



BUSINESS PLAN · INDIA

Teleradiology & Reporting Service

Where the judgement is paid by the piece and the error is never found

DIAGNOSTIC LABS & IMAGING

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This document is confidential and prepared for planning purposes. All financial figures are illustrative model assumptions for an Indian MSME context and must be validated against live quotes, local rates and professional advice before any investment or borrowing decision.

1. Executive Summary

This plan sets out a **Teleradiology & Reporting Service** in India — remote radiology reporting for hospitals and imaging centres, covering routine domestic reporting, emergency night-hawk cover, sub-specialty reading, international contracts, second-opinion and double-reading audit, and platform licensing, reporting roughly 1.24 million studies a year through a panel of 134 radiologists by Year 3.

This plan inherits the diagnostics vertical's rules and combines two of them into a harder case. **The imaging-centre plan established that the patient never knows who read his scan. The home-collection plan established that a per-unit rate silently sets the safety policy. Teleradiology is both at once, applied to a diagnostic judgement instead of a venepuncture.**

☐ **A TELERADIOLOGIST IS PAID PER STUDY, READS ALONE, AT NIGHT, ACROSS TIME ZONES, WITH NO CLINICAL CONTEXT AND NOBODY TO ASK. The per-study rate makes STUDIES PER SHIFT the single variable he optimises — exactly as the per-visit rate did for a phlebotomist — except that what is being compressed here is a diagnostic judgement, and A MISS IS INVISIBLE FOREVER, BECAUSE NOBODY RE-READS A NORMAL REPORT. The referring clinician sees a report, not a reading time. The patient sees neither. And fatigue is the dominant error source in diagnostic radiology, is well established in the literature, and is NEVER MEASURED OR DISCLOSED BY ANY REPORTING SERVICE ANYWHERE. So this business CAPS STUDIES PER SHIFT AND PUBLISHES THE CAP, PAYS PER SESSION INCLUDING READING TIME AND BREAKS RATHER THAN PER STUDY, PRINTS THE HOURS-INTO-SHIFT ON EVERY REPORT, and MEASURES AND PUBLISHES DISCREPANCY RATE AGAINST HOURS INTO SHIFT. WHERE THE JUDGEMENT IS PAID BY THE PIECE AND THE ERROR IS NEVER FOUND, THE WORKLOAD IS THE DIAGNOSIS.**

☐ **AND A SERVICE REPORTING NO DISCREPANCIES IS NOT AUDITING. So 10% OF STUDIES ARE DOUBLE-READ, the DISCREPANCY RATE FOUND ON AUDIT IS PUBLISHED at 2.2%, MAJOR DISCREPANCIES ARE NOTIFIED TO THE REFERRING CLINICIAN AND THE PATIENT at 100%, and any reader returning a zero discrepancy rate is investigated rather than praised.**

☐ **AND A SCAN READ WITHOUT PRIOR IMAGING IS A DIFFERENT AND WORSE TEST. So 89% of studies are read WITH priors available, every report read WITHOUT them says so on its face, and prior retrieval runs at a six-minute median. The reporting radiologist is NAMED with registration number, the REPORTING COUNTRY is disclosed, and NIL reports are signed by a radiologist who did not review the images.**

This plan models an operator requiring **₹20.00 crore** (₹8.60 crore investor + ₹6.80 crore term loan + ₹2.80 crore promoter + ₹1.80 crore working capital), moving from **₹9.00 crore revenue and a ₹3.46 crore loss** to **₹52.00 crore revenue and ₹6.24 crore profit** by Year 3 — a 12.0% net margin and 37.7% return on capital. (Teleradiology — figures illustrative.)

2. Business Description, Vision & Legal Structure

Concept: A reporting service that publishes how many scans one person read that night.

Vision: To make studies-per-shift a disclosed safety number rather than a hidden productivity target.

Mission: Cap the shift and publish the cap; pay for sessions, not for pieces; print how many hours into a shift each report was issued; double-read and publish what we find; and never let a report leave without a name, a country and the priors.

Legal structure

- **Private Limited** — recommended. Hospital contracts, international clients, data obligations and outside capital all assume it.
- **Radiologists engaged on sessional employment rather than per-study contracting — the structural precondition for a cap, since a per-study contractor cannot be capped, rostered or paid for a break.**
- **Quality and audit function reporting to the board, independent of operations — because a discrepancy found is a client relationship at risk and a reader's reputation on the line.**

Regulatory anchor: the National Medical Commission's Telemedicine Practice Guidelines and professional conduct regulations, under which **a radiologist reporting remotely must be registered in India to report for an Indian patient, and remains personally accountable for the report regardless of where he sat**; the Clinical Establishments Act 2010 and state rules for the reporting entity where adopted; **AERB and PCPNDT obligations sitting with the ACQUIRING centre rather than the reporting service — the scanner is theirs, the licence is theirs, and the Form F is theirs, which is precisely the split this plan is about**; the Digital Personal Data Protection Act 2023, under which images and reports are sensitive personal data and **cross-border reporting is a transfer question the contract must address explicitly**; the IT Act, CERT-In directions and intermediary obligations for a platform moving clinical images; medical indemnity and vicarious liability, where **the reporting radiologist, the service and the acquiring centre may each be exposed on the same report**; export of services and GST treatment for international contracts; and EPF/ESI and POSH. **The decisive structural fact is that NOTHING ANYWHERE SPECIFIES HOW MANY STUDIES ONE RADIOLOGIST MAY REPORT IN A SHIFT, OR REQUIRES THAT NUMBER TO BE DISCLOSED TO ANYBODY.**

3. Promoter & Ownership

Led by a promoter with radiology, health-technology or clinical services background, with a consultant radiologist as clinical director. Three competences decide outcomes. *Panel building and retention*, because reporting capacity is the entire product and radiologists are scarce, mobile and easily overworked. *Platform and integration engineering*, since prior retrieval, worklist routing and PACS connectivity determine whether a read is done well or merely quickly. And *the willingness to cap the shift*, which is where this plan's proposition sits and which forgoes the volume every competitor takes. Ownership, equity & investor terms are editable inputs; **the quality and audit function reports to the board independently of operations, and no employee's pay is linked to studies reported.**

4. Market Analysis — India

Rapidly growing demand for reading capacity, priced by the piece almost everywhere.

Demand drivers

- **Radiologist scarcity** relative to installed scanner base, particularly outside metros.
- **Night and weekend cover** that small hospitals cannot staff.
- **Sub-specialty reading** — neuro, MSK, cardiac and paediatric — unavailable locally.
- **Imaging volume growth** across trauma, oncology and preventive screening.
- **International outsourcing** to Indian reporting capacity across time zones.
- **PACS and cloud adoption** making remote reading operationally routine.

Market sizing (illustrative framing)

Layer	Definition	Indicative scale
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TAM	Indian and offshore radiology reporting demand	Large; growing faster than radiologist supply
SAM	Studies deliverable within a published per-shift cap	Bounded by PANEL SIZE, not by demand
SOM (Yr 1-3)	Studies reported through a 134-radiologist panel	₹9cr → ₹52cr; 1.24m studies; 27-minute median

Revenue mix and share (Year 3)

Stream	Share	Gross margin — and what the shift looks like
Domestic routine reporting (X-ray, CT, USG)	35.0%	42.0% — high volume; where a cap bites hardest
Emergency / night-hawk reporting	25.0%	46.0% — night shifts; where fatigue error concentrates
Sub-specialty reporting	20.0%	52.0% — slower reads, scarcer readers, better margin
International reporting contracts	10.0%	56.0% — time-zone arbitrage; daytime reads here
Second-opinion & double-reading audit services	6.0%	62.0% — selling the capability that governs us
Platform, PACS integration & workflow licensing	4.0%	82.0% — carries the cap and the priors engine

The second row is where the finding lives and where the money is: night-hawk emergency reporting carries a good margin precisely because hospitals cannot staff those hours, and it is the shift on which a tired radiologist reads the studies that matter most urgently. Capping a night shift is therefore the most expensive version of this plan's central commitment and the one that matters clinically most. The fourth row is the honest counterweight — international contracts are read during Indian daytime hours against overseas nights, which means the time-zone arbitrage that makes them profitable also makes them the LEAST fatiguing work in the book, and growing them is how a capped operation funds itself. The fifth row is unusual: we sell double-reading and discrepancy audit to other providers, which means the capability that constrains our own readers is also a revenue line rather than pure overhead.

Constraints

- **Panel size**, which is the hard ceiling on volume once a cap exists.
- **Radiologist attrition**, which destroys reading quality faster than it destroys capacity.
- **Prior-image availability** from client PACS, which we influence but do not control.
- **Per-study price competition** from operators without a cap.

5. Competition & Position

Competitor type	Strength	Weakness this plan exploits
Large teleradiology providers	Scale, sub-specialty depth, client base, 24x7 cover, price	Per-study pay; studies-per-shift uncapped and undisclosed
Radiologist marketplaces and pools	Asset-light, elastic capacity, low fixed cost	Cannot cap, roster or audit a marketplace participant
Hospital in-house radiology	Clinical context, priors, tumour boards, direct access	Cannot cover nights or sub-specialties at small scale
Offshore reporting into India	Volume, established international contracts	Reporting country often undisclosed to the patient

This plan	Capped shifts, session pay, hours-into-shift printed, discrepancy published	Lower throughput per radiologist; higher price per study
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The positioning makes one claim a hospital can verify on any report it receives: this scan was read by a named radiologist, in a named country, three hours into a capped shift, with the prior study available. None of those four facts is available anywhere else in the market, and a clinician who has ever wondered why an outside report missed something has been wondering about exactly this. The commercial difficulty is that we are more expensive per study and slower to scale, because our capacity is bounded by panel size rather than by how hard the panel can be worked — and a hospital procurement officer comparing price per study has no column for the cap.

The cost of the honest position is stated in rupees rather than implied. Capping studies per shift and paying per session rather than per study cost ₹3.64 crore of Year-3 margin — the largest item, and the entire structural difference between this service and the category. Double-reading 10% of studies and publishing the discrepancy rate cost ₹1.82 crore. Prior-image retrieval infrastructure to reach 89% availability cost ₹94 lakh. Naming the radiologist and reporting country, and refusing any unreviewed sign-off, cost ₹52 lakh. Total ₹6.92 crore against ₹6.24 crore of profit — so an operator with the same panel running trade-standard practice would earn ₹13.16 crore.

6. The Workload Is the Diagnosis

This is the finding, and every element of it is individually invisible.

What a rushed read changes	Who would ever find out
A small nodule not commented on	Nobody — until the next scan, years later
A subtle fracture missed on the eleventh view	The patient, eventually. Rarely traced back.
Priors not compared because retrieval was slow	Nobody
A hedged report where a definite one was possible	Nobody — hedging looks like caution
A normal report that was not read carefully	NOBODY EVER. Normal reports are not re-read.
The number of studies that reader did that night	Not recorded, not disclosed, not asked

The fifth row is the whole problem. In almost every other setting in this library the harm eventually surfaces through somebody's complaint; here THE MOST COMMON FAILURE MODE IS A NORMAL REPORT THAT NOBODY WILL EVER LOOK AT AGAIN. A missed finding on a scan reported as clear does not generate a complaint, a return visit or a bad review — it generates nothing at all, until a different scan years later shows a lesion that was visible on the first one, by which time nobody is looking for a cause. Against that silence sits a per-study rate, which does exactly what a per-visit rate did in home collection: it converts every additional read into income and every careful minute into a cost borne entirely by the reader. He is not being asked to be careless — HE IS BEING PAID MORE FOR GOING FASTER IN A JOB WHERE GOING FASTER IS UNDETECTABLE. And fatigue is the dominant error source in diagnostic radiology, well established in the literature, entirely predictable across a shift — AND NOT MEASURED OR DISCLOSED BY ANY REPORTING SERVICE ANYWHERE. The single number that governs all of it, studies per shift, is set by the service, experienced by the radiologist, relied on by the patient, and recorded by nobody.

So the rate is removed and the number is printed. RADIOLOGISTS ARE ENGAGED ON SESSIONAL EMPLOYMENT AND PAID PER SESSION INCLUDING READING TIME AND BREAKS, never per study — the structural precondition for everything else, since a per-study contractor cannot be capped, rostered or paid to pause. STUDIES ARE CAPPED PER SHIFT ON A COMPLEXITY-WEIGHTED BASIS AND THE CAP IS PUBLISHED, with every shift that exceeded it investigated: 28 in Year 3 against 186 in Year 1. THE HOURS-INTO-SHIFT AT WHICH EACH REPORT WAS ISSUED IS PRINTED ON THE REPORT ITSELF, so a clinician holding an unexpected result can see whether it was read in the first hour or the eighth. AND DISCREPANCY RATE IS MEASURED AGAINST HOURS INTO SHIFT AND PUBLISHED, which is the only way the relationship everybody assumes exists can actually be demonstrated or refuted. Cost ₹3.64 crore. WHERE THE JUDGEMENT IS PAID BY THE PIECE AND THE ERROR IS NEVER FOUND, THE WORKLOAD IS THE DIAGNOSIS.

7. Double Reading, the Name and the Prior

Three further rules, the first of which is the only way an unfound error becomes findable.

□ A SERVICE REPORTING NO DISCREPANCIES IS NOT AUDITING. Radiology has a well-documented irreducible discrepancy rate between competent readers, so a reporting service claiming none has simply not looked — and per the vertical anchor's rule, a gate with no rejections is not a gate. So 10% OF STUDIES ARE DOUBLE-READ, rising from 6%, with the DISCREPANCY RATE FOUND ON AUDIT PUBLISHED AT 2.2% (from 3.4%), MAJOR DISCREPANCIES NOTIFIED TO THE REFERRING CLINICIAN AND THE PATIENT at 100% rather than corrected quietly in the record, and ANY READER RETURNING A ZERO DISCREPANCY RATE INVESTIGATED. Notifying the patient is the expensive half and the part nobody does: an amended report that reaches only the referring clinician has not reached the person whose scan it was.

□ AND THE PATIENT DOES NOT KNOW WHO READ HIS SCAN OR WHERE THEY WERE SITTING. The imaging-centre plan established the rule; teleradiology is where it is hardest, because the whole model depends on the reader being somewhere else, and "somewhere else" is frequently another country. So THE REPORTING RADIOLOGIST IS NAMED ON EVERY REPORT WITH HIS REGISTRATION NUMBER, THE REPORTING COUNTRY IS DISCLOSED, and NIL REPORTS ARE SIGNED BY A RADIOLOGIST WHO DID NOT PERSONALLY REVIEW THE IMAGES. Turnaround is published with its 90th percentile — 27 minutes median against 2.1 hours at the tail — because a median turnaround conceals precisely the studies that waited.

□ AND A SCAN READ WITHOUT PRIORS IS A DIFFERENT AND WORSE TEST. Comparison with earlier imaging is often the single most informative element of a read — a stable nodule and a new one look identical in isolation — and remote reporting systematically degrades prior availability, because the priors sit in a client's PACS rather than on the reader's worklist. So PRIOR RETRIEVAL IS ENGINEERED RATHER THAN HOPED FOR: 89% of studies read with priors available, up from 62%, a six-minute median retrieval time, and EVERY REPORT READ WITHOUT PRIORS SAYS SO ON ITS FACE rather than leaving a clinician to assume comparison was made.

□ AND A CRITICAL FINDING FROM A REMOTE READER MUST STILL REACH A HUMAN. Per the vertical anchor, 99.6% of critical findings reached a NAMED CLINICIAN at the sending site, median six minutes and 22 minutes at the 90th percentile — which is harder remotely than in-house, because the reader has no corridor to walk down.

8. Operations Plan (roster, read, audit, disclose)

The shift

- **Complexity-weighted study cap per shift**, published to clients and radiologists.
- **Sessional pay including reading time and breaks**; nil per-study pay anywhere.
- **Every shift exceeding the cap investigated** and published — 28 in Year 3.
- **Hours-into-shift printed on every report** issued.

Quality

- **10% of studies double-read**, weighted toward night and high-complexity work.
- **Discrepancy rate published**, measured against hours into shift.
- **Major discrepancies notified to clinician and patient**, not corrected quietly.
- **Zero-discrepancy readers investigated**, per the vertical anchor.

Attribution and context

- **Radiologist named with registration number** on every report.
- **Reporting country disclosed** on every report.
- **Nil reports signed without personal review of the images.**
- **Priors retrieved and compared**; reads without priors flagged on the report.

Client interface

- **Critical findings to a named human** at the sending site, measured to the 90th percentile.
- **Turnaround published with its 90th percentile**, never the median alone.
- **AERB and PCPNDT obligations remain the acquiring centre's**, stated in every contract.
- **Cross-border data transfer addressed explicitly** in international contracts.

The operational hinge is a Sunday night with two radiologists ill, a trauma surge across three client hospitals, and a worklist that will clear only if the four readers on shift take nineteen extra studies each — which no client would ever detect, which every study would be read accurately enough to look fine, and which the radiologists themselves would mostly accept, because a hospital waiting on a head CT is a real person and refusing feels like abandonment. So **THE WORKLIST ENGINE CANNOT ASSIGN BEYOND THE CAP**: it is a hard constraint with no per-night, per-client or per-supervisor override, and the alternative is to **ESCALATE TO THE CLIENT AND DIVERT**, which is what happens. Diversions are published alongside cap breaches, because a service that caps shifts and hides the resulting diversions has only moved the number it is embarrassed by. No operations or client-management pay is affected by studies reported.

9. Telemedicine, Liability & Data Compliance (India)

- **NMC Telemedicine Practice Guidelines and conduct regulations** — a radiologist reporting remotely must be registered in India to report for an Indian patient, and remains personally accountable regardless of where he sat.
- **Clinical Establishments Act 2010** and state rules for the reporting entity where adopted.
- **AERB and PCPNDT** — obligations sit with the **ACQUIRING** centre, not the reporting service: the scanner, the licence and the Form F are theirs, which is precisely the split this plan is about.

- **Digital Personal Data Protection Act 2023** — images and reports are sensitive personal data; **cross-border reporting is a transfer question the contract must address explicitly.**
- **IT Act, CERT-In directions and intermediary obligations** for a platform moving clinical images at volume.
- **Indemnity and vicarious liability** — **the reporting radiologist, the service and the acquiring centre may each be exposed on the same report.**
- **Export of services and GST treatment** for international contracts; transfer pricing where applicable.
- **EPF/ESI and POSH** for a night-shift workforce. **Nothing anywhere specifies how many studies one radiologist may report in a shift, or requires that number to be disclosed to anybody.**

10. Organisation & Manpower Plan

Function	Yr 1	Yr 3	Notes
Promoter / managing director	1	1	Owens the shift cap
Reporting radiologists — sessional employment	23	134	Capped, session-paid; the entire product
Technology, PACS, worklist & priors engine	12	32	Cap is a hard constraint in the router
Client integration & support	8	24	Critical findings to a named human
Admin, finance, legal & business development	8	21	Nil pay linked to studies reported
Quality — double reading, discrepancy audit & peer review	5	18	Board-reporting; independent of operations
Panel management, rostering & wellbeing	4	12	Attrition 38% → 16%
Total	61	242	Radiologists at 55% of headcount

A hundred and thirty-four radiologists reading 1.24 million studies is roughly 9,250 studies each a year, or about 42 on a capped shift — and that arithmetic is the whole business model, because a competitor paying per study extracts materially more from the same panel and prices accordingly. The radiologist cost line is the cost of goods here rather than an overhead, which is unusual and makes the trade-off unusually visible: every point of margin comes from either the price a client pays or the volume a reader carries, and this plan has fixed the second. The quality function at eighteen people reports to the board rather than to operations, because **A DISCREPANCY FOUND IS A CLIENT RELATIONSHIP AT RISK AND A READER'S REPUTATION ON THE LINE**, and neither of those pressures should sit with the people deciding how hard to look. Attrition falling from 38% to 16% is the operating figure that matters most: a panel losing a third of its readers annually is permanently staffed by people learning our protocols.

11. Implementation Timeline & Milestones

Phase	Window	Milestones
Formation & platform build	Month 0–8	Incorporation, PACS and worklist, first 23 radiologists credentialed
Cap in the worklist router	Month 3–8	Complexity-weighted hard cap; no override; diversions published
Hours-into-shift reporting	Month 6–12	Printed on every report; discrepancy measured against it
Double-reading programme	Month 9–20	6% → 8% of studies; discrepancy rate published; patient notification live
Priors engine & international contracts	Month 14–28	Prior availability 62% → 78%; daytime international reading

Scale & publication	Month 26–36	1.24m studies; 10% double-read; 2.2% discrepancy published
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Training and competence

- **Reading without clinical context** — what to ask for and when to decline to report.
- **Peer review conduct**, where a discrepancy is a finding rather than an accusation.
- **Critical-finding escalation** to a named human at a site you have never visited.
- **Fatigue self-assessment**, taught explicitly rather than left to professionalism.

12. Financial Plan (Illustrative)

All figures are illustrative model assumptions, not forecasts or guarantees. They exist to show the drivers of a teleradiology P&L under a capped, session-paid model. Every input is editable. **The defining economics are that radiologist cost is the cost of goods rather than an overhead — so the only two levers are price per study and studies per reader, and this plan has deliberately fixed the second.**

12.1 Project cost & funding

Item	₹ lakh	Notes
Technology platform, PACS, worklist, viewers & triage	664	The cap is a hard constraint here, not a policy
Reporting workstations, diagnostic monitors & reading rooms	386	Calibrated displays; reading environment matters
Working capital — client receivables	336	Hospitals settle at 60–90 days
Radiologist recruitment, credentialing & training	246	Panel size is the ceiling on volume
Redundant connectivity, storage & disaster recovery	208	Night-hawk cover cannot fail
Quality infrastructure — double-reading & audit systems	100	Finds errors nobody else looks for
Licences, accreditation, deposits & pre-operative	60	Registration, indemnity, international contracting
Total project cost	2,000	₹860L investor + ₹680L term loan + ₹280L promoter + ₹180L WC

12.2 Operating metrics

Metric	Yr 1	Yr 2	Yr 3
STUDIES PER RADIOLOGIST PER SHIFT — complexity-weighted cap, PUBLISHED to clients and readers / radiologists paid PER STUDY / paid PER SESSION including reading time and breaks / shifts on which the cap was exceeded, each investigated	42 / NIL / 100% / 186	42 / NIL / 100% / 84	42 / NIL / 100% / 28
HOURS-INTO-SHIFT PRINTED ON EVERY REPORT / discrepancy rate MEASURED AGAINST hours into shift and published / reports issued in the final hour of a shift	100% / 100% / 8.2%	100% / 100% / 6.4%	100% / 100% / 4.8%

STUDIES DOUBLE-READ / discrepancy rate found on audit, published / MAJOR discrepancies notified to the referring clinician AND THE PATIENT / readers returning a ZERO discrepancy rate, investigated	6.0% / 3.4% / 100% / 100%	8.0% / 2.8% / 100% / 100%	10.0% / 2.2% / 100% / 100%
REPORTING RADIOLOGIST NAMED with registration number / REPORTING COUNTRY disclosed / reports signed by a radiologist who did NOT personally review the images	100% / 100% / NIL	100% / 100% / NIL	100% / 100% / NIL
Studies read WITH prior imaging available / reads WITHOUT priors flagged as such on the report / median prior-retrieval time	62% / 100% / 22 min	78% / 100% / 11 min	89% / 100% / 6 min
Critical findings reaching a NAMED HUMAN at the sending site (median, 90th pct) / studies reported / turnaround median (90th percentile) / radiologists / radiologist attrition	96.8% (14, 46 min) / 0.21m / 42 min (3.8h) / 23 / 38%	98.4% (9, 32 min) / 0.62m / 34 min (2.9h) / 67 / 26%	99.6% (6, 22 min) / 1.24m / 27 min (2.1h) / 134 / 16%

Row two contains the disclosure no reporting service in the world makes: the hours-into-shift at which each report was issued, printed on the report, so a clinician holding an unexpected result can see whether it was read in the first hour or the eighth. Publishing discrepancy rate AGAINST that variable is the only way the relationship everybody assumes exists can be demonstrated or refuted, and it exposes us to a finding we may not like. Row three's 2.2% discrepancy rate is published rather than concealed, because radiology has a well-documented irreducible discrepancy rate between competent readers and a service claiming none has simply not looked — and notifying the PATIENT as well as the clinician is the expensive half, since an amended report reaching only the referrer has not reached the person whose scan it was. Row six's attrition falling from 38% to 16% matters more than any throughput figure, because a panel losing a third of its readers annually is permanently staffed by people still learning.

12.3 Revenue build

Stream	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)	Gross margin
Domestic routine reporting (X-ray, CT, USG)	315	910	1,820	42.0%
Emergency / night-hawk reporting	225	650	1,300	46.0%
Sub-specialty reporting	180	520	1,040	52.0%
International reporting contracts	90	260	520	56.0%
Second-opinion & double-reading audit services	54	156	312	62.0%
Platform, PACS integration & workflow licensing	36	104	208	82.0%
Total revenue	900	2,600	5,200	49.2% blended

12.4 P&L summary

Line	Yr 1 (₹L)	Yr 2 (₹L)	Yr 3 (₹L)
Revenue	900	2,600	5,200
Cost of reporting — radiologist sessional fees	(457)	(1,321)	(2,642)
Gross profit	443	1,279	2,558

Technology, PACS, worklist & priors engine	(168)	(246)	(364)
Quality — double reading, discrepancy audit & peer review	(142)	(218)	(364)
Client integration & support	(96)	(148)	(208)
Panel management, rostering & wellbeing	(82)	(118)	(182)
Marketing & business development	(78)	(112)	(156)
Admin, legal, compliance & other	(128)	(186)	(270)
EBITDA	(251)	251	1,014
Depreciation & amortisation	(118)	(186)	(260)
Finance cost	(38)	(58)	(78)
Other income — platform licensing and audit engagements <i>(disclosed)</i>	54	104	156
PBT	(461)	111	832
Tax	115	(28)	(208)
PAT	(346)	83	624
Net margin	(38.4%)	3.2%	12.0%
ROCE	(18.5%)	3.3%	37.7%

Radiologist sessional fees at ₹26.42 crore are 50.8% of revenue and sit in cost of goods rather than in overhead, which makes the central trade-off unusually visible: the only two levers in this business are price per study and studies per reader, and this plan has fixed the second by rule. Quality at ₹3.64 crore is 7.0% of revenue spent looking for errors that nobody would otherwise find, and part of that capability is sold back to the market as second-opinion and audit services at 62% margin — the same structure the surgical-supplies plan used, where the capability that constrains you also funds you. Other income of ₹1.56 crore is platform licensing and audit engagements, disclosed as a line. Commitments of ₹6.92 crore against ₹6.24 crore of profit mean an operator with the same 134-radiologist panel running trade-standard practice would earn ₹13.16 crore.

12.5 Break-even & sensitivity

Scenario	Yr 3 revenue	Yr 3 PAT	Comment
Base	₹52.0cr	₹6.24cr	As modelled, capped at 42 studies per shift
Per-study pay, no cap	₹61.4cr	₹11.82cr	The category's model, computed rather than dismissed
Cap raised to 58 studies per shift	₹71.8cr	₹17.56cr	Same panel, longer worklists, invisible to every client
Radiologist fee inflation +20%	₹52.0cr	₹2.28cr	Reader cost IS the cost of goods
Attrition doubles to 32%	₹48.9cr	₹4.45cr	Capability loss, not capacity loss
Half the international book lost	₹49.4cr	₹5.14cr	Daytime reading is what funds the cap

13. Funding Requirement & Bankability

Source	₹ lakh	Terms (indicative)
Investor equity	860	Platform and panel build; shift-cap covenant
Term loan	680	Technology, workstations and infrastructure; 5 years
Promoter contribution	280	Cash and clinical leadership
Working capital facility	180	Client receivables at 60–90 days
Total	2,000	Illustrative structure

An investor should read attrition, panel size and the discrepancy series, and should understand that the shift cap is a deliberate ceiling on revenue rather than an operational inefficiency. The single most striking number in the sensitivity table is that raising the cap from 42 to 58 studies would take profit from ₹6.24 crore to ₹17.56 crore with the same panel, the same clients and the same technology — a change no client could detect, no regulator specifies, and no patient would ever learn of. That is precisely why it is a covenant. Radiologist fee inflation is the sharpest operating exposure at ₹2.28 crore for a 20% movement, because reader cost is cost of goods here. Attrition doubling costs ₹1.79 crore of profit and, more importantly, replaces experienced readers with new ones — a capability loss rather than a capacity loss, which is the harder thing to recover.

- **Use of funds** — 33% technology platform, 19% workstations and reading rooms, 17% working capital, 12% recruitment and credentialing, 10% connectivity and disaster recovery, 5% quality infrastructure, 3% licences.
 - **Repayment** — term loan from Year 3 cash flow; working capital revolving against client receivables.
 - **Investor exit** — sale to a diagnostics chain, a hospital network or a health-technology group; or promoter buyback.
- Shift-cap, disclosure and double-reading commitments survive change of control.**

14. Risk Analysis & Mitigation

Risk	Impact	Mitigation
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The workload is the diagnosis	A teleradiologist is PAID PER STUDY, READS ALONE, AT NIGHT, ACROSS TIME ZONES, WITH NO CLINICAL CONTEXT AND NOBODY TO ASK. The per-study rate makes STUDIES PER SHIFT the variable he optimises — and what is compressed is A DIAGNOSTIC JUDGEMENT. THE MOST COMMON FAILURE MODE IS A NORMAL REPORT THAT NOBODY WILL EVER LOOK AT AGAIN: a missed finding on a scan reported as clear generates NO COMPLAINT, NO RETURN VISIT AND NO BAD REVIEW — it generates NOTHING AT ALL, until a different scan years later shows a lesion visible on the first, BY WHICH TIME NOBODY IS LOOKING FOR A CAUSE. HE IS NOT BEING ASKED TO BE CARELESS — HE IS BEING PAID MORE FOR GOING FASTER IN A JOB WHERE GOING FASTER IS UNDETECTABLE. And FATIGUE IS THE DOMINANT ERROR SOURCE IN DIAGNOSTIC RADIOLOGY, WELL ESTABLISHED IN THE LITERATURE, ENTIRELY PREDICTABLE ACROSS A SHIFT — AND NOT MEASURED OR DISCLOSED BY ANY REPORTING SERVICE ANYWHERE. THE SINGLE NUMBER GOVERNING ALL OF IT IS SET BY THE SERVICE, EXPERIENCED BY THE RADIOLOGIST, RELIED ON BY THE PATIENT, AND RECORDED BY NOBODY	REMOVE THE RATE AND PRINT THE NUMBER. RADIOLOGISTS ON SESSIONAL EMPLOYMENT PAID PER SESSION INCLUDING READING TIME AND BREAKS, NEVER PER STUDY — THE STRUCTURAL PRECONDITION, SINCE A PER-STUDY CONTRACTOR CANNOT BE CAPPED, ROSTERED OR PAID TO PAUSE. STUDIES CAPPED PER SHIFT ON A COMPLEXITY-WEIGHTED BASIS AND THE CAP PUBLISHED TO CLIENTS AND READERS, with every exceeding shift INVESTIGATED (28 from 186). HOURS-INTO-SHIFT PRINTED ON EVERY REPORT, so a clinician holding an unexpected result CAN SEE WHETHER IT WAS READ IN THE FIRST HOUR OR THE EIGHTH. AND DISCREPANCY RATE MEASURED AGAINST HOURS INTO SHIFT AND PUBLISHED — THE ONLY WAY THE RELATIONSHIP EVERYBODY ASSUMES EXISTS CAN BE DEMONSTRATED OR REFUTED, EXPOSING US TO A FINDING WE MAY NOT LIKE (₹3.64cr). GENERAL RULE: WHERE THE JUDGEMENT IS PAID BY THE PIECE AND THE ERROR IS NEVER FOUND, THE WORKLOAD IS THE DIAGNOSIS
Sunday night, two readers ill	A trauma surge across three client hospitals and a worklist that clears ONLY IF FOUR READERS TAKE NINETEEN EXTRA STUDIES EACH — WHICH NO CLIENT WOULD EVER DETECT, which every study would be read accurately enough TO LOOK FINE, and WHICH THE RADIOLOGISTS THEMSELVES WOULD MOSTLY ACCEPT, BECAUSE A HOSPITAL WAITING ON A HEAD CT IS A REAL PERSON AND REFUSING FEELS LIKE ABANDONMENT	THE WORKLIST ENGINE CANNOT ASSIGN BEYOND THE CAP — a hard constraint with NO PER-NIGHT, PER-CLIENT OR PER-SUPERVISOR OVERRIDE — and the alternative is TO ESCALATE TO THE CLIENT AND DIVERT. THE SYSTEM REFUSES RATHER THAN WARNS. DIVERSIONS ARE PUBLISHED ALONGSIDE CAP BREACHES, BECAUSE A SERVICE THAT CAPS SHIFTS AND HIDES THE RESULTING DIVERSIONS HAS ONLY MOVED THE NUMBER IT IS EMBARRASSED BY; and NO OPERATIONS OR CLIENT-MANAGEMENT PAY IS AFFECTED BY STUDIES REPORTED
A service reporting no discrepancies is not auditing	Radiology has a WELL-DOCUMENTED IRREDUCIBLE DISCREPANCY RATE BETWEEN COMPETENT READERS, so a service claiming none HAS SIMPLY NOT LOOKED — and an amended report that reaches only the referring clinician HAS NOT REACHED THE PERSON WHOSE SCAN IT WAS	10% OF STUDIES DOUBLE-READ (from 6%), weighted toward NIGHT AND HIGH-COMPLEXITY work; DISCREPANCY RATE FOUND ON AUDIT PUBLISHED AT 2.2% (from 3.4%); MAJOR DISCREPANCIES NOTIFIED TO THE REFERRING CLINICIAN AND THE PATIENT at 100% RATHER THAN CORRECTED QUIETLY IN THE RECORD — the expensive half and the part nobody does; and ANY READER RETURNING A ZERO DISCREPANCY RATE INVESTIGATED (vertical anchor rule d). Quality reports TO THE BOARD, because A DISCREPANCY FOUND IS A CLIENT RELATIONSHIP AT RISK AND A READER'S REPUTATION ON THE LINE (₹1.82cr)

Nobody knows who read it or where they sat	The imaging-centre rule is HARDEST HERE, because the whole model depends on the reader being SOMEWHERE ELSE — and "somewhere else" is frequently ANOTHER COUNTRY, which the patient is never told	REPORTING RADIOLOGIST NAMED ON EVERY REPORT WITH REGISTRATION NUMBER; REPORTING COUNTRY DISCLOSED; NIL REPORTS SIGNED BY A RADIOLOGIST WHO DID NOT PERSONALLY REVIEW THE IMAGES; and turnaround published WITH ITS 90TH PERCENTILE (27 min median against 2.1h at the tail), because A MEDIAN CONCEALS PRECISELY THE STUDIES THAT WAITED (₹52L)
A scan read without priors is a different and worse test	Comparison with earlier imaging is often THE SINGLE MOST INFORMATIVE ELEMENT OF A READ — A STABLE NODULE AND A NEW ONE LOOK IDENTICAL IN ISOLATION — and remote reporting SYSTEMATICALLY DEGRADES PRIOR AVAILABILITY, because the priors sit in A CLIENT'S PACS RATHER THAN ON THE READER'S WORKLIST	PRIOR RETRIEVAL ENGINEERED RATHER THAN HOPED FOR: 89% of studies read WITH priors (from 62%), a SIX-MINUTE median retrieval, and EVERY REPORT READ WITHOUT PRIORS SAYS SO ON ITS FACE rather than leaving a clinician TO ASSUME COMPARISON WAS MADE (₹94L); client PACS integration treated as a contractual obligation rather than a convenience
Critical findings from a remote reader	A critical finding must still reach a human, which is HARDER REMOTELY THAN IN-HOUSE BECAUSE THE READER HAS NO CORRIDOR TO WALK DOWN	99.6% of critical findings reaching a NAMED CLINICIAN at the sending site, median 6 minutes and 22 minutes at the 90th percentile (vertical anchor rule c); escalation path defined per client site with a named backup; and unclosed escalations investigated individually
Panel size, attrition and fee inflation	Panel size is the HARD CEILING on volume once a cap exists; attrition doubling to 32% takes profit to ₹4.45cr as A CAPABILITY LOSS RATHER THAN A CAPACITY LOSS; and 20% fee inflation takes it to ₹2.28cr because READER COST IS COST OF GOODS	Sessional employment with predictable rosters as the retention proposition in a market of per-study contracting; attrition driven 38% → 16% and reported as an operating metric; sub-specialty and daytime international work offered as varied, less fatiguing rotation; panel recruitment run continuously ahead of demand; and wellbeing and fatigue self-assessment taught explicitly rather than left to professionalism
Liability, jurisdiction and data transfer	THE REPORTING RADIOLOGIST, THE SERVICE AND THE ACQUIRING CENTRE MAY EACH BE EXPOSED ON THE SAME REPORT, and cross-border reporting raises a data-transfer question under DPDP that contracts frequently leave silent	Indian registration verified for every radiologist reporting on an Indian patient; indemnity carried at service and reader level; AERB and PCPNDT obligations stated in every contract as THE ACQUIRING CENTRE'S; cross-border transfer addressed EXPLICITLY in international contracts rather than by silence; and CERT-In logging and incident procedures live across the image platform

15. SWOT Analysis

Strengths • 42-study shift cap, published to clients and readers • Session pay; nil per-study pay anywhere • Hours-into-shift printed on every report • 10% double-read; 2.2% discrepancy published • Radiologist and country named; 89% read with priors	Weaknesses • ₹6.92cr forgone against ₹6.24cr of profit • Higher price per study; capacity bounded by panel • Reader cost is cost of goods, not overhead • Publishes a discrepancy rate competitors do not
Opportunities • Hospitals that have received a missed finding from elsewhere • Daytime international reading funding the cap • Second-opinion and audit sold as a service • Radiologists seeking employment over piece rates • Any regulation of reporting workload favours us	Threats • Uncapped competitors pricing below our cost base • Radiologist fee inflation and scarcity • Attrition eroding capability faster than capacity • Client PACS integration limiting prior availability

16. Recommended AiSevak Tools for This Business

- **Hard shift cap in the worklist router** — a study beyond the cap cannot be assigned; no override role exists.
- **Hours-into-shift stamp** — printed on every report, and the axis against which discrepancy is measured.
- **Double-reading allocator** — 10% of studies, weighted to night and complexity, with results published.
- **Discrepancy notification** — major discrepancies routed to clinician and patient, not amended silently.
- **Priors engine** — retrieval from client PACS, with reads lacking priors flagged on the report.
- **Attribution block** — radiologist name, registration and reporting country on every report.
- **Critical-finding escalation** — named human at the sending site, median and 90th percentile tracked.

17. Key Assumptions & Notes

- **All financials are illustrative model assumptions, not forecasts, projections or guarantees.** Revenue, study volumes, panel size, cap levels, discrepancy and attrition rates are editable inputs; actual outcomes depend on radiologist supply, client integration, fee levels and international contracting. Figures are in Indian rupees. **This plan inherits the diagnostics vertical's anchor rules and hardens the attribution rule first set in `diagnostic-imaging-centre`.**
- **The central integrity finding is that a teleradiologist is paid per study, reads alone, at night, across time zones, with no clinical context and nobody to ask.** The per-study rate makes studies per shift the single variable he optimises — exactly as the per-visit rate did for a phlebotomist — except that what is compressed here is a diagnostic judgement. **And the most common failure mode is a normal report that nobody will ever look at again: a missed finding on a scan reported as clear generates no complaint, no return visit and no bad review, only a lesion visible in hindsight on a different scan years later, by which time nobody is looking for a cause. He is not being asked to be careless — he is being paid more for going faster in a job where going faster is undetectable.** Fatigue is the dominant error source in diagnostic radiology, well established in the literature and entirely predictable across a shift, and it is not measured or disclosed by any reporting service anywhere.

- **So the rate is removed and the number is printed.** Radiologists are engaged on sessional employment and paid per session including reading time and breaks, never per study — the structural precondition, since a per-study contractor cannot be capped, rostered or paid to pause. Studies are capped per shift on a complexity-weighted basis and the cap is published to clients and readers, with every exceeding shift investigated: 28 in Year 3 against 186 in Year 1. The hours-into-shift at which each report was issued is printed on the report, so a clinician holding an unexpected result can see whether it was read in the first hour or the eighth. **And discrepancy rate is measured against hours into shift and published, which is the only way the relationship everybody assumes exists can be demonstrated or refuted — and which exposes us to a finding we may not like. It costs ₹3.64 crore. WHERE THE JUDGEMENT IS PAID BY THE PIECE AND THE ERROR IS NEVER FOUND, THE WORKLOAD IS THE DIAGNOSIS.**
- **A service reporting no discrepancies is not auditing.** Radiology has a well-documented irreducible discrepancy rate between competent readers, so a service claiming none has simply not looked. **10% of studies are double-read, weighted toward night and high-complexity work; the discrepancy rate found on audit is published at 2.2%; major discrepancies are notified to the referring clinician AND the patient rather than corrected quietly in the record — the expensive half and the part nobody does, since an amended report reaching only the referrer has not reached the person whose scan it was; and any reader returning a zero discrepancy rate is investigated.** The quality function reports to the board, because a discrepancy found is a client relationship at risk and a reader's reputation on the line.
- **Nobody knows who read the scan, where they were sitting, or whether they had the priors.** The attribution rule is hardest here because the whole model depends on the reader being somewhere else, and somewhere else is frequently another country — so the radiologist is named with registration number, the reporting country is disclosed, and nil reports are signed without personal review of the images. **And because comparison with earlier imaging is often the single most informative element of a read — a stable nodule and a new one look identical in isolation — prior retrieval is engineered rather than hoped for: 89% read with priors from 62%, a six-minute median, and every report read without them says so on its face rather than leaving a clinician to assume comparison was made.**
- **The hardest operational moment is a Sunday night with two readers ill.** A trauma surge and a worklist that clears only if four readers take nineteen extra studies each — invisible to every client, read accurately enough to look fine, and accepted by most radiologists because a hospital waiting on a head CT is a real person. **So the worklist engine cannot assign beyond the cap, with no per-night, per-client or per-supervisor override, and the alternative is to escalate and divert — with diversions published alongside cap breaches, because a service that caps shifts and hides the resulting diversions has only moved the number it is embarrassed by.**
- **The economics make the trade-off unusually visible.** Radiologist sessional fees at ₹26.42 crore are 50.8% of revenue and sit in cost of goods rather than overhead, so the only two levers are price per study and studies per reader — and this plan has fixed the second by rule. **The starkest figure in the model is that raising the cap from 42 to 58 studies would take profit from ₹6.24 crore to ₹17.56 crore with the same panel, the same clients and the same technology: a change no client could detect, no regulator specifies, and no patient would ever learn of. That is exactly why it is a covenant.** Commitments of ₹6.92 crore against ₹6.24 crore of profit mean a trade-standard operator with the same panel would earn ₹13.16 crore, and attrition doubling costs ₹1.79 crore — a capability loss rather than a capacity loss, which is the harder thing to recover.
- **Compliance and professional advice.** NMC Telemedicine Practice Guidelines and conduct regulations, under which a radiologist reporting remotely must be registered in India to report for an Indian patient and remains personally accountable regardless of where he sat; the Clinical Establishments Act 2010 and state rules for the reporting entity; **AERB and PCPNDT obligations sitting with the acquiring centre rather than the reporting service — the scanner, the licence and the Form F are theirs, which is precisely the split this plan is about** the Digital Personal Data Protection Act 2023, under which images and reports are sensitive personal data and cross-border

reporting is a transfer question the contract must address explicitly; the IT Act, CERT-In directions and intermediary obligations; indemnity and vicarious liability, where the reporting radiologist, the service and the acquiring centre may each be exposed on the same report; export of services and GST treatment for international contracts; and EPF/ESI and POSH for a night-shift workforce. **Nothing anywhere specifies how many studies one radiologist may report in a shift, or requires that number to be disclosed to anybody — which is why the cap is a business decision rather than a compliance one.** Professional advice should be taken on registration requirements for cross-border reporting, liability allocation between service and acquiring centre, data transfer terms and indemnity structure.

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