experts provide EMR/EHR support to streamline revenue cycle workflows. We have experience working with various EHR systems, helping healthcare providers reduce claim denials, improve billing efficiency and maximize reimbursements.

What it means for you: billing support that works with the systems your practice already uses.

HOW IT WORKS

The revenue cycle, end to end

Every claim follows a disciplined path, with clear reporting at each stage.

1

Eligibility & charge capture

Coverage and benefits are verified and billable services are captured, so earned revenue is not missed.

2

Coding review

Diagnoses, procedures, modifiers and documentation are reviewed to help prevent avoidable errors.

3

Claim submission

Clean claims go to payers promptly, supporting faster adjudication and first-pass acceptance.

4

Payment posting

Payments are posted accurately and reviewed so underpayments can be spotted.

5

Denials & A/R follow-up

Denial reasons are investigated, issues corrected, appeals submitted where appropriate and older balances worked until resolved.

SPECIALTIES

30+ specialties, one specialty-aware approach

Every specialty has different coding requirements, documentation standards, payer policies and reimbursement challenges.

Primary care

Family Medicine, Dentistry, Internal Medicine, Pediatrics, Geriatrics, General Practice

Surgery & procedures

General Surgery, Orthopedics, Cardiothoracic Surgery, Neurosurgery, Plastic & Reconstructive Surgery, Urology, Otolaryngology (ENT), Vascular Surgery

Medical subspecialties

Cardiology, Pulmonology, Gastroenterology, Nephrology, Endocrinology, Rheumatology, Infectious Diseases, Hematology / Oncology

Women's & maternal health

Obstetrics & Gynaecology, Maternal Fetal Medicine

Neurology & behavioral

Neurology, Psychiatry, Pain Management

Acute & hospital care

Emergency Medicine / Urgent Care, Critical Care Medicine, Anesthesiology

Diagnostics & rehabilitation

Radiology, Pathology, Physical Medicine & Rehabilitation, Chiropractic Medicine

COMPANY RECORDS

Results that matter to your bottom line

Our data-driven key performance indicators are precise, results-oriented and tailored to support your practice's financial success.

Up to 38%
Reduction in A/R

7–14 days
Turnaround time

Up to 30%
Potential revenue increase

97.95%
Collection ratio

Up to 98%
First-pass clean claims rate

30+
Specialties supported

Reported performance indicators from the InterPulse Global website. Results may vary by practice, specialty, payer mix, documentation quality and claim volume, and are not guaranteed.

WHY INTERPULSE

Why practices choose specialty-focused billing

Specialized knowledge

Your billing workflow is aligned with the services your practice actually provides.

Accurate medical coding

Diagnoses, procedures, modifiers and documentation are reviewed to minimize avoidable errors.

Effective denial management

We investigate denial reasons, correct issues when appropriate, submit appeals and track claims through resolution.

Proactive A/R management

We monitor A/R, follow up with payers, investigate delayed payments and work older balances.

Complete revenue cycle support

From eligibility and coding to posting, denials and A/R follow-up.

Customized billing solutions

Built around your providers, payer mix, specialty and claim volume.

OUR TEAM

Trained billers and coders, kept up to date

Trained billers and coders

Our billers, coders and A/R specialists are trained in medical billing, coding, payer rules and documentation requirements before they work on your claims.

Professional credentials

Our billing and coding team holds recognized industry credentials such as CPC, CCS and CPB. Credentials can be shared on request.

Ongoing training

Training does not stop after onboarding. Our team takes part in regular refresher and update sessions, so their knowledge stays current as rules change.

Annual code and payer updates

CPT, ICD-10 and HCPCS code sets are updated every year, and payers revise their policies throughout the year. Our team is trained on these changes so claims follow current rules.

Privacy and HIPAA training

Staff are trained on privacy and the careful handling of patient information, with access limited to authorized personnel.

What it means for you: claims prepared by people who know the rules, and who keep learning as the rules change.

FREE PRACTICE REVIEW / AUDIT SERVICES

See where your revenue is leaking, at no cost

Share a few details and our billing specialists will map your specialty mix, your denial patterns and a practical path to cleaner first-pass claims.

What we look at

Your specialty mix and the coding and payer rules that apply to it.

Your denial patterns and where claims are being held up.

Revenue leakage, coding weaknesses and denial trends, the same areas our Medical Billing Audit focuses on.

What you receive

A practical path to cleaner first-pass claims, based on your own specialty mix and denial patterns.

A clearer picture of where earned revenue may be going missing.

How it works

1

Request your free review / audit

Complete the short consultation form on interpulseglobal.com with your name, phone and email, or contact us directly.

2

We follow up quickly

A member of our team gets back to you within one business day.

3

Your path forward

Our specialists map your specialty mix and denial patterns and outline practical next steps.

Scope and details are confirmed during your consultation.

RESOURCES

Insights from the InterPulse blog

Practical reading for practices that want to protect revenue.

1

Why Medical Claim Denials Cost Healthcare Practices More Than They Realize

Denial prevention. Lower recovery cost. Stronger cash flow. A denied claim is often viewed as delayed reimbursement, but the financial impact extends far beyond the original unpaid amount.

2

Where Healthcare Practices Are Losing Revenue Without Realizing It

Find leakage. Capture earned revenue. Close the payment gap. Revenue leakage is the difference between what a provider should receive and what is actually collected, often without an obvious rejected claim.

3

When Accurate Claims Still Get Denied: Understanding Medical Payer Decisions

Decode payer decisions. Reduce repeat denials. Improve adjudication outcomes. A claim can be accurately coded and submitted correctly yet still encounter a denial during complex payer adjudication.

Read more at interpulseglobal.com/blogs

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Ready to tighten claims and accelerate collections?

Request our free practice review / audit services. Share a few details and our billing specialists will map your specialty mix, your denial patterns and a practical path to cleaner first-pass claims. We follow up within one business day.

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