

BUSINESS OF MEDICINE

dpm

Financially empowering doctors

Welcome to Mastering the Business of Medicine

Sean O’Neil
Tax Consultant



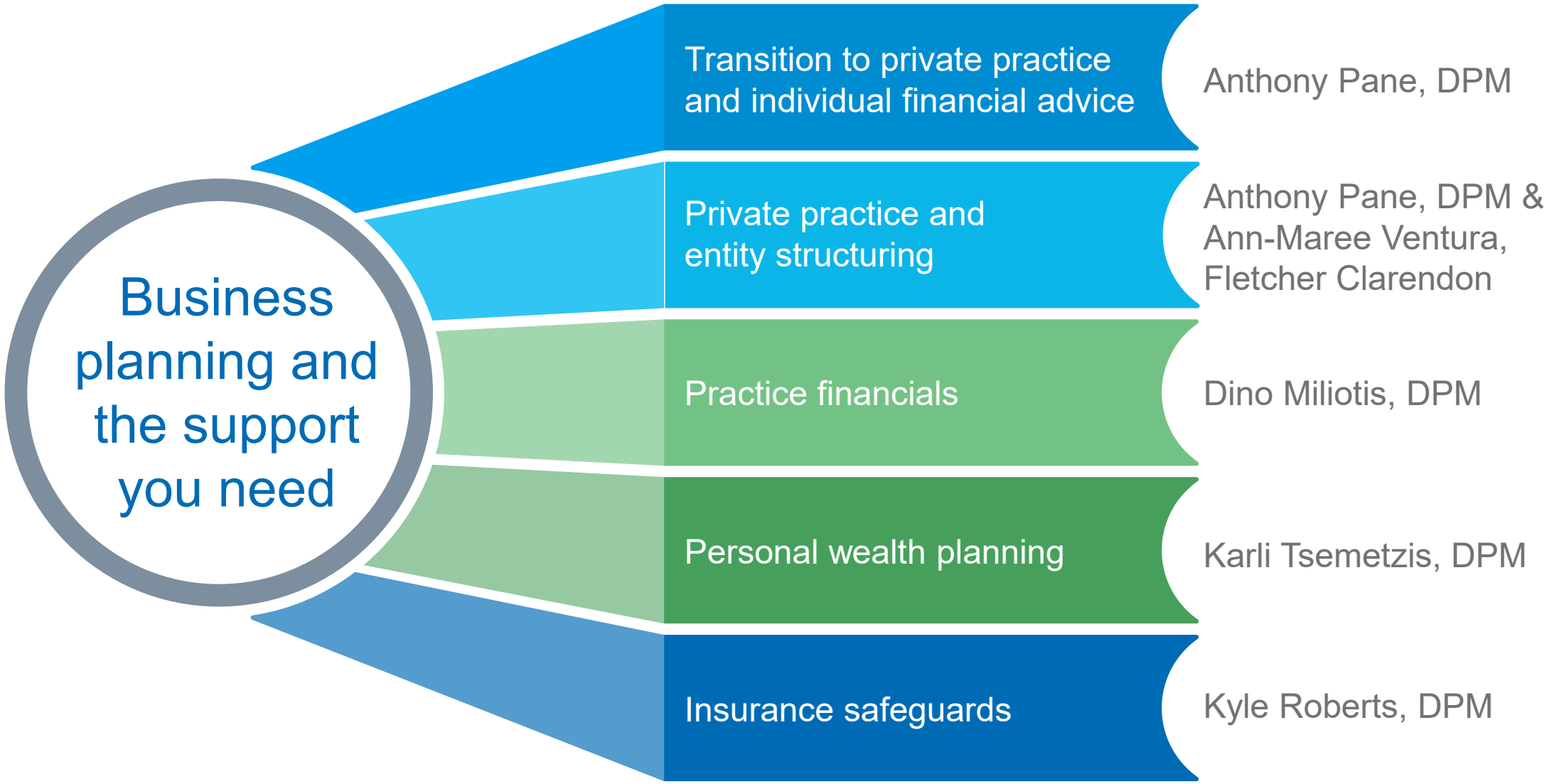
What does the day look like

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8.45	Business planning and the support you need
10.30	Morning tea
12.15	Lunch
1.15	Practice management
3.00	Afternoon tea
5.30	Networking Drinks

Business planning and the support you need

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Transitioning to Private Practice

Setting yourself up for success

Anthony Pane
Tax Principal



General information

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You've trained for many years to become a specialist in your field…

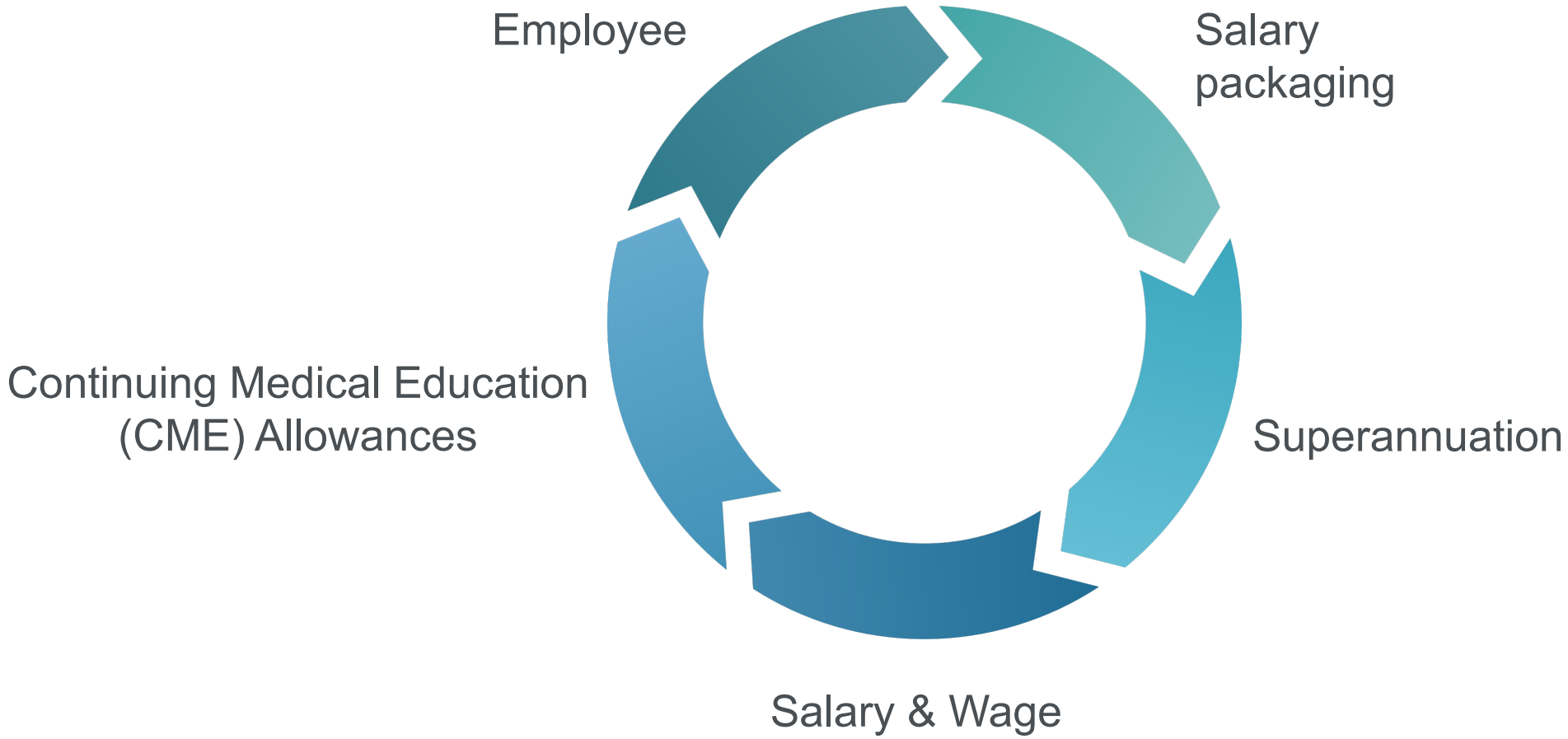
…You should understand what being a specialist means, financially

What we'll cover

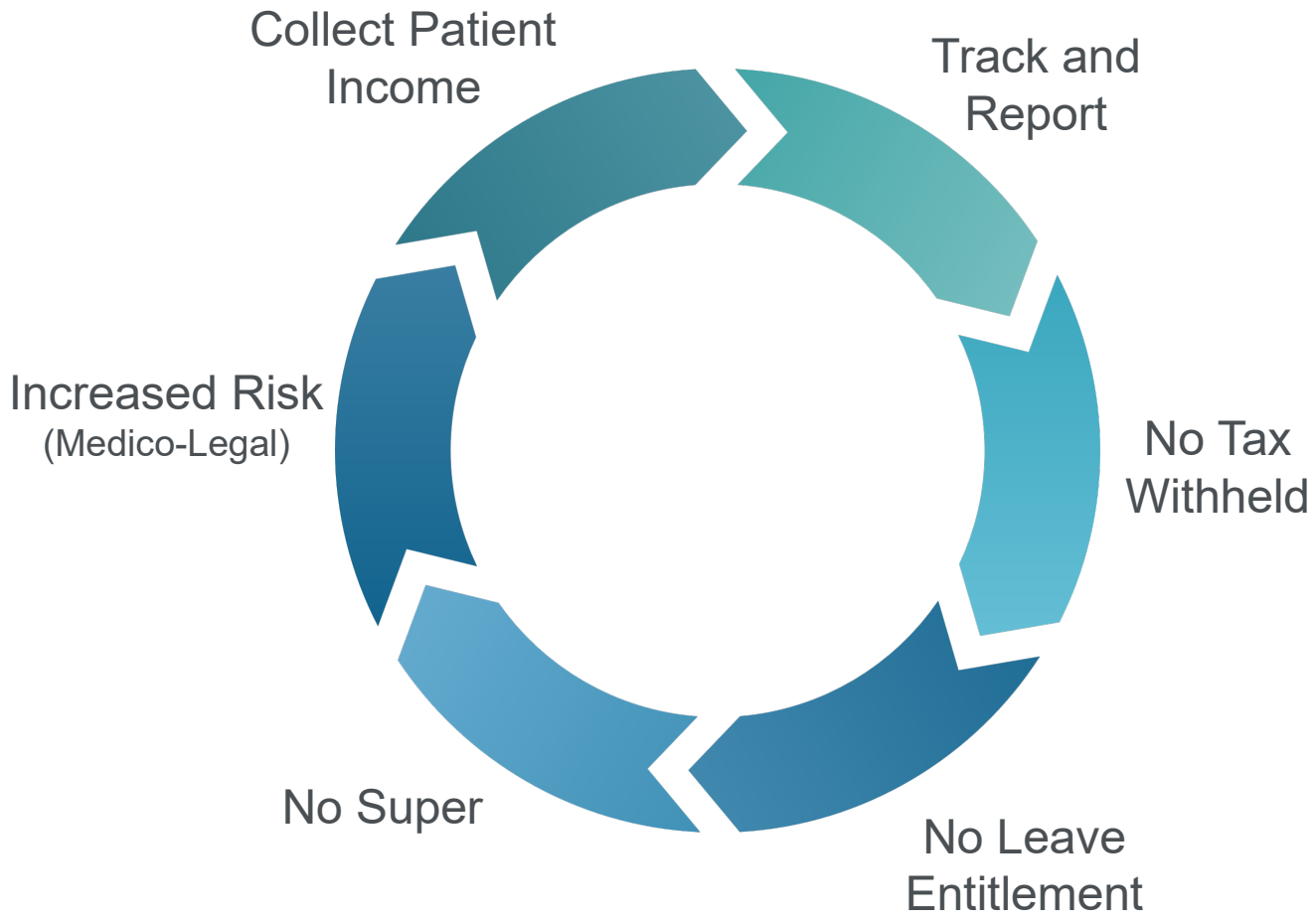
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1. Employee Consultant
2. Private Consultant
3. Personal Finances
4. Entering Private Practice
5. Practice Structuring
6. Questions

Hospital provides you with the services you need



You become responsible for everything



Private Consultant

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Structure

Sole Trader



Operate as a business

Under your personal ABN



Why?

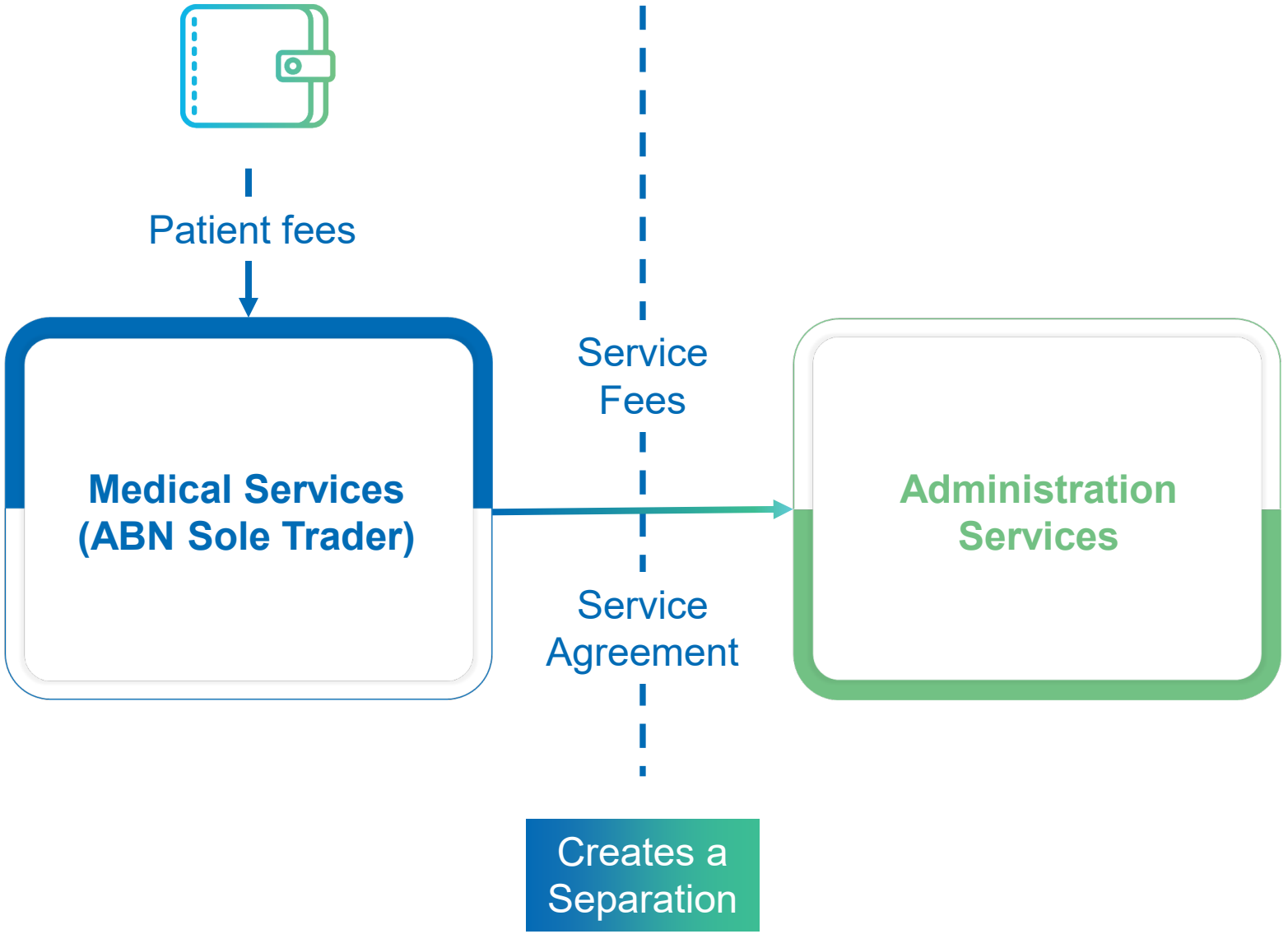
Personal Services Income (PSI) rules

- Your effort/exertion
- Your provider number
- Your indemnity insurance

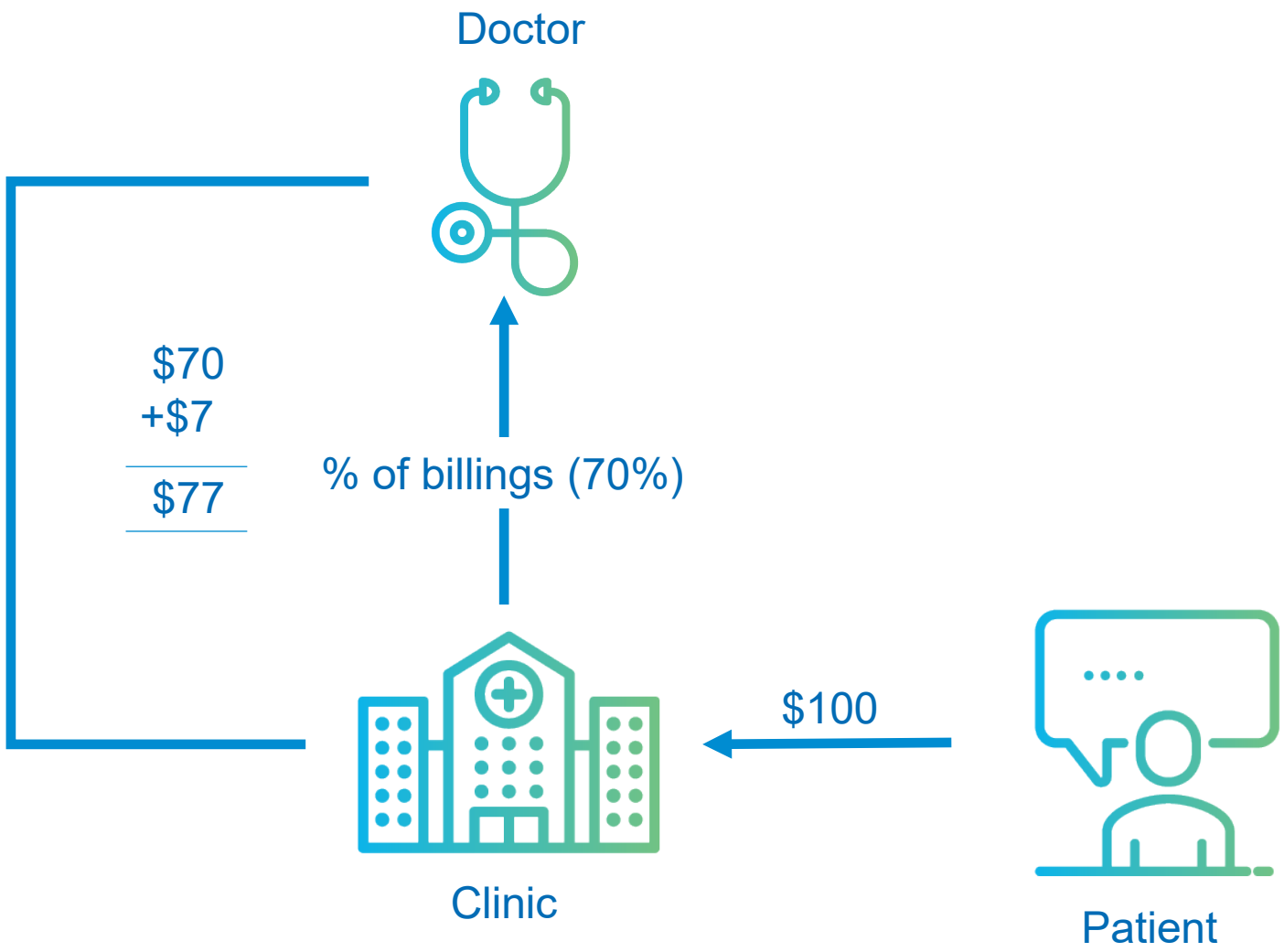
Billing, GST & BAS



Private Income Structure



Billing Method: % of Billing Model



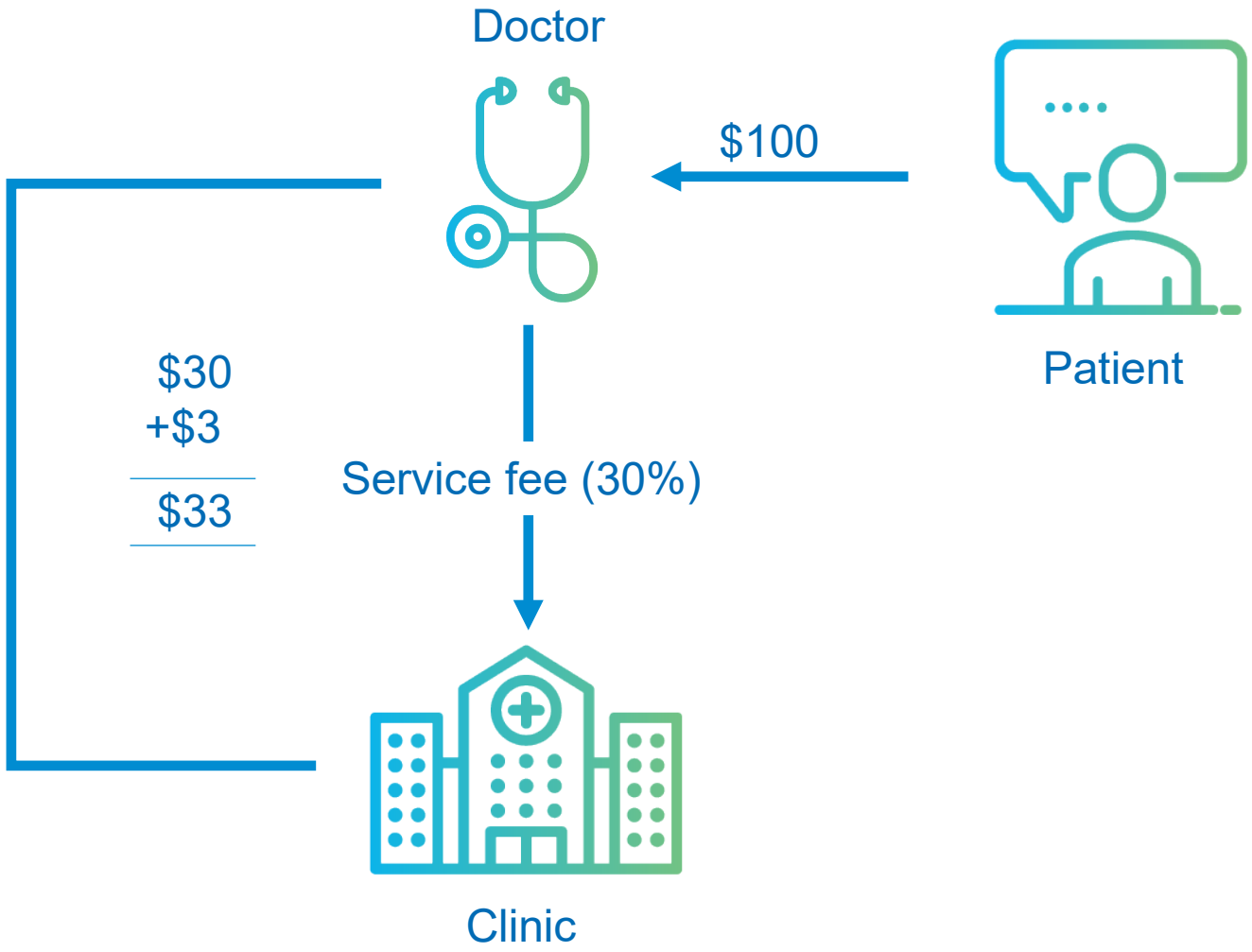
Issues to consider:

- Payroll tax
- Super
- PAYGW
- Workcover

Business Activity Statements

Income	=	$ 77	
Expenses	=	$ 0	
		$ 77	
		$ - 7	>ATO
		$ 70	

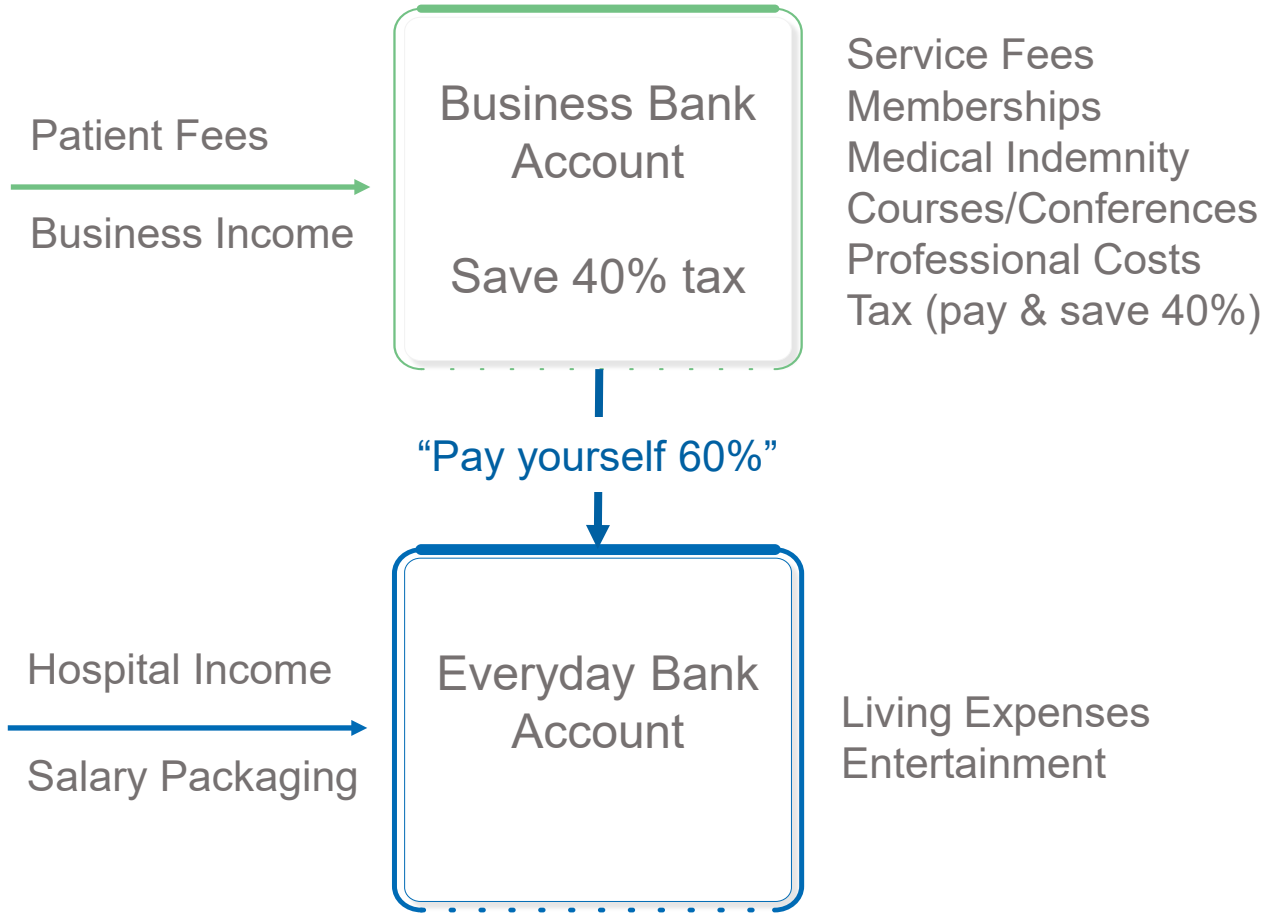
Billing Method: Service Fee Model



Business Activity Statements

Income	=	$	100	
Expenses	=	$	33	
		$	67	
		$	+ 3	<ATO
		$	70	

Banking Structure



SYSTEMS

xero

Your Income Tax Return

- One Tax Return
- Now Includes a Business Schedule
- “Net” Figures Reported to ATO
  - College Fees $2,200
    GST Refunded in BAS ($200)
  - Deductible Expense $2,000



Summary so far…

- Public consulting
- Sole Trader with ABN
- Understand your billing method
- Set up your bank accounts
- Report on Income Quarterly for GST
- Annual Tax Return



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PERSONAL FINANCES



Budget – have one!

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Purpose

- Understand cash flow
- Make informed decisions
- Step 1 towards financial independence



Frequency

- Annual vs Monthly
- Review regularly



Having a goal or target

- More likely to follow



Options

- Spreadsheet
- Apps
- Online banking tools (DPM Calculators, MoneySmart)

Banking



- Flow of cash
- Dedicated "Business" bank account
- Offset accounts (multiple) / saving account
- Setting cash aside for tax

Tax Planning

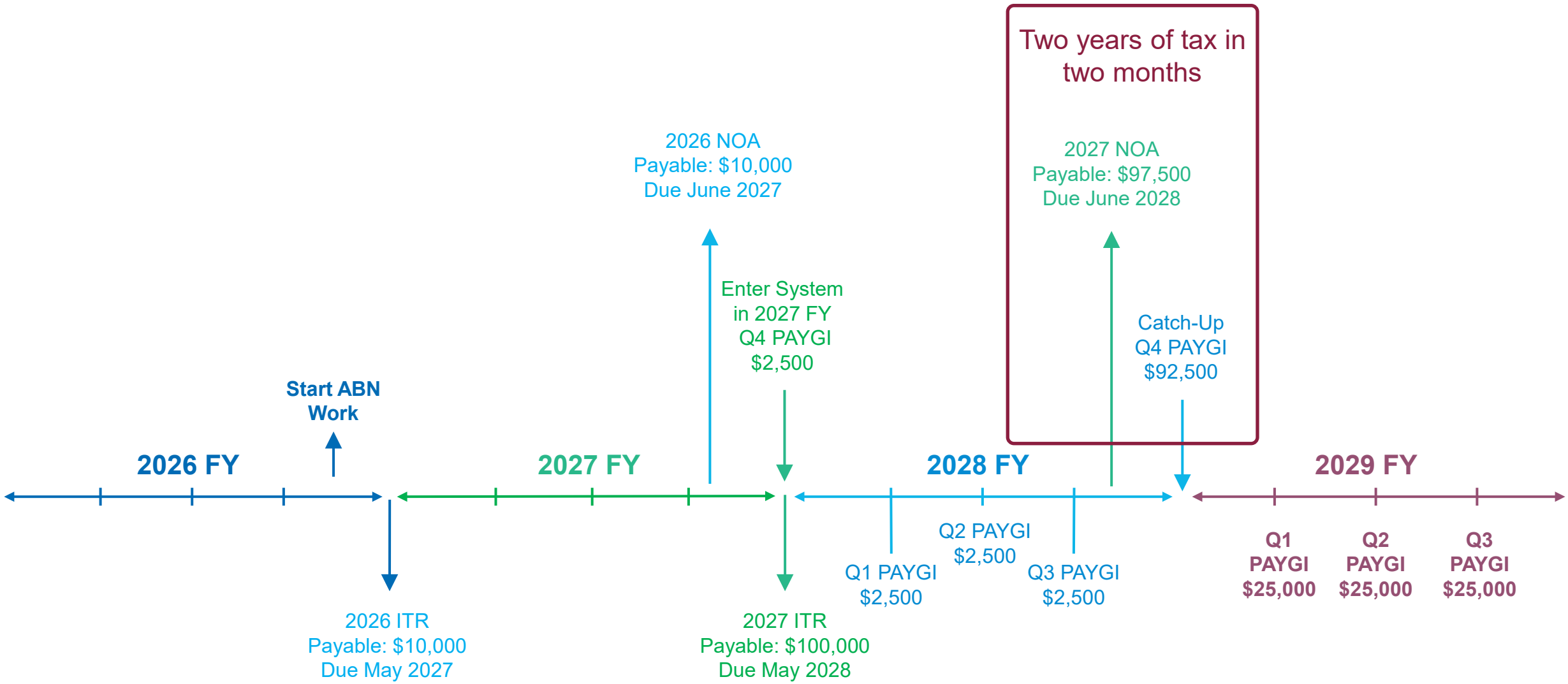
Paying Tax

- Initially, you save & pay when you lodge your first tax return

Enter PAYGI System

- Instalments are based on the last tax return lodged
- “Notional tax" amount

Tax Timeline



Debt Structuring

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Decisions to be made for homeowners with a mortgage

a) Pay off mortgage (with redraw available)

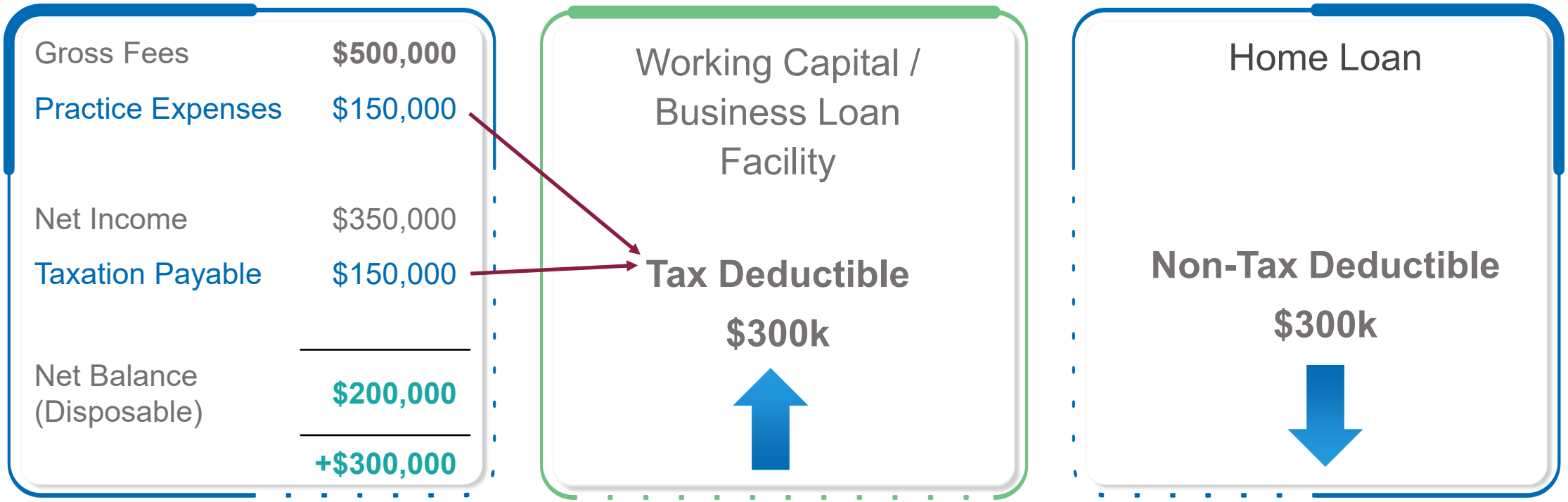
OR

b) Keep the cash in an offset account

Why?

- Saves the same amount of interest as paying down the debt
- Integrity of purpose of the loan is maintained

Tax Efficient Debt Structuring



Debt Structuring

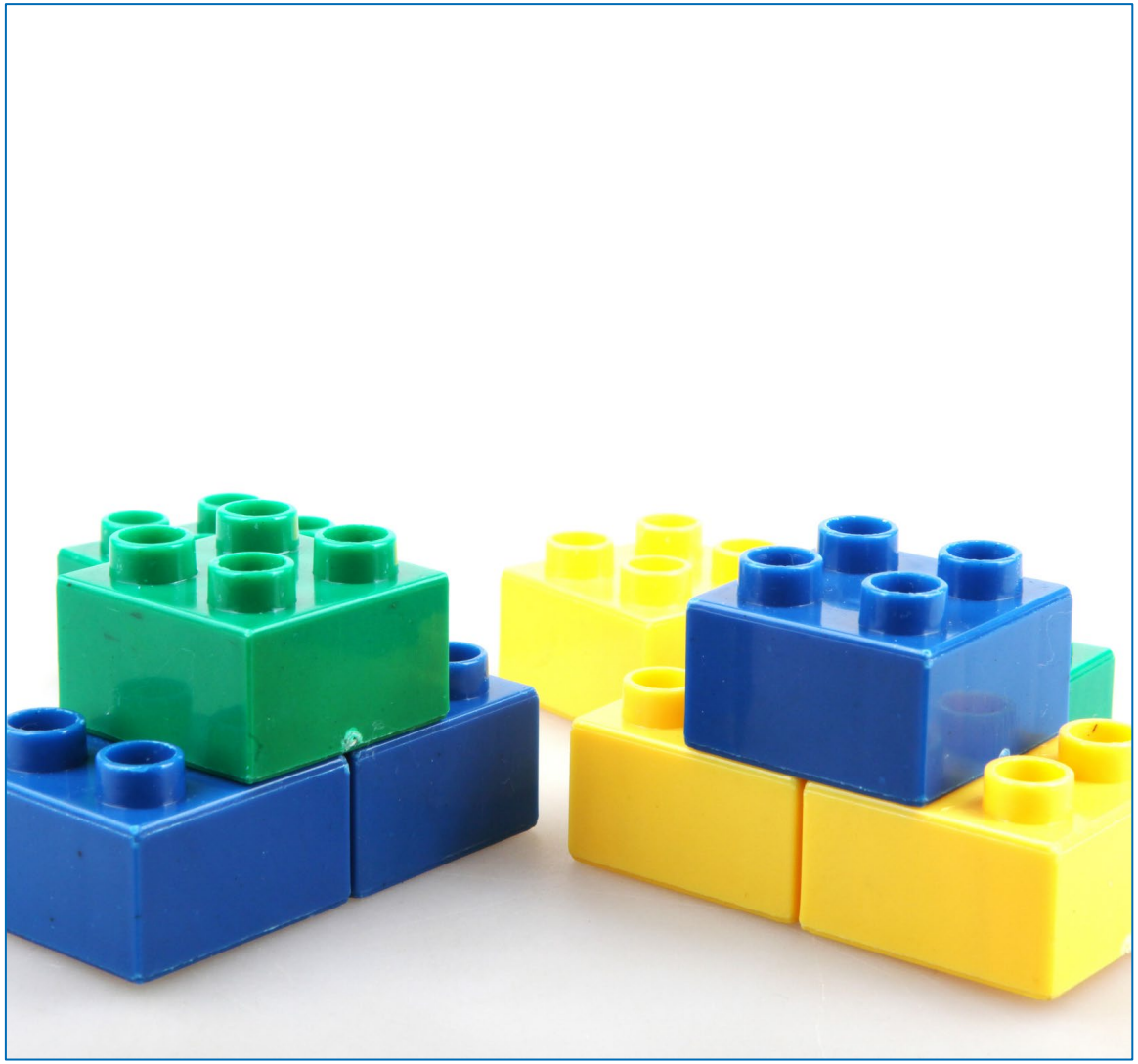
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Why is it important?

- Reduce overall cost of debt
- Increase take home/net income
- Minimise tax in a legitimate manner
- Free up cash flow for other purposes e.g. investing or contributing to super

Choosing a bank is not simple

- Interest vs flexibility
- Ability to utilise home equity vs unsecured lending



Investment Structuring

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Asset Risk

- Protection from Creditors

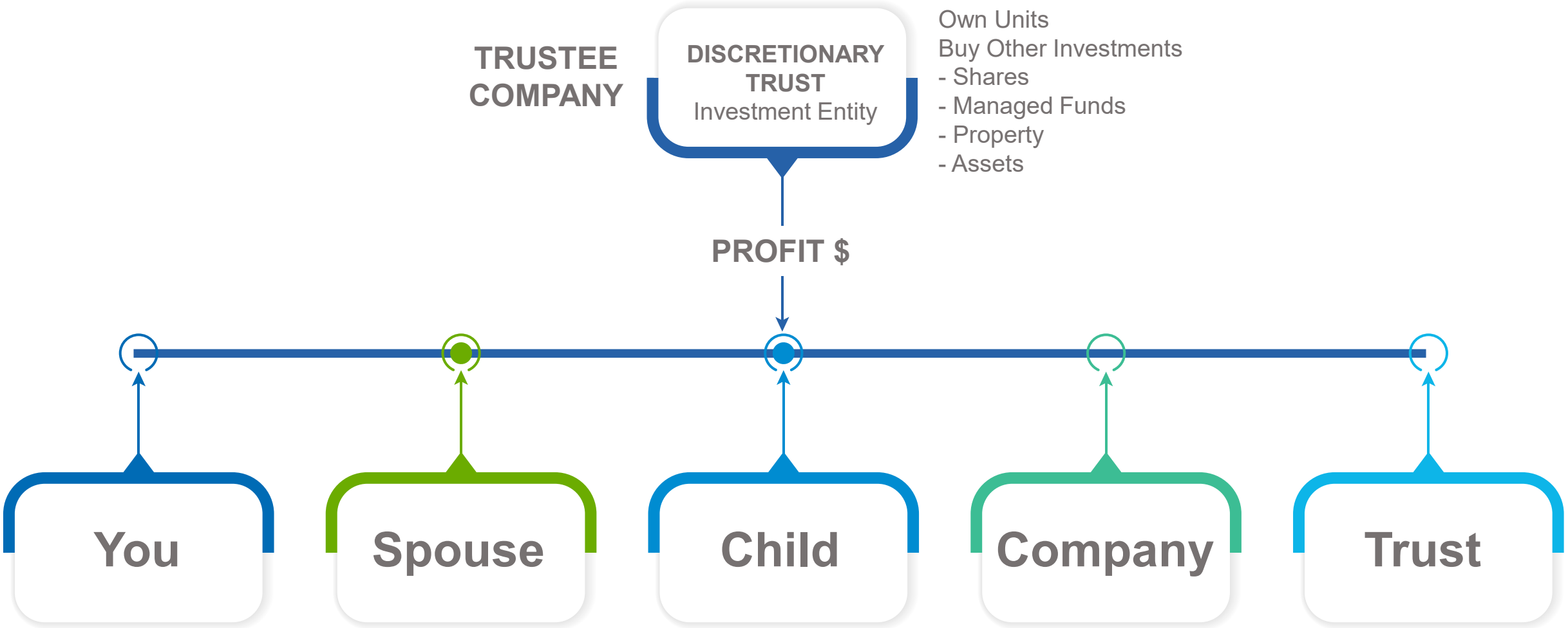
Ownership options

- Individual
- Trust
- Company
- Superannuation

Entity Consideration

- Asset protection benefits
- Liquidity/Access
- Taxation

Structure Investments and Taxes



Superannuation

Optional as Sole Trader

Retirement Savings



Tax Incentivised system

- Div 293 (ATI > $250K) and ECC
- Catch Up Contributions

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PRIVATE PRACTICE



Private Practice



Sole Trader

Responsible for yourself

- Patient fees
- Pay service fees
- Personal compliance



Running Own Clinic

Responsible for everything

- Renting rooms
- Employing staff
- Paying utilities
- Buy & lease equipment
- Business compliance

Private Practice Options

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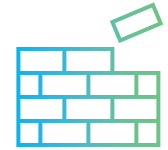
Working in someone else's practice



Buying into a practice



Buy out an existing practice



Starting your own practice

Private Practice Considerations

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Cashflow

- Ongoing Expenses



Responsibilities

- Employing Staff
- Lease
- Loans



Liability

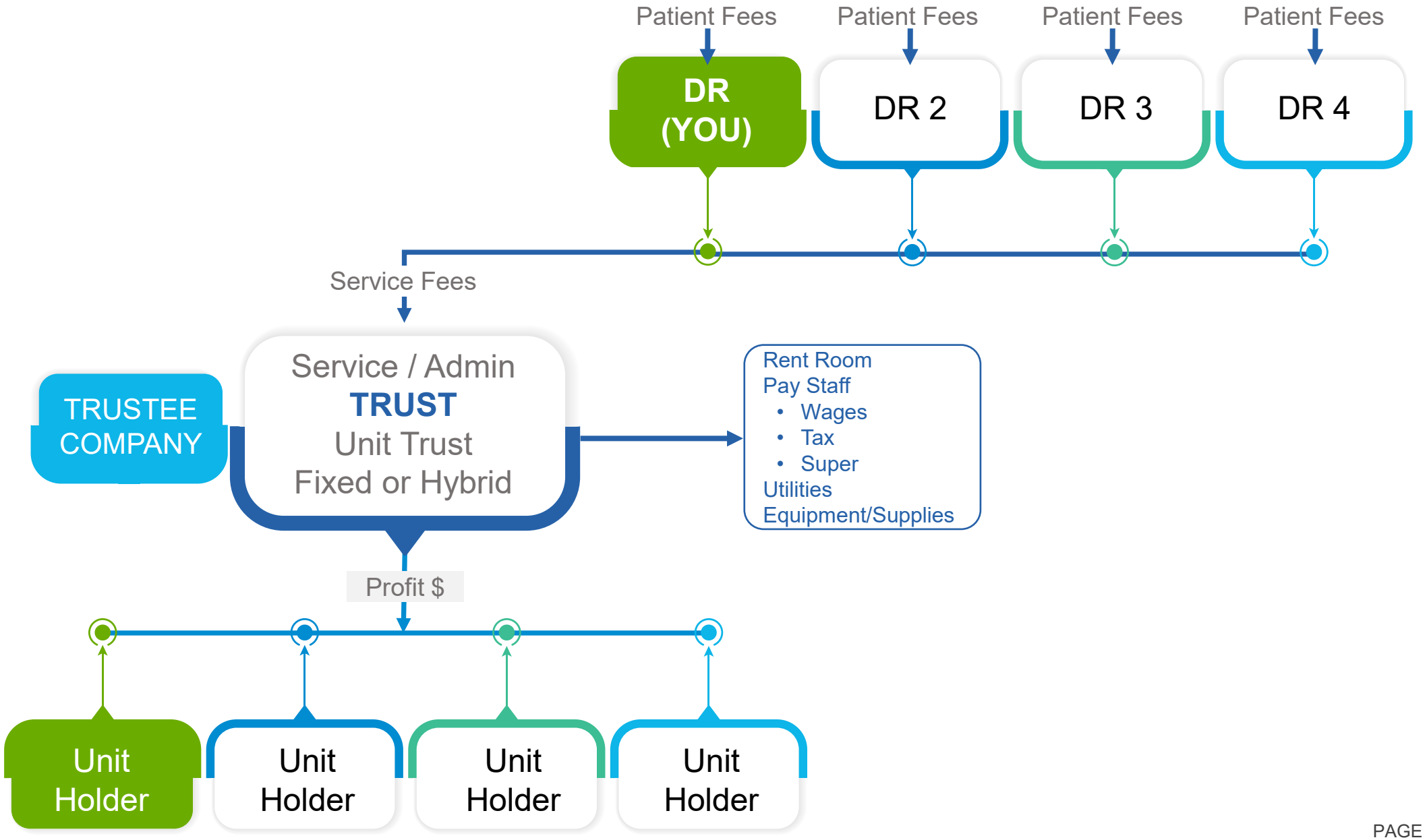
- Asset Protection



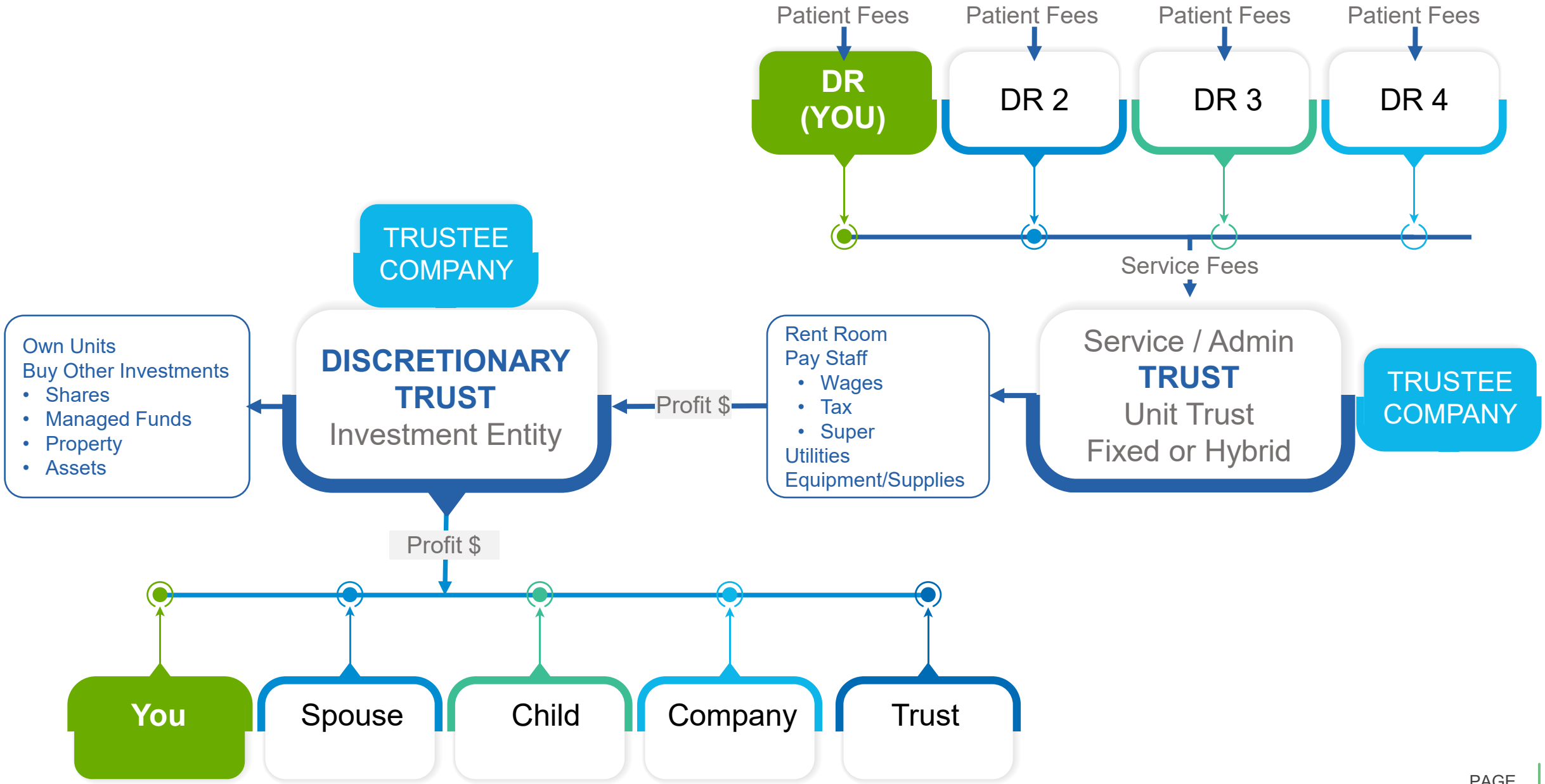
Structures

- Reduce Liability

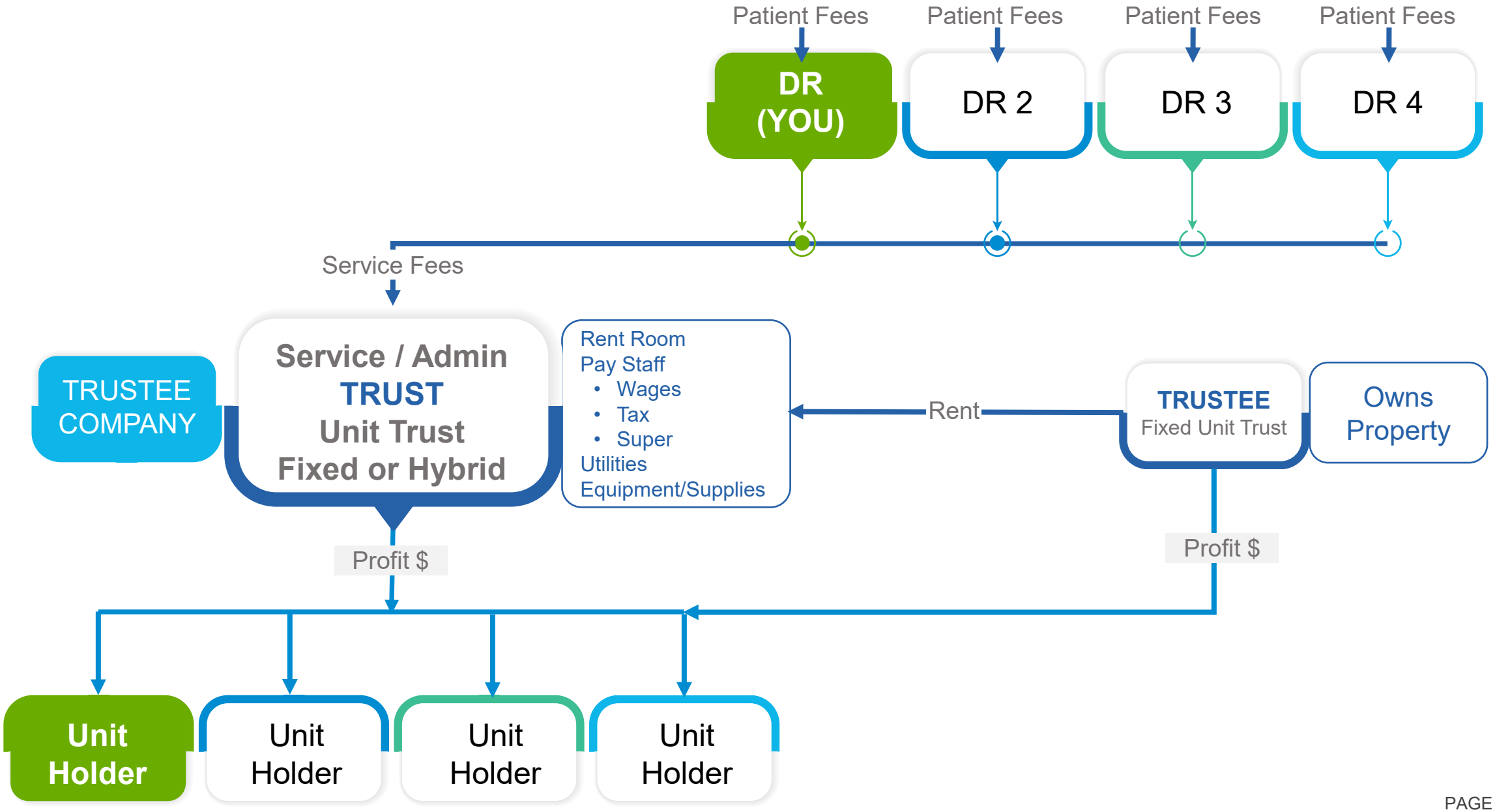
Multi Owner Private Practice



Owning Units



Owning Rooms





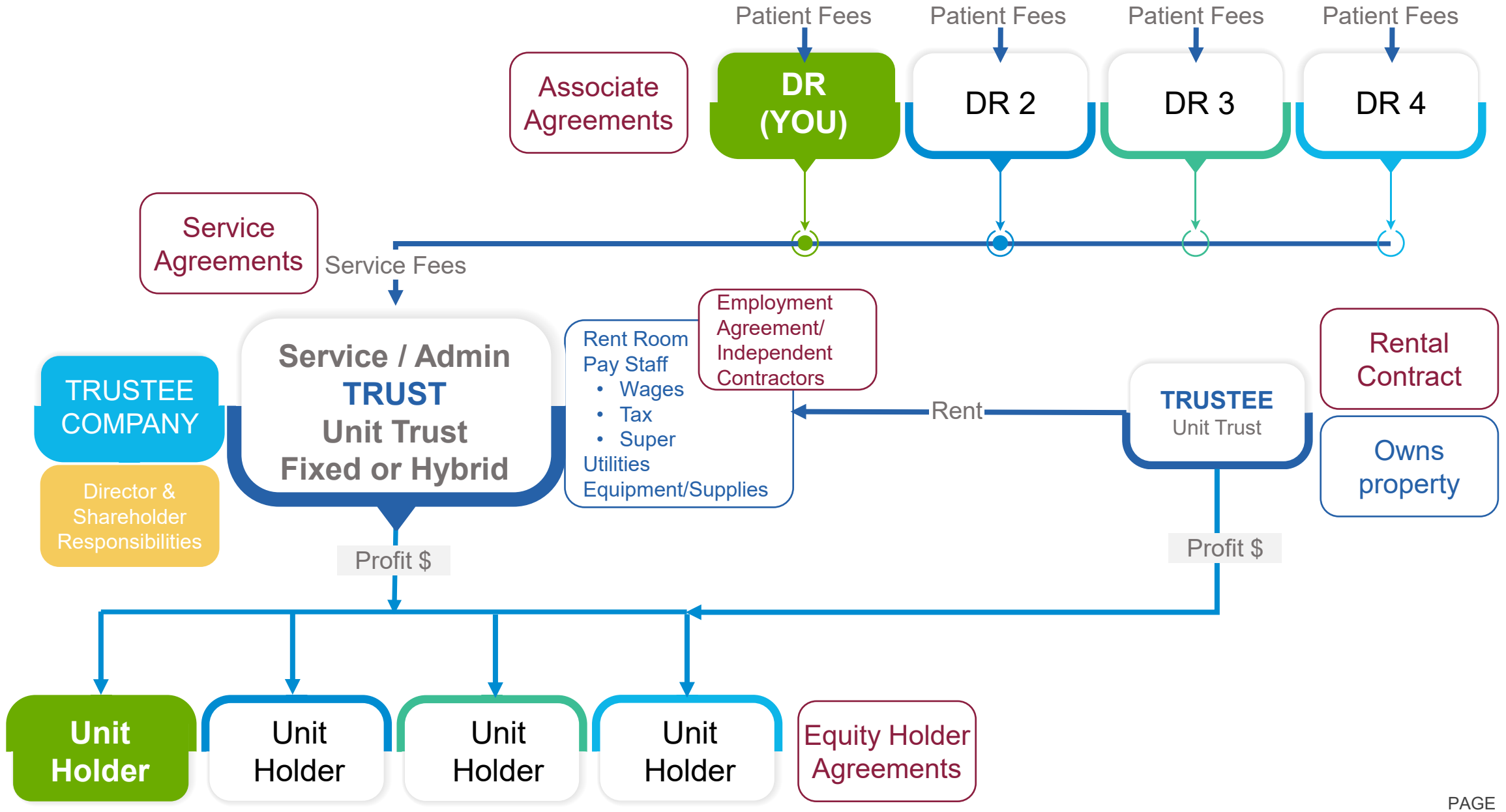
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Contracts & Agreements

Formalise the rules and protect your rights

Contracts and Agreements



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Questions?

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THANK YOU

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Fletcher | Clarendon

The Legal Side of Establishing your Private Practice

Ann-Maree Ventura | Director of Fletcher Clarendon

Equityholder Agreement

What's covered

The instruction manual for running the business

Regulates decisions including

- Director
- The board
- Shareholder
- Unitholder

Process for

- Admitting and exiting owners
- Meetings
- Absence, death, disability
- Termination and restraints

Fletcher | Clarendon

Service Agreements

What's covered

For owner and non-owner practitioners

In return for the services, the practitioner pays a service fee, usually representing a % of patient fees each fortnight

Essential that payment is made by the practitioner to the service provide, otherwise risk of deemed employment/contractor arragement

Service entity (being the service structure) provides services to the practitioner for the conduct of their medical practice

% depends on type and number of services required

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Employment Agreements

What's covered

- Most practices employ support staff and nurses
- These employees should enter employment agreements documenting employer and employee rights and obligations
- Performance management and dismissal
- Modern awards
- Superannuation
- Vicarious liability

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Contractor Agreements



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Associateship Agreements

- Documents the relationship between each practitioner who is conducting their own independent medical practice and for reasons of economy and convenience share certain expenses as detailed in the service agreement
- Set out the terms by which clinical practices operate in associations (i.e. receipt of fees, expenses, charging for work for patients of another associate, holidays, insurance and so on)
- Used to mitigate the risk of a deemed partnership for tax and at law
- Independent with the equityholder agreement and service agreement

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Thank you

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Fletcher Clarendon | Corporate Law Firm

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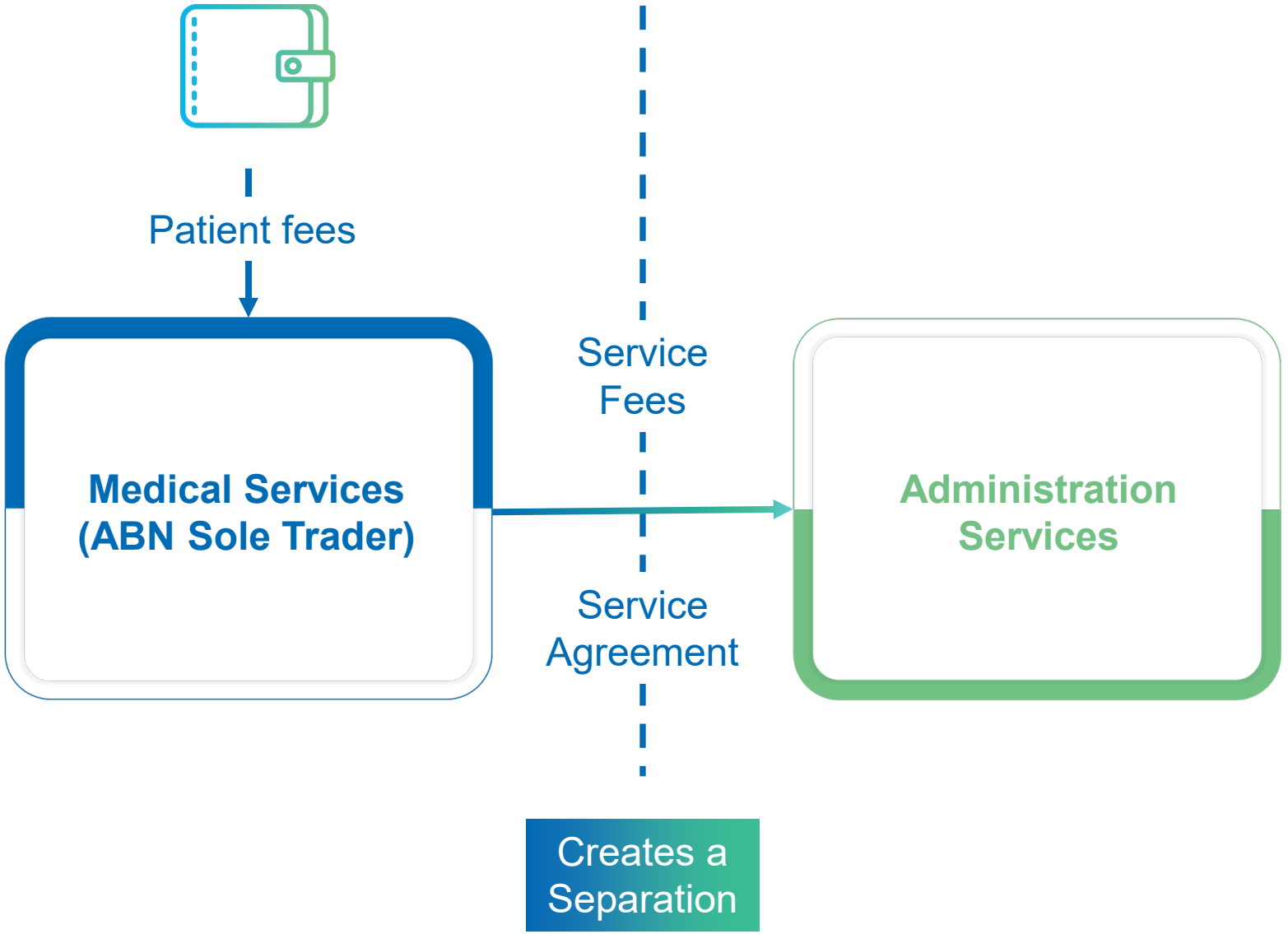
Private Practice Financials



Dino Miliotis
Tax Consultant

14th March

Private Income Structure



Private Practice Structure

Commercial reality rather than $$s justifies need/ability for structuring

- Employing staff
- Having a lease
- Use of material equipment and assets

Practice expenses covered by a service fee payable by the practitioner(s)

Provides benefits including

- Asset protection
- Tax minimisation

Working in private practice or a clinic

Options…



Continue in an established practice

- **Pros**: typically pay a % service fee or sessional fee, do not have overhead/fixed expenses, limited involvement in operations, can walk away at any time
- **Cons**: no control on operations (unless have bought into practice), some uncertainty



Start your own practice

- **Pros**: have direct control on how things are set up and done, build (and own) a business that has a value and can be sold
- **Cons**: incur set up costs, put in place systems and processes, pay for overheads as well as variable expenses

When is a good time?

Tipping points

- ✓ When your service fee expense paid to third party is greater than the expenses to run own practice
- ✓ Want greater control over operational side of practice
- ✓ Want to create your own “brand” for a practice (build goodwill)

Set up costs

- ✓ **Accounting Fees** – Consulting and advice on structure, set up of practice, assistance with financial calculations, setup of accounting software
- ✓ **Legal fees** – Entity establishments, agreements/contracts
- ✓ **Fit-out** – Includes interior of premises, purchase of equipment and furniture

Practice Expenses

Overhead/Fixed expenses

- Rent/interest on mortgage
- Staff – practice manager, receptionist
- I.T. costs – practice software, server costs, website hosting
- Telephone and Internet
- Advertising
- Insurance (general business, public liability etc.)
- Land Tax and rates
- Utilities (supply charges)



Variable expenses

- Drugs, dressings and supplies
- Nursing staff
- Stationery, office consumables, printing and postage
- Repairs & Maintenance
- Utilities (usage charges)

Private Practice Example – Service Entity

Description	Monthly Amount	Annual Amount
Service Fee Income (35% on gross patient fees)	$ 20,000	$ 240,000
Overhead Expenses		
- Rent	3,000	36,000
- Land tax and rates	750	9,000
- Salaries & Wages + super (Admin)	8,333	100,000
- Telephone and Internet	250	3,000
- Advertising	100	1,200
- Insurance	200	2,400
- I.T.	500	6,000
Total Overheads	$ 13,133	$ 157,600
Variable Expenses		
- Drugs, dressings & Supplies	800	9,600
- Printing, Office consumables	200	2,400
- Salaries & Wages + super (Nurse)	2,917	35,000
Total Variable Expenses	$ 3,917	$ 47,000
Net Profit	$ 2,950	$ 35,400

Planning for the site

Scope out potential sites

- Location, location, location
- What is included in the lease? Parking?
- Are you liable for the “statutory outgoings”? (Probably)
- Does the lease have a “make good clause”? (i.e. demolish fit-out)
- Seek advice – property advisory & legal advice



Consider scalability and future proofing

- Does your structure allow for this (higher cost in short-term may be lower cost long-term)?
- Does the clinic site provide flexibility (e.g. other practitioners joining)?
- How is your lease structured? Do you have ability to extend?

Preparing for the future

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Get an understanding of initial costs

- Do you have the cash?
- Will you borrow from the bank?



Have a buffer

- 3-6 months of expenses
- Things may not go according to plan



Consider how you pay for expenses going forward

- Cash vs. debt
- How do you expand or buy new equipment?



Succession planning

- What is your exit strategy?

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Questions

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Private Wealth Planning



Karli Tsemetzis
Private Wealth Consultant

14th March

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What we'll cover

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1. Financial reality of the medical career timeline
2. What happens when income increases
3. Surplus cash and what should we be thinking about
4. Saving versus investing
5. Diversification and asset allocation
6. Investing and the importance of ownership
7. Understanding superannuation
8. Questions

Why financial advice matters for Medical Professionals

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The medical profession is unique. Your income trajectory and time pressures can be different to most people.

Many medical professionals find as their income rises, so does their financial complexity.

Common challenges we see…

Not having time to manage money effectively.

Not knowing how to best structure assets (personal name vs super vs entities).

Changes to legislation.

What happens when income increases

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When income increases…



Lifestyle expands



Debt increases



Investing gets delayed

Surplus cash and what should we be thinking about?

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A structured approach to surplus income…



Emergency cash buffer



Lifestyle goals & debt management



Investing – inside and/or outside of superannuation

Saving versus Investing

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Saving **protects** your wealth



Investing **grows** your wealth

Inflation reduces the purchasing power of cash.

Diversification and Asset Allocation

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Growth Investments

- Income and capital gain returns – i.e. shares and property
- Higher expected returns but higher risk/volatility



Defensive Investments

- Income returns – i.e. cash and fixed interest
- Lower expected returns but lower risk/volatility

The allocation to Growth and Defensive (investment asset allocation) is critical to your financial plan. This is referred to as an 'Asset Allocation'.

Capital markets have rewarded long-term investors

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S&P 500 - 30-year historical chart



Dot-Com Bubble Crash (2000–2002)

Global Financial Crisis (2007–2009)

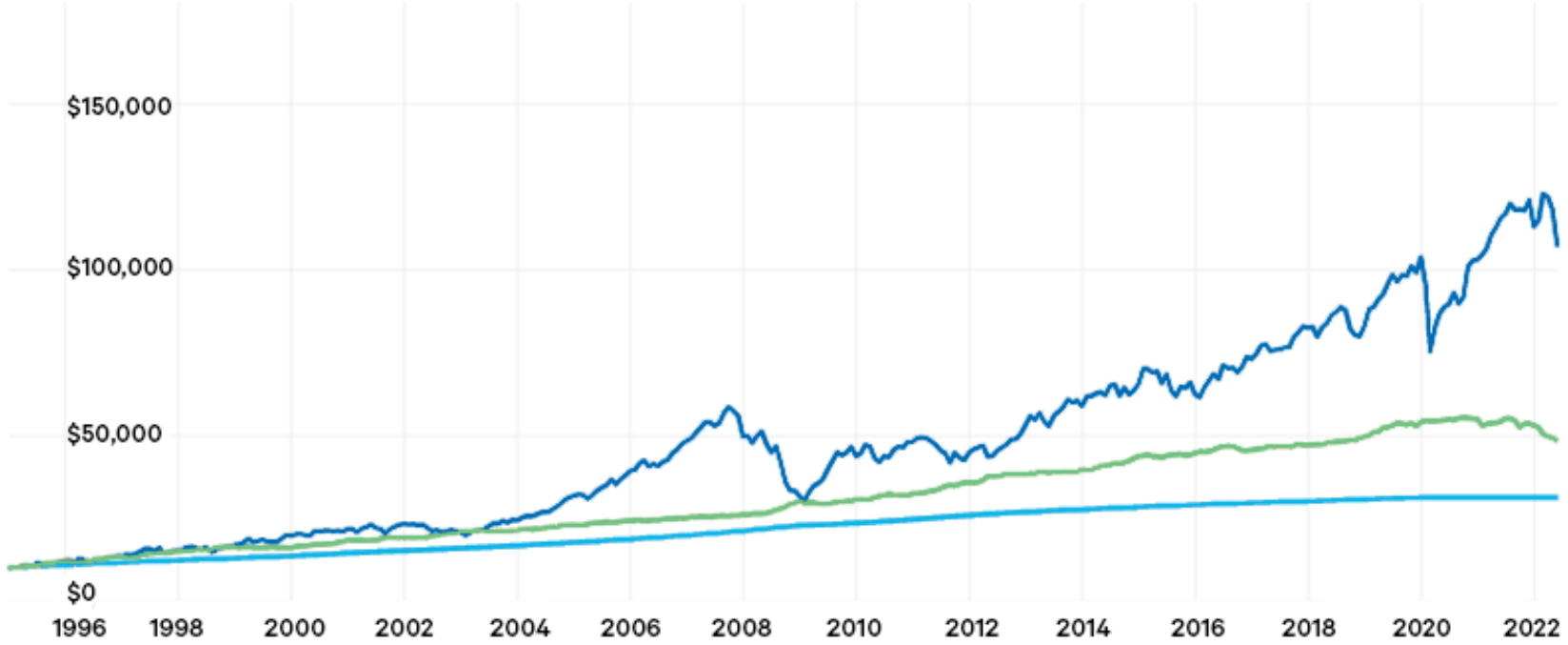
COVID-19 Crash (2020)

Inflation & Interest Rate Shock (2022)

- Over the last 30 years the market has experienced terrorist attacks, financial crises, pandemics, wars and recessions. Yet long-term investors who stayed invested have still seen significant growth.

Capital markets have rewarded long-term investors

Growth of $10,000, January 1995 – June 2022 (Compounded annual growth)



Australian Shares: $106,883

Fixed Interest: $48,436

Cash: $31,255

- The financial markets have rewarded long-term investors.
- People expect a positive return on the money they supply, and historically, the equity and bond markets have provided growth of wealth that has more than offset inflation.

Diversification helps take the guesswork out of Investing

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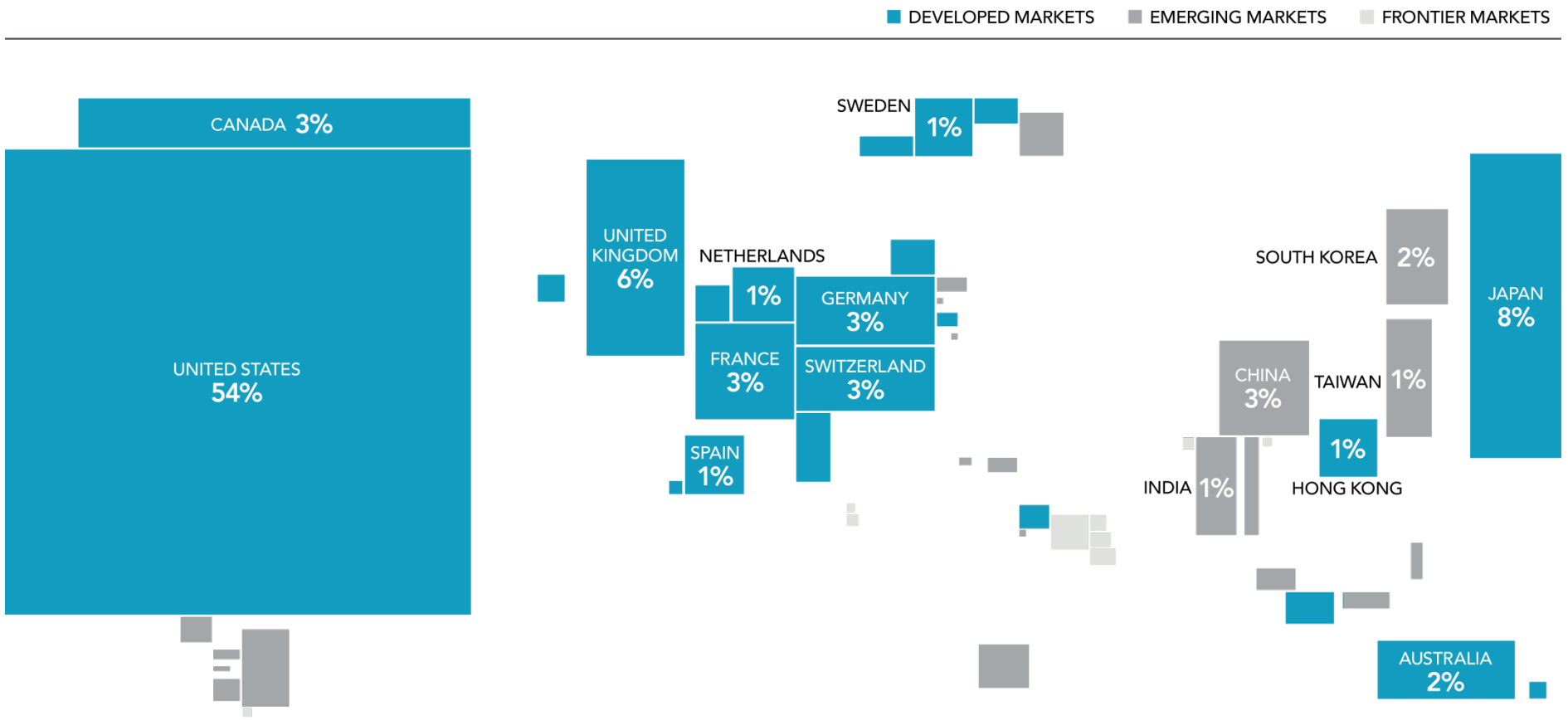
Annual returns by Market Index – 2004 to 2022

Asset Type	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Aus Shares	28.7	24.7	24.3	30.3	8.6	11.5	31.3	22.3	12.4	35.0	21.9	31.9	24.6	18.9	18.7	19.3	9.6	37.1	0.1
Int'l Shares	22.4	21.2	24.2	25.9	7.3	10.8	20.4	12.2	11.9	33.1	20.8	25.2	20.4	14.7	15.4	16.3	5.4	33.2	-2.4
Int'l Shares (H)	20.2	18.1	19.9	21.4	4.4	5.5	13.8	9.2	11.0	24.3	20.4	23.1	10.8	14.4	13.7	13.5	5.2	30.2	-5.5
US Shares	19.4	12.3	18.0	7.8	-12.1	-12.4	11.5	5.8	10.1	24.2	17.6	20.3	7.3	13.1	13.0	11.9	4.2	29.1	-6.5
Aus Bonds	17.2	9.8	15.0	6.4	-15.7	-16.3	9.5	5.7	7.5	21.3	11.8	8.5	7.0	1.8	10.8	11.0	3.6	27.5	-7.4
Int'l Bonds	14.7	7.8	11.5	5.6	-21.3	-22.1	9.3	5.5	4.7	20.7	11.1	6.3	2.2	0.2	9.0	9.6	0.8	23.3	-8.2
Cash	5.3	5.6	5.8	5.2	-23.2	-26.6	7.9	5.0	-0.5	4.4	7.2	5.7	2.0	-1.0	3.1	7.0	-7.2	0.1	-10.5
Aus Listed Property	3.5	0.1	3.4	4.0	-28.6	-31.2	5.2	3.1	-2.1	3.3	6.1	5.6	0.4	-4.8	2.5	6.6	-13.4	-0.8	-11.3
Int'l Listed Property	2.3	-2.8	1.2	3.0	-36.3	-42.3	3.9	2.7	-7.0	2.8	2.7	2.6	-2.7	-6.3	1.8	2.0	-21.3	-1.4	-12.3

- You never know which markets will outperform from year to year.
- Holding a globally diversified portfolio, investors and positioned to capture returns wherever they occur.

There's a world of opportunity in equities

Percent of world market capitalisation as of December 31, 2022



Data provided by Bloomberg. Market cap data is free-float adjusted and meets minimum liquidity and listing requirements.

Investing and the importance of ownership



Ownership structures

- Personal Name
- Entities – eg: Discretionary Trust and companies
- Superannuation



Ownership affects

- Asset Protection
- Tax
- Flexibility
- Estate Planning

Ethical Investment Options

Positive screening

Identifies companies who are doing good work and invests in them. eg. renewable energy, health care, or a company like Tesla.

01

Company engagement & shareholder action

02

Investors will ‘engage’ with companies to discuss major issues that they feel the company can improve using their size and power to influence company policy.



Negative screening

Involves screening out industries, or individual companies so that the investors has no stake in them eg. guns manufacturers, gambling etc.

03

ESG integration

04

Analyse potential investments and consider ESG factors. This guides which companies and amount owned in portfolio

Eg. an oil company investment - an ESG approach will find the oil company that has a superior environmental performance and treats its employees well.

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SUPERANNUATION

See through the fog

- **The 2 Phases of Super**
- **Contributions**
- **Income Streams & Tax**
- **Structure & Control**



What is Super and why is it important?

Grow your retirement assets for the future

Compulsory saving for retirement



Tax advantages

Long-term investment growth

Superannuation – Structure Summary

Super exists in 2 primary forms

The change from Accumulation to Pension phase is triggered by reaching a condition of release – Age 60 and retirement or age 65 irrespective of retirement.

You can hold both Accumulation and Pension phase accounts upon reaching a condition of release.

Accumulation Phase

- Receives pre/post tax super contributions
- Income taxed within fund at 15% and realised capital gains taxed at 10% (after 12-month discount)

Pension Phase

- 0% income and capital gains tax within fund (on asset base up to $1.9m each)
- Drawdown on capital/income to fund personal expenses (pension payments)
- Maximum starting balance $2m (referred to as Transfer Balance Cap)
- Minimum pension income stream must be drawn each year dependent upon your age - 4% of your balance pa between age 60 and 65, 5% of your balance pa between 65 and 70 and increasing over time
- There is no maximum withdrawal amount from your pension account

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Super contribution summary…

Pre-tax (concessional) contributions are limited to $30,000 per annum

- Able to make contributions up to age 67
- Between 67 and 75 you must meet the 'work-test', 40 hours work within a 30 day period, to make a concessional contribution each year.

Post-tax (non-concessional) contributions are limited to $120,000 per annum

- Able to make contributions up to age 75 (subject to 1 July total super balance below $2m)
- Individuals under 75 can make x3 years of non-concessional contributions, of up to $360,000, in year 1 and no subsequent non-concessional contributions for year 2 and 3. This is referred to as the 'bring forward rule'.

Carry forward unused concessional contributions

- If you don't use your full concessional contributions cap in a year, you can carry it forward for up to 5 years.
- Available if your balance is under $500,000 at the end of the previous financial year.

Types of Super Structures

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Industry Super Funds

- ✓ Industry funds are known to be a 'low-cost' super option.
- ✓ Low in administration costs due to its simplicity.
- ✓ Limited investment options.

Retail 'Wrap' Super Funds

- ✓ Usually an advised products with a financial adviser.
- ✓ Comprehensive style account.
- ✓ Access to over 600 managed funds, ETFs, direct shares and term deposits.
- ✓ Access to ethical investments.

Self Managed Super Fund (SMSF)

- ✓ Provide investment flexibility and the ability to purchase direct property (residential property, medical rooms and commercial property) – which cannot be held in industry and retail funds.
- ✓ Upfront establishment and ongoing costs to maintain this structure.

The value of advice

Financial planning is not about ‘getting rich’ - it is about **creating clarity, confidence and control over your finances to achieve financial freedom.**

We help you:

- ✓ Identify what’s most important to you financially and build on your goals.
- ✓ Create a clear plan to achieve your goals.
- ✓ Implement tax-effective strategies to grow your wealth.
- ✓ Regularly review and adjust your plan as your career evolves.

Common mistakes we see:

- ✓ Not having a financial plan, especially when moving into private practice.
- ✓ Ignoring asset protection.
- ✓ Neglecting super contributions.
- ✓ Focusing solely on paying down debt.

Are you on track?

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- Discipline and accountability
- Financial modelling
- Changes in investments and economic environment
- Changes in legislation



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Questions

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Transitioning to Private Practice

Insurance

Protecting your income, family and practice as you move from public to private work

Kyle Roberts
Insurance Consultant



General information

Every effort has been made to offer the most current, correct and clearly expressed information possible within this presentation. Nonetheless, inadvertent errors can occur, and applicable laws, rules and regulations may change.

The information contained in this presentation is of general nature only and is not intended to serve as advice. No warranty is given in relation to the accuracy or reliability of any information

The audience should not act or fail to act on the basis of the information contained herein. The audience are encouraged to contact their DPM Consultant for advice concerning specific matters before making a decision.

Life insurance fundamentals

172
New cancer diagnoses each day (average) under age 65

95
New TPD claims received each day (industry average)

Sources: APRA life insurance claims and disputes data 2024/25 | AIHW Deaths in Australia, 2023

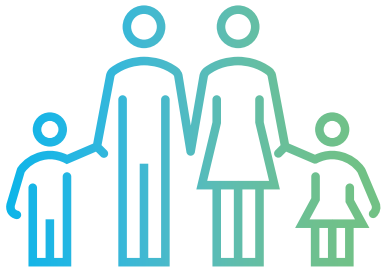


111
New disability income claims received each day (industry average)

82
Young lives lost each day (average) under age 65

Insurance

When you go private, you are protecting two things at once:



Family & Lifestyle

Support your family



Practice

Support your practice

Why this matters when you go private

dpm

A different risk profile - not just a higher income

Income can become variable

Billings-dependent
Less predictable cashflow

Public safety nets shrink

Less sick leave
Less employer support

Fixed costs rise

Mortgage
Rooms
Staff
Software

You become the engine

If you stop working, revenue can slow quickly

Private practice changes both your personal cashflow risk and your business cashflow risk.

Higher incomes: IP may not replace full income

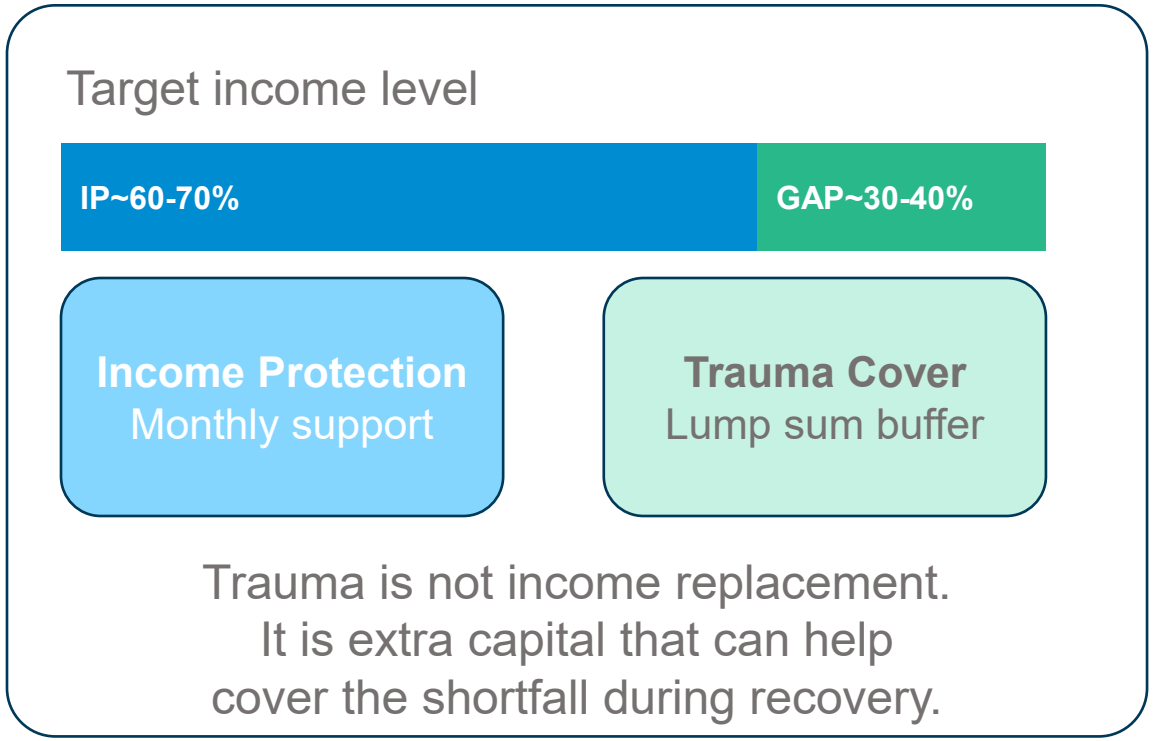
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A practical point for higher-earning specialists

Modern IP benefits can reduce on a sliding scale at higher incomes

That means higher earners may only protect part of total income

Trauma can provide a lump sum buffer if a defined serious event occurs



IP protects part of income.
Trauma Cover can help fund the gap.

Lump sum cover at a glance

Match debt, dependents and recovery needs to the right cover type

Life

(if you pass away)

- Supports debt repayment
- Protects dependents
- Helps preserve lifestyle

TPD

(if you become Totally & Permanently Disabled)

- If you cannot work again
- Protects long-term plans
- Supports debt and capital needs

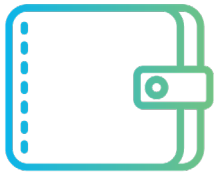
Trauma

(serious illness e.g. Stroke, heart attack)

- Diagnosis of serious illness
- Funds treatment / recovery
- Buys time and options

Income Protection — review, don’t reinvent

Most doctors already have it; the question is whether it is still appropriate



Benefit amount

- Match current earnings
- Allow for variable income



Waiting period

- Match sick leave + buffer
- Avoid a cashflow gap

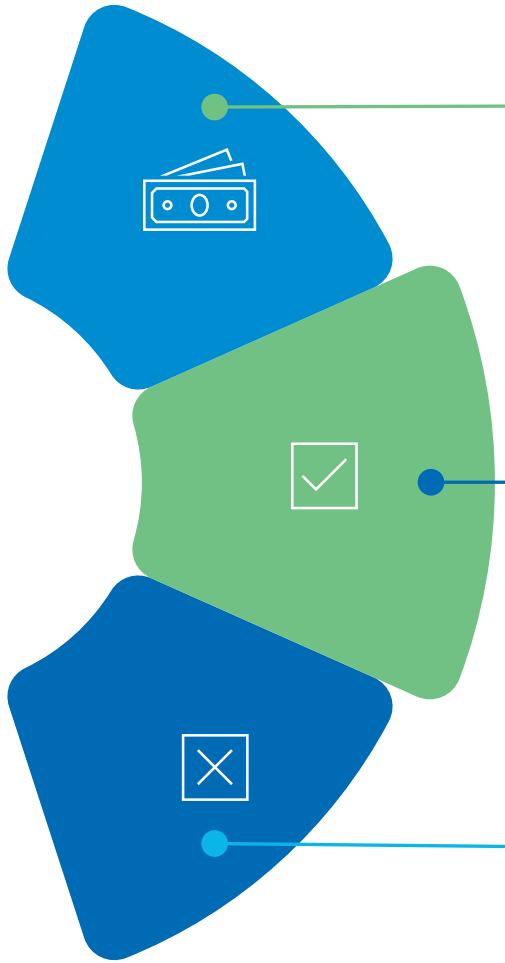


Definitions

- Fit your role and specialty
- Review when work changes

Business expenses cover — what it covers

The keep-the-lights-on cover for private practice



Typical costs

- Rooms or service fees
- Utilities / software
- Staff and admin costs

What it does

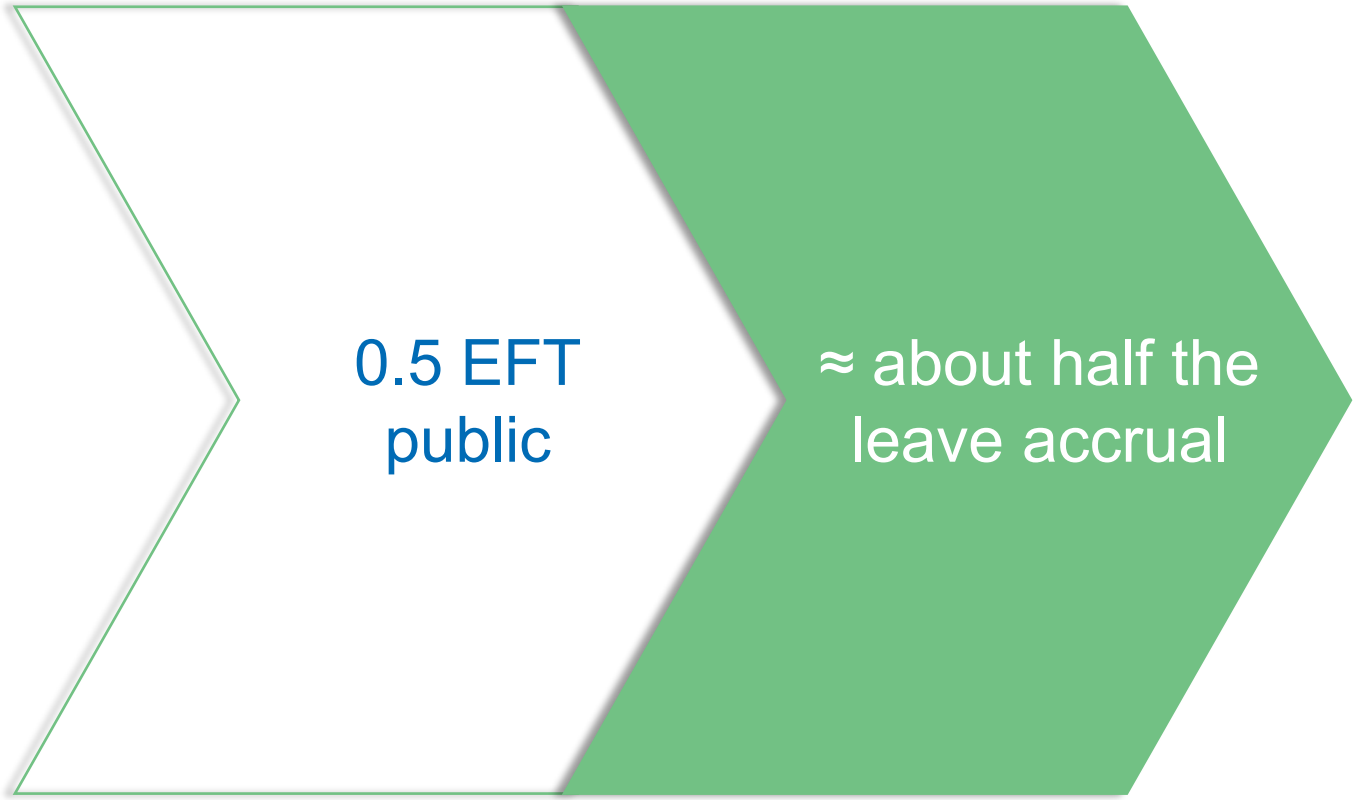
- Supports fixed overheads
- Protects business cash reserves

What it does not do

- Does not replace personal income
- That remains the job of Income Protection

Public + private mix: sick leave is pro-rata

Your public leave accrues on your public work — not your private billings

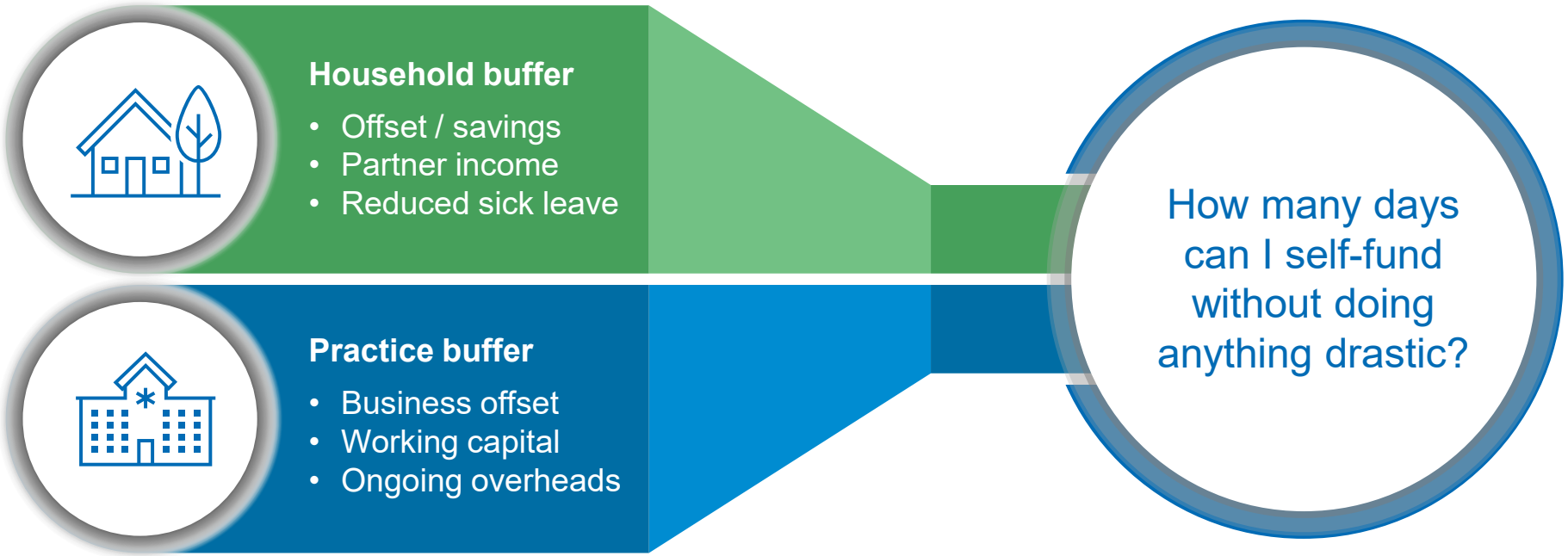


- Covers your public roster
- Does not replace private income
- Review waiting periods as public hours fall

Waiting periods should match buffers

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This is a cash-buffer decision, not a guess

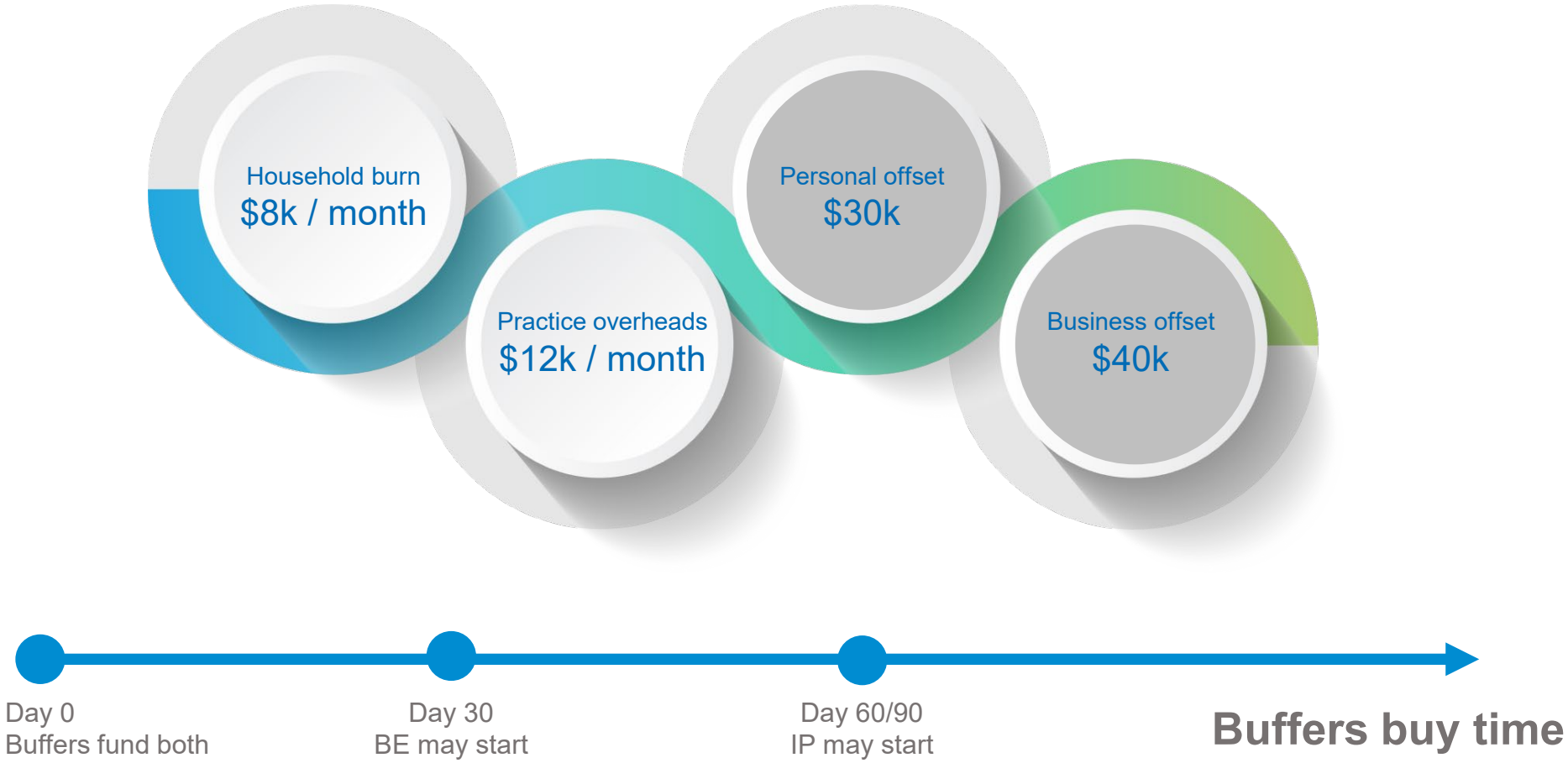


Design waiting periods around reality not optimism

Example: cash buffers in action

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A simple private-practice scenario



Common mistakes in the transition

The errors that cause the most pain later

Set & forget

- Leave Income Protection as is
- No review as income changes

No BE plan

- Rooms or staff costs
- No overhead strategy



Buffer mismatch

- Waiting period too long/short
- Cash gap too wide

Old lump sums

- Mortgage / kids changed
- Cover stayed the same

Private practice checklist

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A 60-second review before you begin private

- ❑ Do I know my household burn + practice burn?
- ❑ Does Income Protection still match how I earn today?
- ❑ Does my waiting period match sick leave + savings?
- ❑ If overheads continue, do I have a plan for them?
- ❑ Have lump sum covers been reviewed for life changes?

Review triggers

- Moving private
- Signing a lease / hiring staff
- Taking on debt
- Marriage / home purchase / children

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Questions

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DPM Financial Services

1800 376 376

hello@dpm.com.au

Practice management

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8.45	Practice management introduction	Sean O'Neill, DPM
10.30	Setting up your practice team	Ann-Maree Ventura Fletcher Clarendon
12.15	Plugging the leaks: maximising practice revenue for specialists through Medicare compliance (medical billing)	Brendan Homann, Medbill
1.15	Building a client list | Medical marketing	Caroline Chaplin Rooms with Style
3.00	From patients to practice: building a safety net against modern risks	Leonard Sack, ProfMed
5.30	Medical Mentor panel with Q&A	

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Business of Medicine
Setting up your Practice Team

Ann-Maree Ventura | Director of Fletcher Clarendon

Your Practice may be clinical by nature- but your risks are often administrative

One of the fastest ways for legal risk to enter a new practice is through the wrong engagement model

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Why this matters

- Early engagement decisions shape legal and tax risk
- Wrong classification can lead to underpayments, super, payroll tax and penalty exposure
- Good planning helps build your team on the right footing

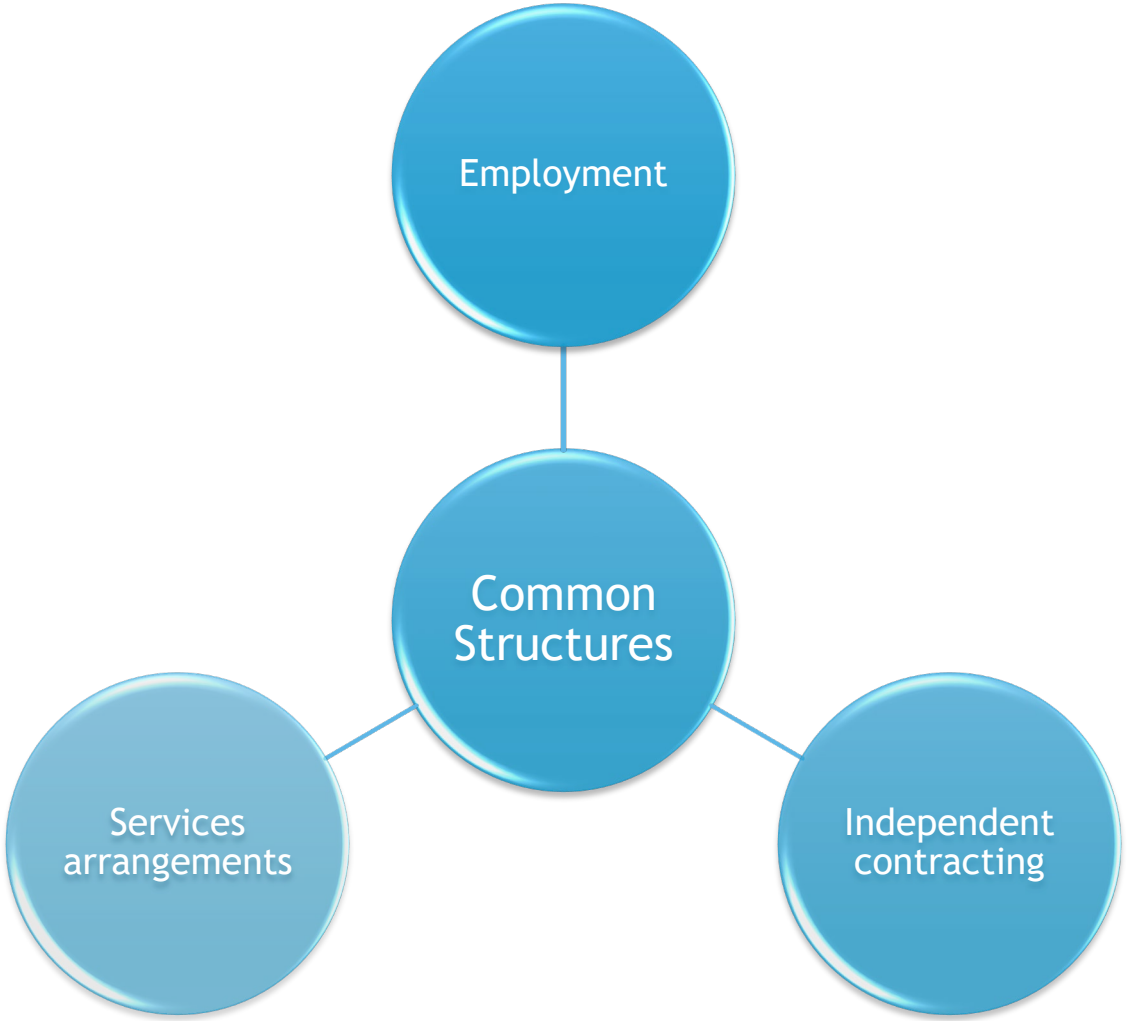
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What we will cover

- Common engagement models
- Employees v contractors
- Why labels are not enough
- Key classification factors
- Fair Work, super, PAYG and payroll tax risks
- Practical setup steps

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Common Engagement Models



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Employees

Common Examples



Receptionists



Admin staff



Practice managers



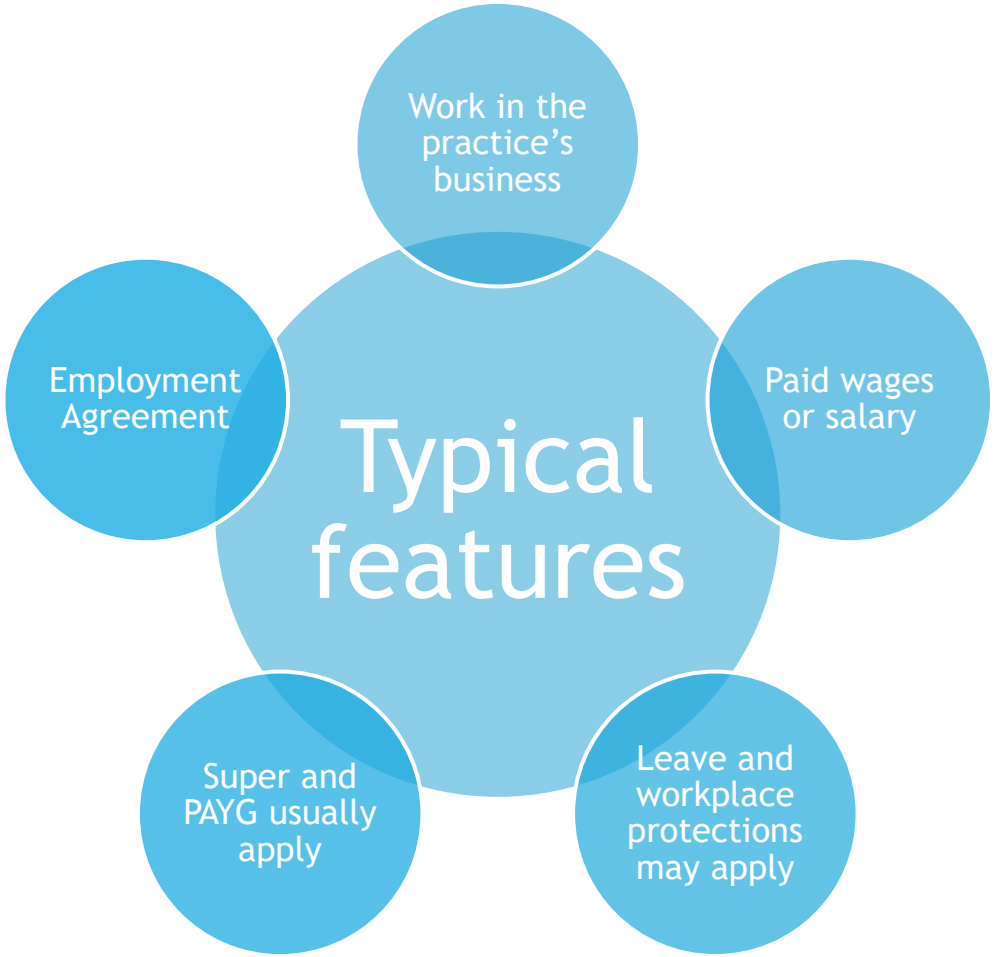
Nurses



Sometimes doctors or allied health practitioners

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Employees



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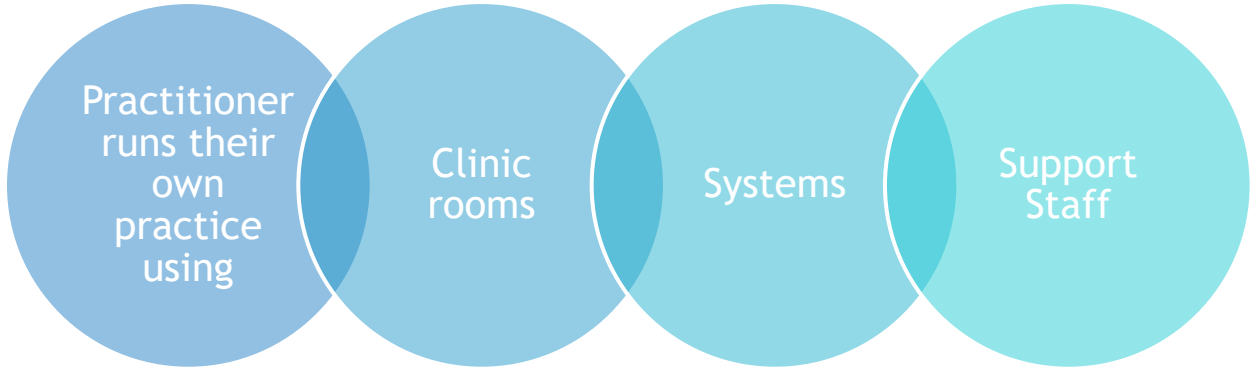
Independent Contractors

- Operate their own business
- Engaged under a contractor arrangement
- Contract and day-to-day reality must align
- Super may still apply in some cases
- Contractor Agreement or Services Agreement

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Service Arrangements

Common Examples



Typical features

- Independent practice model
- Practitioner pays service or facility fee
- Usually documented in a Services Agreement

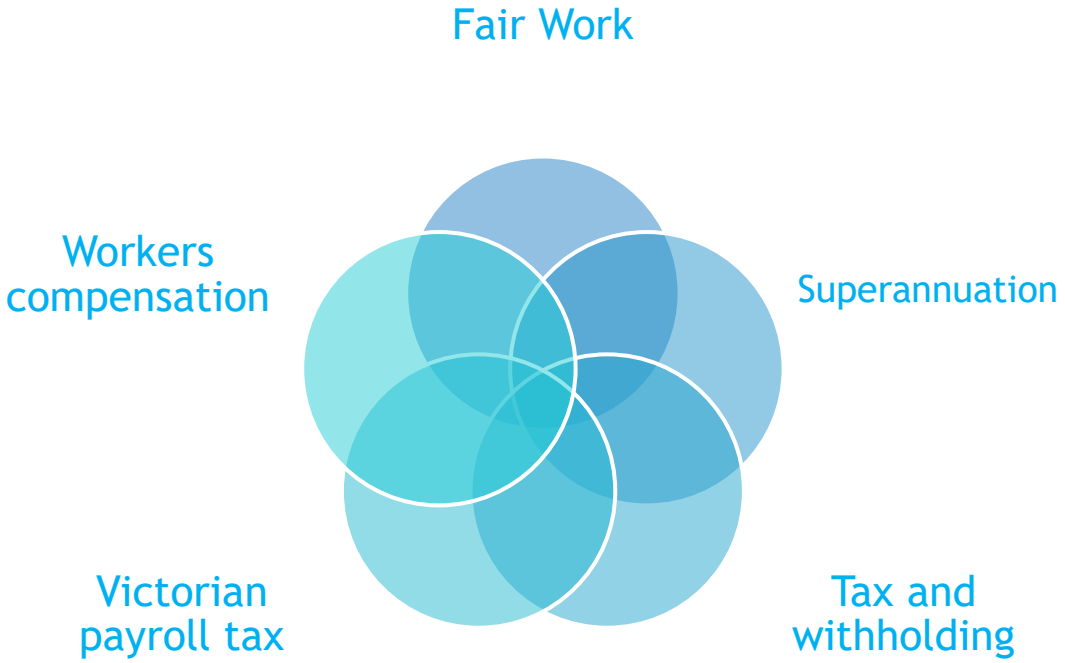
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Why Classification matters



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Different Laws, Different Outcomes



Important: one arrangement can be treated differently under different laws

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Labels are not enough

- “Contractor” is not decisive
- The law looks at substance, not just wording
- Contract terms matter
- Practical reality matters too

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Key Factors



Who controls hours and work?



Is the person running their own business?



Who contracts with patients?



Who invoices and receives fees?



Is there a genuine right to delegate?



Who provides rooms, tools and systems?



Who carries the financial risk?



Is the person integrated into the practice?

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Examples

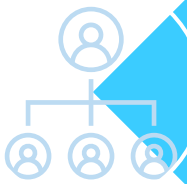
Most likely to be employees



Receptionist on regular roster

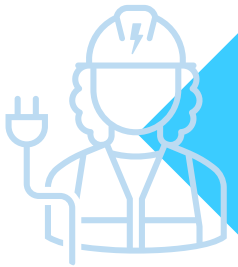


Nurse supervised by the practice



Practice manager under owner direction

Most likely to be contractors



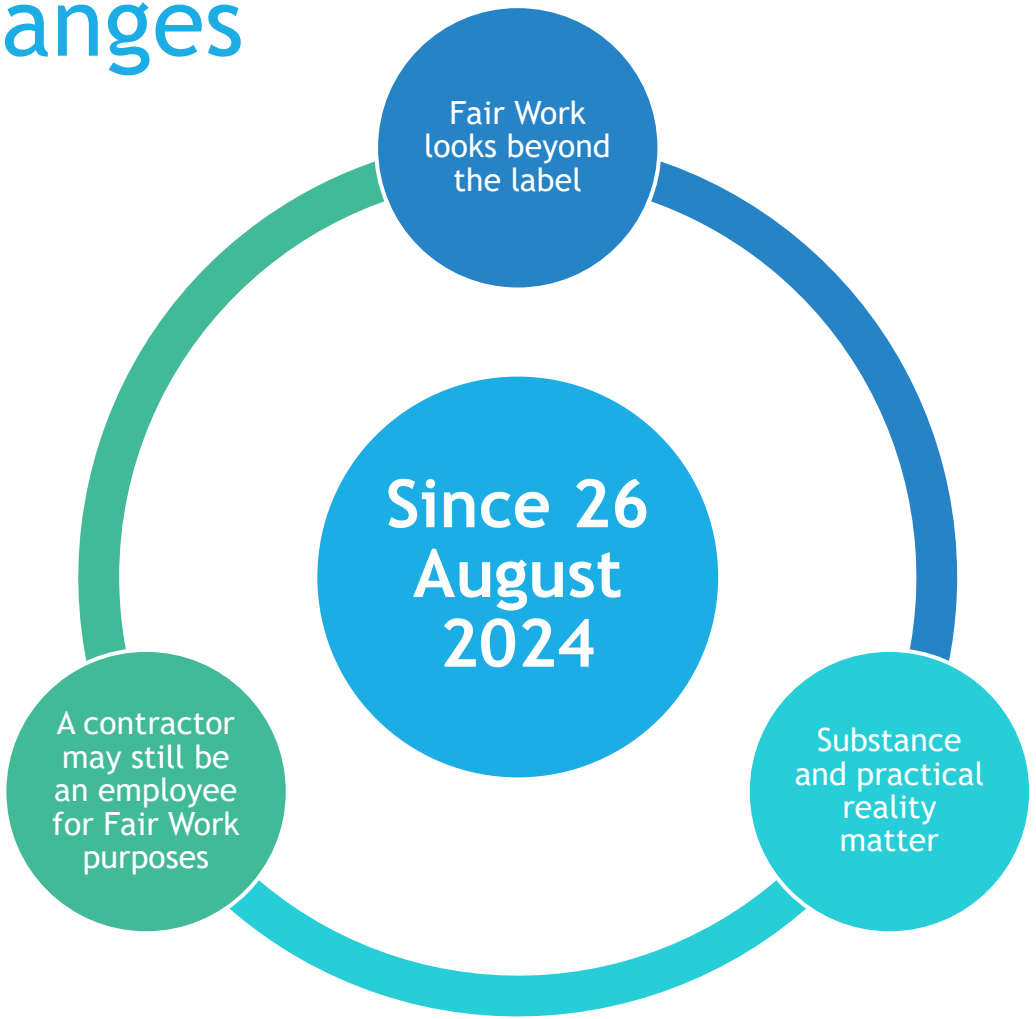
External IT provider



Allied Health genuinely running their own practice

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Fair Work Act Changes



This may affect:

- NES entitlements
- Awards
- Adverse action protections
- Unfair dismissal rights

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Superannuation Risk

Super may apply to contractors where the contract is mainly for the person's labour



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Payroll Tax Risks



Do not assume an ABN or contractor agreement avoids payroll tax

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Sham Contracting



Calling an employee a contractor



Re-engaging an employee as a contractor to avoid entitlements



Using documents that do not match reality

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Summary: Engaging your practice team

1. Identify each role clearly
2. Choose the right engagement model
3. Match the contract to the reality
4. Review Fair Work, super, PAYG and payroll tax separately
5. Use tailored written agreements
6. Review arrangements as the practice changes

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Thank you

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Director of Flecther Clarendon

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Fletcher Clarendon | Corporate Law Firm

Medbill

Billing Compliance & Revenue Cycle Management Solutions for Australian Private Health Providers



Plugging the Leaks

Maximising Practice Revenue for Specialists through Medicare Compliance

Brendan Homann | General Manager

"You trained to be a doctor, not a billing department. But in private practice, billing is the engine that funds everything."

- Billing Compliance & Audit
- Medical Billing Services
- Revenue Cycle Management

Introduction

How not to lose over $2m over your career...

"Medical Billing — how hard can it really be?"

PUBLIC SYSTEM

You delivered care — someone else handled the Item Codes, the billing, and the revenue collection

PRIVATE PRACTICE

The claim rejection lands on YOUR desk — and nobody knows why.

You have provided the medical service – but you have zero funds in your bank account.

TODAY'S GOAL

Build a practice that is fully compliant & maximises it billing and never has to chase its own revenue...

TLDR: Save me $2m over my career!

WELCOME TO A DIFFERENT WORLD!

From Shift Worker to Business Owner

PUBLIC SYSTEM

- Salary paid regardless of the billing outcomes
- Revenue managed by the institution
- Coding & compliance someone else's problem
- Managing debts, rejections and cash flow someone else's problem
- Payer relationships handled centrally

- Clinical excellence = job done

PRIVATE PRACTICE

- Revenue flows only when billing is correct
- YOU are the institution — all functions are yours
- Coding errors = your financial and legal exposure
- Every payer relationship must be managed
- Cash flow is the life blood of your business & your ability to meet your financial obligations (staff costs, rent, your salary etc)

- Clinical excellence is necessary - but not sufficient

WELCOME TO A DIFFERENT WORLD!

The Payer Ecosystem

Unlike a hospital salary, no two payers work the same way — and none are designed to make it easy for you.

Private Health Insurers

Multiple funds, varied schedules, own gap policies & benefit limits.
28-30 different private insurers across Australia

Medicare

MBS schedule sets codes & pricing, strict item rules, co-claiming restrictions, bulk billing rules

DVA

Separate fee schedules & approval requirements for veteran patients

Third Party Insurers

State-based, employer liability claims, prior approval often required.
Eg WorkCover, 3rd Party Motor

Self-Pay Patients

Fee transparency obligations (eg Informed Financial Consent), gap payment collection (Pre or Post), hardship discount policies

The Key Point

The payer landscape shifts constantly — rules, schedules & denial rates change every year

WELCOME TO A DIFFERENT WORLD

Pricing Policy & Billing Codes

YOUR FEE POSITION — A REVENUE STRATEGY DECISION

No Gap

Bill at insurer schedule fee. Patient pays nothing. High volume, capped ceiling.

Known Gap

Charge above schedule. Gap disclosed upfront. Balances access with revenue.

Gap - AMA Rates or Your Own Fee

Set your own fee schedule. Maximum revenue potential. Requires strong patient comms & payment collection processes.

⚠ **Inconsistency in fee position & discount policy implementation is one of the most costly early mistakes.**

BILLING CODES — NOT OPTIONAL KNOWLEDGE

- **Item numbers are specialty-specific** and updated regularly by Medicare.
- **Get it wrong:** undercharge, overbill, or trigger a compliance audit.
- **MBS bundling, co-claiming & modifier rules** are not intuitive - they require ongoing education.
- **Most in-house billing errors trace back to the doctor,** not admin - because the clinical decision drives the billing codes.
- **Coding compliance** is a continuous professional obligation with direct financial and legal consequences.

REVENUE VS CASH FLOW

Two Numbers — One Critical Gap

REVENUE / BILLING

What you are entitled to earn
from the health services delivered

Determined by:

- Fee position chosen
- Billing codes submitted
- Services actually delivered

≠

CASH FLOW

What actually lands
in your bank account — and when

Determined by:

- Claim accuracy & timeliness
- Payer processing & approval
- Denial management process, follow-up & patient collection discipline

The gap between revenue and cash flow is where billing lives — and where practices thrive or struggle.
Cash Flow pays the bills and keeps your practice running.

REVENUE VS CASH FLOW

Revenue Cycle Management — Closing the Gap

10–20%

of ‘earned revenue’ unrecovered annually by practices with poor RCM

That’s 1-2 months a year that you are ‘working for free’

1

Pre-Visit

Eligibility check, referral confirmation, correct item numbers identified

2

At Point of Care

Accurate documentation, correct & complete code selection by the clinician for all services

3

Claim Submission

Clean claims submitted promptly to correct payers with right modifiers

4

Payer Processing

Monitor claim status, respond to requests for information quickly. Follow up unpaid patient debt

5

Denial Management

Review, appeal and resubmit rejected claims — don't leave money behind

6

Reconciliation

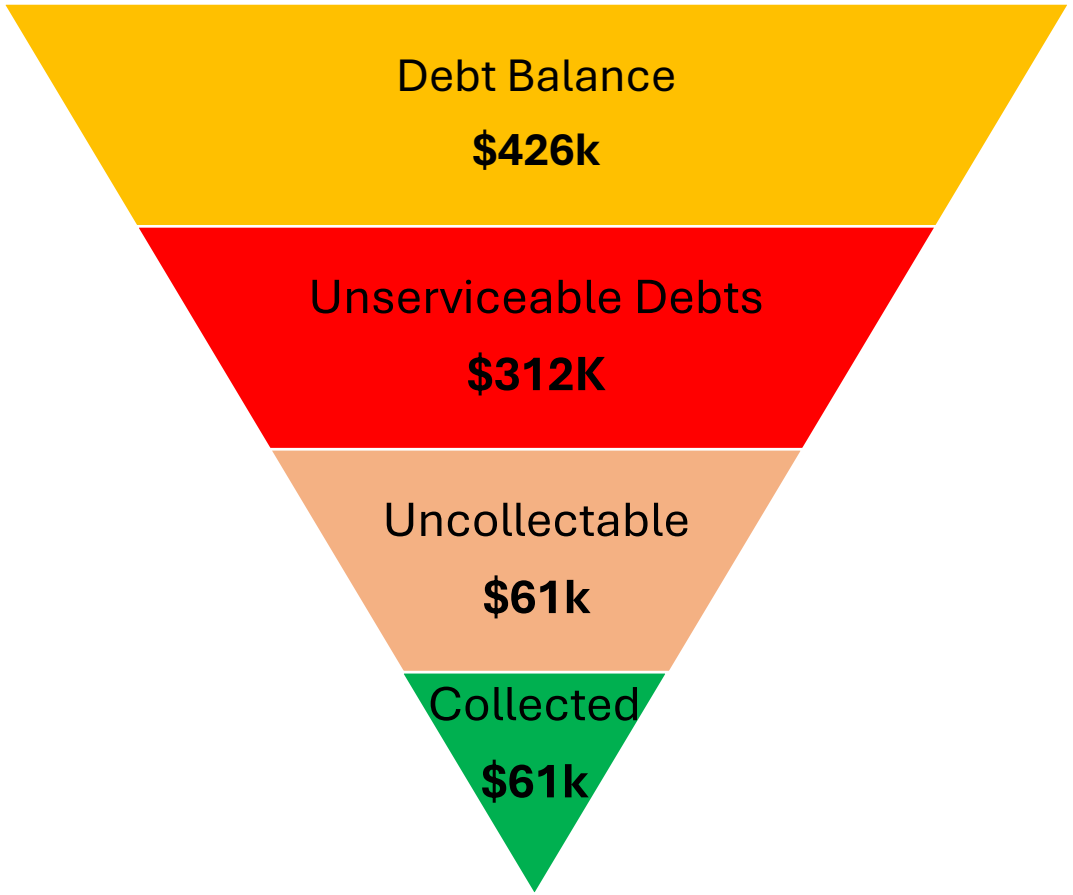
Payment posted, gaps collected, account closed — cycle complete

Strong RCM = predictable revenue = a practice you can plan, invest in, and grow.

REVENUE VS CASH FLOW

Case Study – Debt not managed over time

Surgeon Sydney - own PMS + own Admin team



Key Failure Points:

- No regular reporting or review of financial performance with the PM and Accountant
- Failing to pivot patient debt to Medicare Bulk Bill
- Failing to reconcile Invoice to Cash (Bank Rec)
- Failing to identify and correct Disputed Claims (in time).
- Failure to bill correct items, locations, inpatient/outpatient.
- Failure to align to schemes/agreements.

Failure to manage debt correctly for over a decade actually cost this provider $373k!

The “Leaky Bucket”



Average Lost Revenue per annum

10% - 20%

Lifetime lost earnings at risk

$2m ++

Close your Loops from the start!

WHAT BILLING ACTUALLY INVOLVES

The Full Billing Operation

Most doctors don't know what they don't know. Billing is not something that you are taught in your medical training.
Here is what 'billing' actually requires:

Qualified Staff

Medical billing specialists — not general admin — with specialty-specific coding knowledge

Billing Software & Payment Gateways

Practice management platforms with strong billing capabilities with ongoing licensing, updates & integration costs

Compliance & Financial Oversight

MBS audit readiness, documentation standards, AHPRA and ATO obligations. Clear responsibilities & separation of duties for key financial tasks to manage fraud risks

Payer Contracting

Registering and establishing and maintaining agreements with major funds (eg Known Gap) for all Provider Numbers

Credentialing

Ensuring provider numbers are active and correctly assigned per payer

Claim Appeals

Systematic review and resubmission of every denial — time-intensive and specialist skills required

MBS Billing Updates

Continuous training as MBS schedules, item numbers, timing limits and rules as they change

Revenue Reporting

Dashboards that tell you where revenue is, what's outstanding, and what's at risk. Regular and ongoing review with key staff and your Accountant / Financial Advisor

WHAT BILLING ACTUALLY INVOLVES

The Billing Engine Room...



Provider Numbers

Registration per place you work with Medicare.

Health Funds

Registration per Health fund prior to providing services.

Patient Demographics

Accurate Patient Demographics Name, DOB, Fund, Medicare, DVA

Accurate & Compliant Item Codes & Details

Ensuring you have collected Referral, Procedure, Times, Locations, Item Codes, Additional Details as required.

Timely

Ensuring you submit claims on time to avoid unserviceability windows, don't delay, do it consistently each week.

Priced Correctly

Ensuring pricing aligns to IFC, AMA Rates, Bulk Billing, Agreements

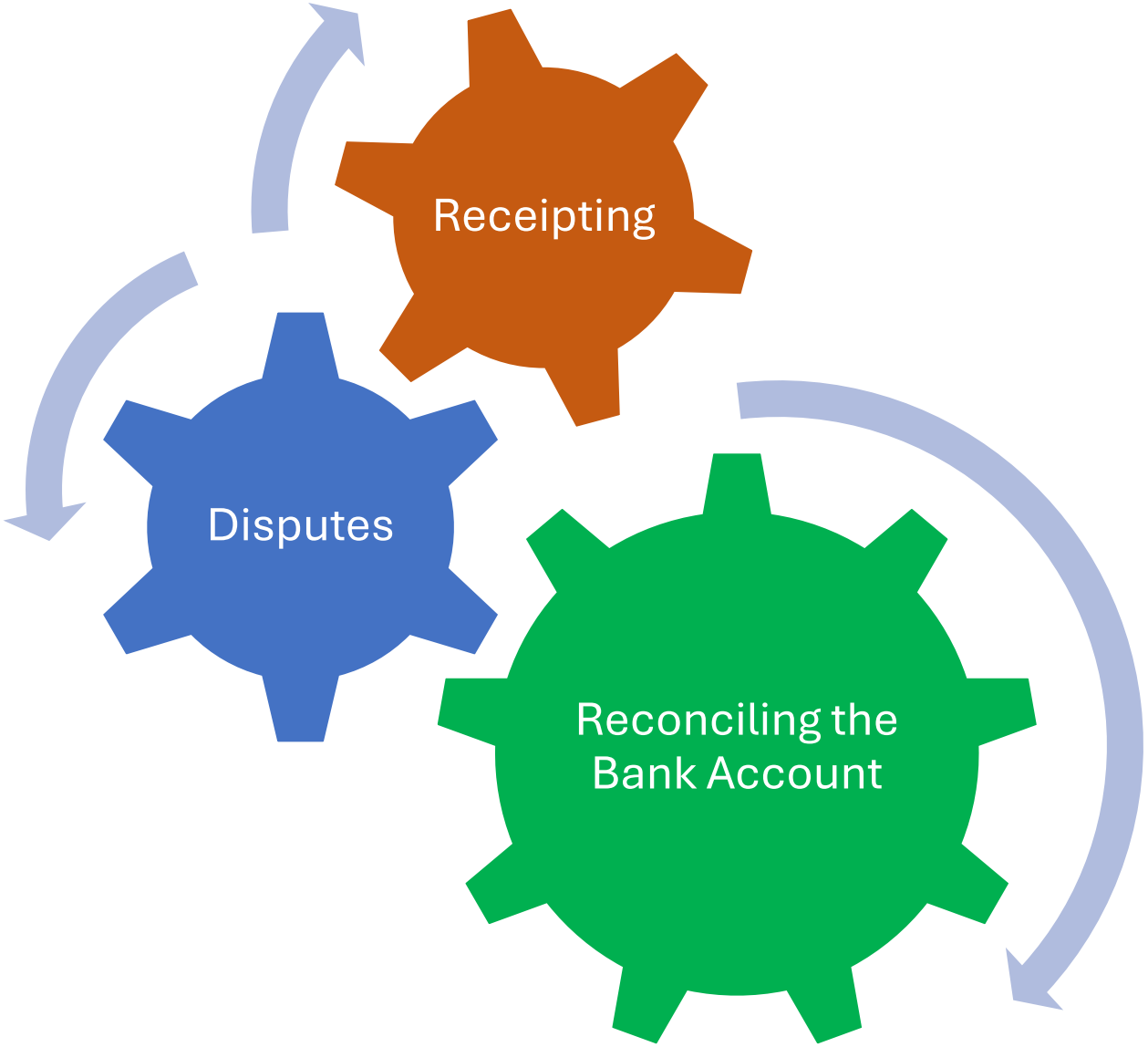
Close your Gaps

Have a way to ensure you bill for every Patient seen, every appointment held, every follow up, checks and balances.

Cont...

WHAT BILLING ACTUALLY INVOLVES

The Billing Engine Room...



Receipting
Ensuring items that are “paid” are marked as paid whether letter, email, or digital.

Identify Disputed or Unpaid Claims
These may be strategically underpaid, rejected with reasons or without.

Follow the Dispute Resolution Workflow
Noting it varies for the type of dispute, Funder, rejection reasons and more.

Call / Email / Mailout to Funders

30+ minute hold time + 5 questions max per call.

Chase Unpaid Patient Debt
Rapid and systematic follow up of patient debt is critical. Pre Payment is becoming more common for Gap collection

Did the money hit your account?

For every receipted claim, are you sure it hit your account in full?

If not, why not?
Does the funder have the right details, did they forget to make payment, is it just a timing issue.

WHAT BILLING ACTUALLY INVOLVES

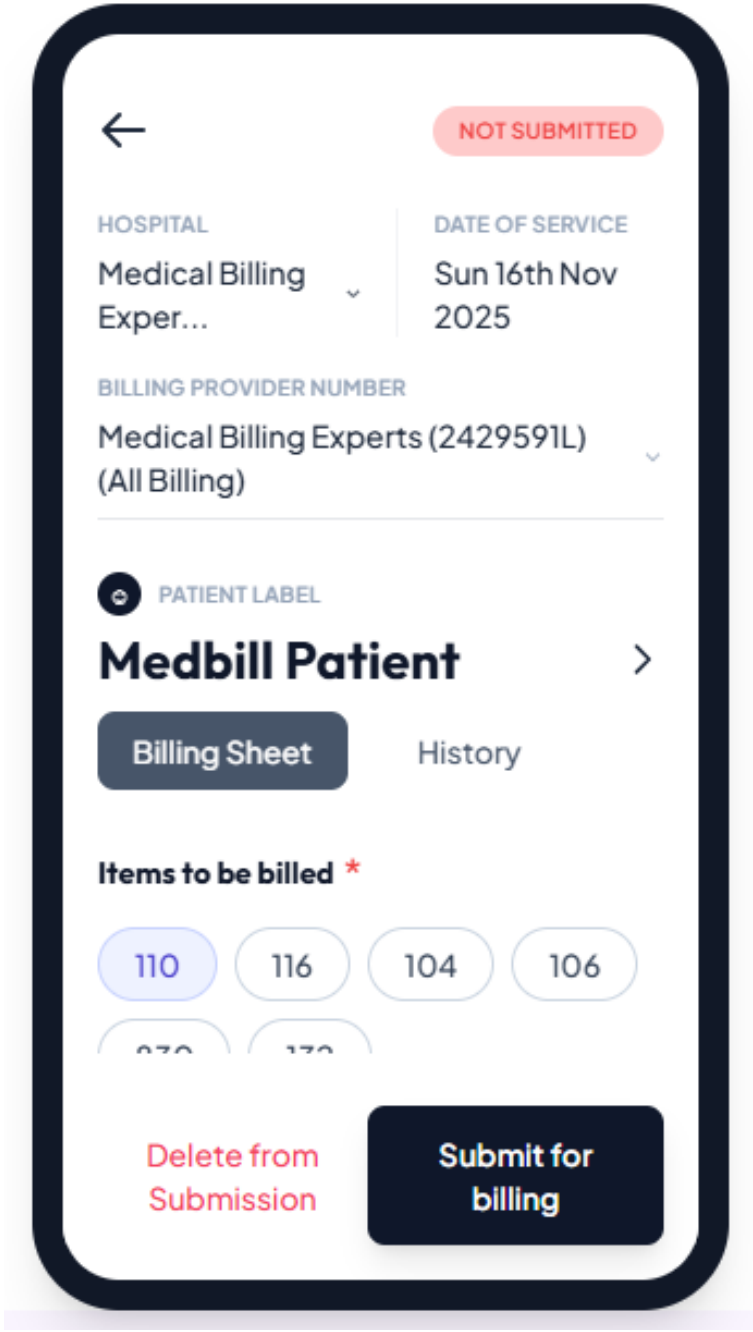
Close the Loops

Your Top 3 End of Month reports

1. Un-invoiced Appointments
Ensure you have invoiced every patient you saw.

2. Aged Debt
Rigour around tracking your Aged Debt within your Practice

3. Banking Report
Compare Bank Statement to Receipted Funds



DOHAC is very clear where their billing compliance focus lies in 2025-2030.

Australian Government
Department of Health and Aged Care

Health Provider Compliance Priorities 2025

Bulk billing

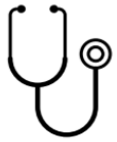
Access to affordable health care for all Australians is a high priority. When a health professional chooses to bulk bill a service, they accept the relevant Medicare benefit as full payment for the service.

Charging a co-payment or membership fee is a breach of the *Health Insurance Act 1973*. Where we find that a health professional has charged a co-payment or membership fee for a bulk-billed service, we take compliance action.

Specialist and consultant physician claiming of attendance items and management plans

Professional attendance services are the largest contributor to Medicare Benefits Schedule (MBS) expenditure. Our data shows specialist and consultant physician attendance items drove the growth of attendance services in financial year 2023-24. This includes management plans such as MBS items 132 and 133.

Our focus is ensuring providers understand how to claim correctly to protect the sustainability of Medicare.



Claiming MBS services while overseas

Medicare benefits are only payable where the service is performed in Australia to an eligible patient.

We take compliance action where a provider performs and claims MBS services while overseas.

Suspected fraud

We are committed to tackling illegal activity and behaviour of concern to protect the integrity of Medicare.

Duplicate payments

Medicare benefits are only payable where a service has not already been paid for through another funding arrangement. Duplicate payments breach Section 19 of the *Health Insurance Act 1973*. This requirement ensures the sustainability of Australia's healthcare system.



We take compliance action where we find duplicate payments.

Opportunistic billing and emerging business models

In an environment of rising costs, technology advancements and innovation in healthcare delivery, there is increasing risk of business models prioritising revenue generation over clinically relevant patient care.

The integrity of Australian Government health program payments is impacted where:

- arrangements between an organisation and a health professional remove health provider control over their claiming, or
- a practitioner's clinical independence is undermined by corporate billing requirements.

We take compliance action to address inappropriate practice and mitigate the potential for patient harm.

Inappropriate claiming of high-cost PBS medicines

The Pharmaceutical Benefits Scheme (PBS) provides patients with access to safe, proven and cost-effective medicines. Ensuring PBS compliance safeguards the sustainability of the PBS.

When a pharmacist supplies an invalid prescription, patient care can be impacted. In some cases, it can result in health program benefits being obtained fraudulently. We take compliance action where:

- PBS supplies are more than what was prescribed or clinically needed
- PBS medicines are claimed without a prescription.



Open and uncertified PBS claims

We have identified an increasing number of PBS claims where the supply of pharmaceutical benefits was not certified, and the claim closed. This breaches the Claims Rules made under the *National Health Act 1953*.

Collaborating with Services Australia, our focus is on:

- supporting approved suppliers understand their claiming obligations, and
- implementing up-front controls to ensure future compliance.

The Australian Compliance Framework



Australian Government
Department of Health

7 February 2019

Our reference: [redacted]

[redacted]

REVIEW & ACT NOW

Dear Dr [redacted]

The Department of Health (the department) is responsible for compliance activities relating to health programs. Information held by the department indicates that some providers may not be meeting the Medicare Benefits Schedule (MBS) requirements for patient consultant physician treatment and management plan items (MBS Items 132 and 133).

You have been identified as a health provider that has claimed at or above the 90th percentile compared to your peers that claim MBS Item 132 and/or 133.

To satisfy the requirements under the *Health Insurance Act 1973* (Cth) and the instruments made under it, the claiming of item 132 or 133 must meet the MBS Item requirements outlined in the attached document.

Between 1 May 2017 and 30 April 2018, you claimed services relating to MBS Item 132 and/or 133 on 770 occasions.

To assist you in reviewing your claims, please find your schedule of claims attached for this period. If you identify any MBS payments that you were not entitled to receive, these must be repaid to the department. If you are unsure if you have met the requirements to claim MBS Item 132 or 133, you can seek clarification through the Department of Human Services at askMBS@humanservices.gov.au or call on 13 21 50.

What you need to do

Review the attached schedule of claims. Each claim needs to meet the item requirement outlined in the attached document.

If required, **fill out** the attached *Voluntary Acknowledgment of Incorrect Payments* form for any claims you were not entitled to receive.

Where required, **return** the completed *Voluntary Acknowledgment of Incorrect Payments* form, containing your completed schedule of claims.

If you are completing and returning a *Voluntary Acknowledgment of Incorrect Payments* form, please return by **7 March 2019**.

Non-Linear Process

The entire process we are about to discuss is not Linear

Selection for Targeted "Education"

The DoH regularly selects providers who's claims fall within certain parameters (ie 90th Percentile).

Advise your Insurer

Your first step should be to notify your insurer.

Respond

You will need to review each of the Claims, justifying why each is correct, agreeing to amend and repay or adjust the amounts.
- Clinical Notes VS Billing Details

Big Data & Algorithms at Work

Note the government has huge volumes of data, and teams to analyse everything from:
- The detail included in your claims (referrals, item codes).
- How your claims stood out differently to your peers.
- Your overseas travel overlapping claiming.

The Australian Compliance Framework

Targeted Campaign

DoH Audit

Response

Referral to the PSR

STAGE 1
The Director of PSR



Decision: Should the matter be reviewed?

STAGE 2
The Committee of Peers



Decision: Did inappropriate practice occur?

STAGE 3
The Determining Authority



Decision: What is the suitable sanction?

Plea Bargain
S192 Agreement

- Repay funds
- Agree not bill certain Items

Committee of Peers
18-24 months process of

Intensive review of Clinical Files
Items, Clinical Notes, Behaviours

WHAT BILLING ACTUALLY INVOLVES

The Hidden Costs — and the Compounding Burden

WHAT YOU SEE

- Staff salary × 1–2 FTE
- Practice management software subscription

WHAT'S HIDING BELOW

- Recruitment & turnover cost when your admin leaves
- Training time for coding updates & compliance changes
- Timing gaps for holidays, sick leave etc
- Invoice Write offs or deletions you never see
- Revenue lost during knowledge gaps and staff transitions
- Compliance exposure — audits, penalties, write-backs
- Your time: managing, supervising, fixing billing issues

THE BILLING BURDEN COMPOUNDS

More patients ≠ more of the same.
More patients = more payers, more codes, more denials, more patient debt, more compliance risk, more management time.

- Every new procedure adds new item number complexity
- Every new payer adds a new set of rules to manage
- Every staff gap creates a revenue recovery backlog
- Every coding error compounds into a compliance pattern

Every failure point in the billing cycle is a direct leak in your revenue cycle.

Case Study – Key Person Risk Management

ER Dr Group – Own Single Admin Person



Key Failure Points:

- Mitigate the key person risk.
- What checks & balances are in place on this person.

Failure to manage debt correctly for over a decade actually cost this provider $373k!

THE DECISION

The Fork in the Road

Every doctor entering private practice reaches this decision — most make it too quickly, based on instinct rather than analysis.

INSOURCE

Hire experienced billing staff
Understand & Own the process
Keep it in-house

At first glance:

- Feels like control and visibility
- Staff on-site and accessible
- Familiar to hospital-trained mindset

OR

OUTSOURCE

Engage a specialist
Hand off the submission & cash collection function
Focus on medicine & patient care

At first glance:

- Specialist expertise from day one
- No staffing, training or turnover risk
- Scalable as your practice grows
- Alignment of incentives with your billing partner

This decision deserves more than a gut feel. Let's look at what it really means to insource.

Before You Decide — Answer These Questions Honestly

1

Do I have the expertise in-house to manage a complex, compliance-heavy revenue cycle?

Specialty coding, payer rules, MBS changes, consumer law, appeals — all of it.

2

Can I absorb the cost and disruption if my billing operation underperforms or breaks down?

Staff turnover or knowledge gaps, revenue gaps (debt), compliance exposure — what's your tolerance?

3

Is building a billing department the best use of my capital and attention at this stage of my practice?

Your time, focus and money are finite. What do you want to build? What do your staff prefer spend their time doing – dealing with patients or ringing insurers to manage rejections and collecting outstanding debts?

Most new practice owners' answer: No. No. No.

Why Insourcing Feels Safe — But Isn't

THE ILLUSION

- "I can see it and manage it"
- "I trust my own staff more"
- "It's cheaper than outsourcing"
- "I have direct control over the process"
- "I'll know if something goes wrong“
- This is what the previous generation of doctors do

THE REALITY

- Staff turnover is the #1 threat to RCM — your revenue cycle walks out when your biller or PM does
- In-house staff rarely have deep specialty-specific coding expertise
- True cost (salary, super, training, software, recruitment) often exceeds outsourcing
- Compliance errors carry personal liability for the practice principal
- No alignment of financial incentives with your staff - rejected claims or unpaid patient bills do not impact them
- Revenue leaks are often invisible until significant damage is done

"Do you want to build a billing department — or a medical practice?"

2026: The Stakes Have Never Been Higher

The billing environment in 2026 is fundamentally more demanding than even 3 years ago.

AI-Driven & Algorithmic Denial & Compliance Engines

Medicare & Insurers now deploy AI & data matching to identify claim anomalies and auto-deny at scale. In-house billers without specialist tools and knowledge are outgunned from the start.

Real-Time Claims Processing Demands

Payers expect faster, cleaner claims. Delays and errors that were tolerated previously now trigger automatic rejection, requiring rapid re-submission capability.

Increasing Audit Activity

Medicare and private funds have significantly increased audit frequency. Patterns of incorrect coding — even inadvertent — now attract formal investigation.

Patient Contribution – & associated debt – is growing

Patients are paying more Gaps than ever before due to Medicare rebates not being indexed.
This is unlikely to change – so patient debt exposure for many Doctors is growing at a rapid rate each year.

WHAT BEST PRACTICE LOOKS LIKE

What a Best-in-Class RCM Operation Delivers

1

Clean Claim Rate Above Benchmark

95%+ first-pass acceptance — fewer rejections, faster payment, less rework

2

Systematic Denial Management

Every denial reviewed, appealed and tracked — no revenue left behind

3

Specialty-Specific Coding Expertise

Deep knowledge of your area's MBS codes, bundling rules and billing nuances — kept current

4

Active Payer Relationship Management

Proactive engagement with funds, schemes and Medicare to resolve issues before they become patterns

5

Real-Time Revenue Reporting

You know where your revenue is, what's outstanding, what's at risk — at all times

6

Compliance Assurance

Audit-ready documentation, correct coding, and protection of the practice principal from personal liability

Could I build this in-house — and should I?

Build the Practice You Intended

The doctors who thrive in private practice protect two things fiercely:

Their Clinical Time

Their Revenue Cycle

"What is one hour of my time worth —
and how many hours a week will a poorly run revenue cycle cost me?"

Medbill

Billing Compliance & Revenue Cycle Management
Solutions for Australian Private Health Providers

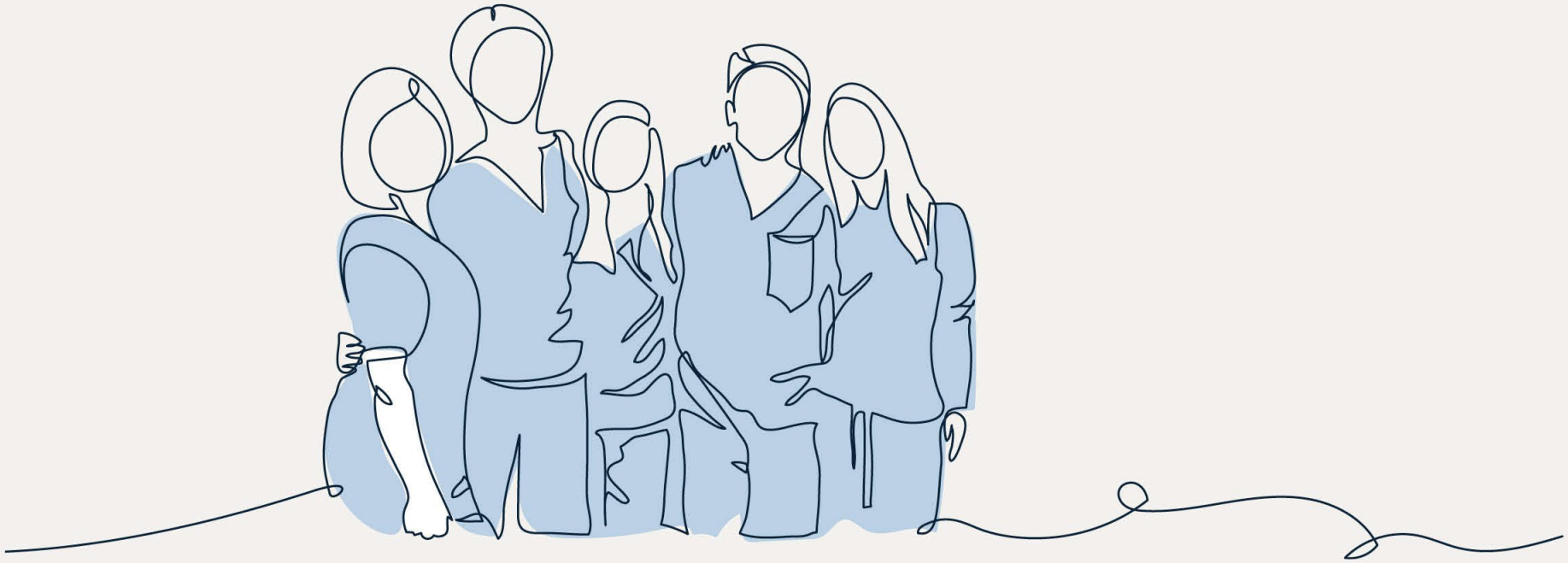
If you want to see what a well-run revenue cycle looks like in practice, Medbill would love to show you.

Scan the QR code and fill out the contact form and a Medbill Team member will be in touch in 24 hours to discuss your requirements

- Billing Compliance & Audit
- Medical Billing Services
- Revenue Cycle Management

RWS

practice | marketing | staff | rooms



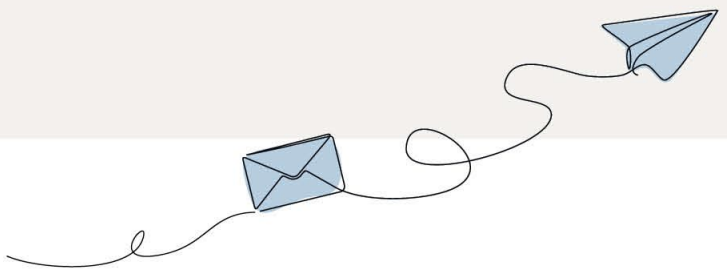
DPM Presentation

Med Meet

You know why you need a referral base –

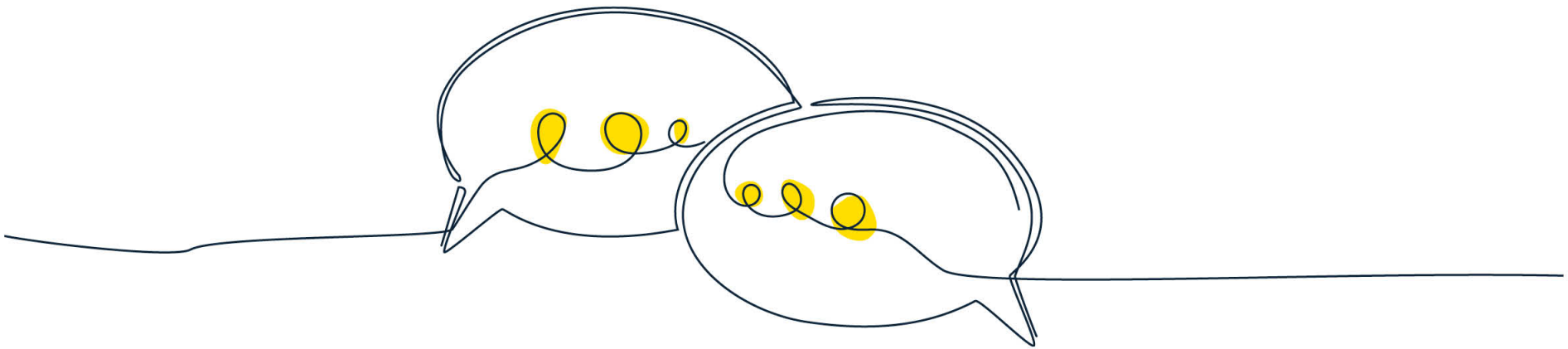
- Referral base = Patients
- No referral base = No patients

1. What ‘marketing’ means for doctors
2. A lesson on what happens in most private practices
3. How to create your referral base
4. How to keep your referral base
5. What we see happen to a doctor’s referral base as they move through private practice

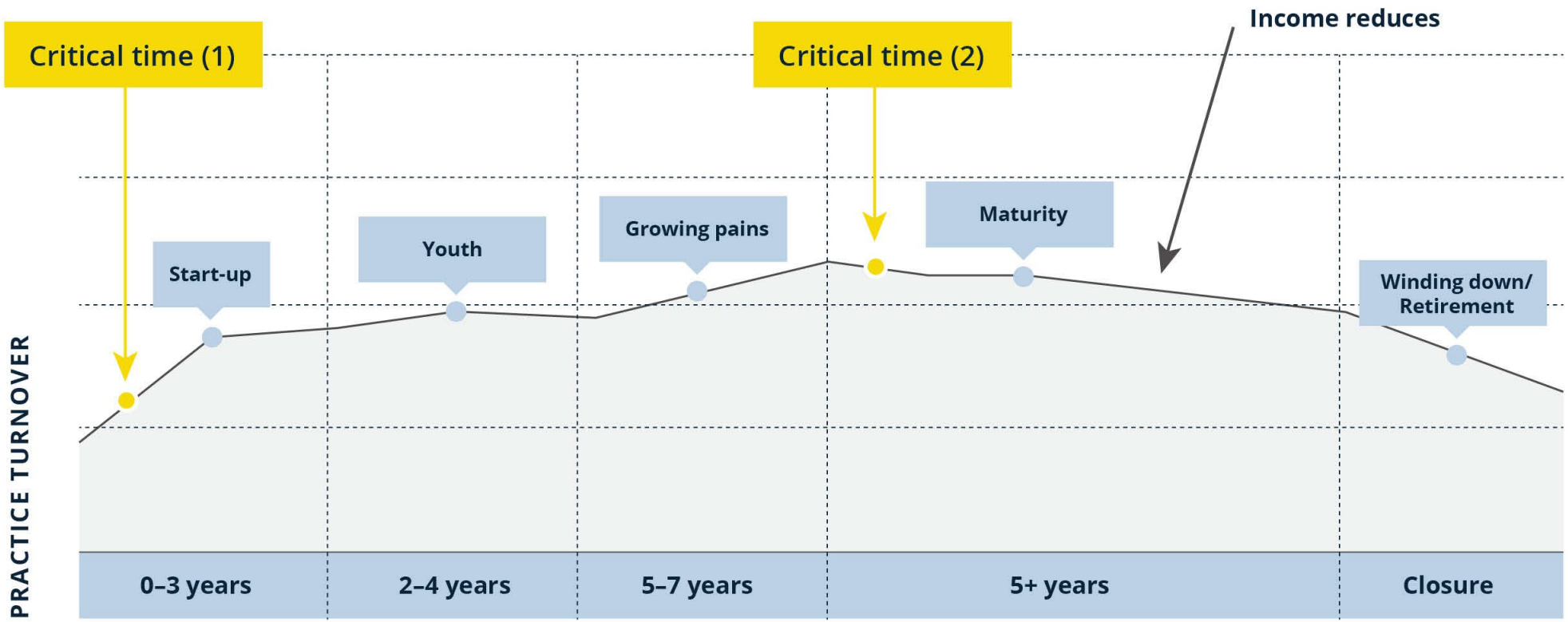


What does marketing mean?

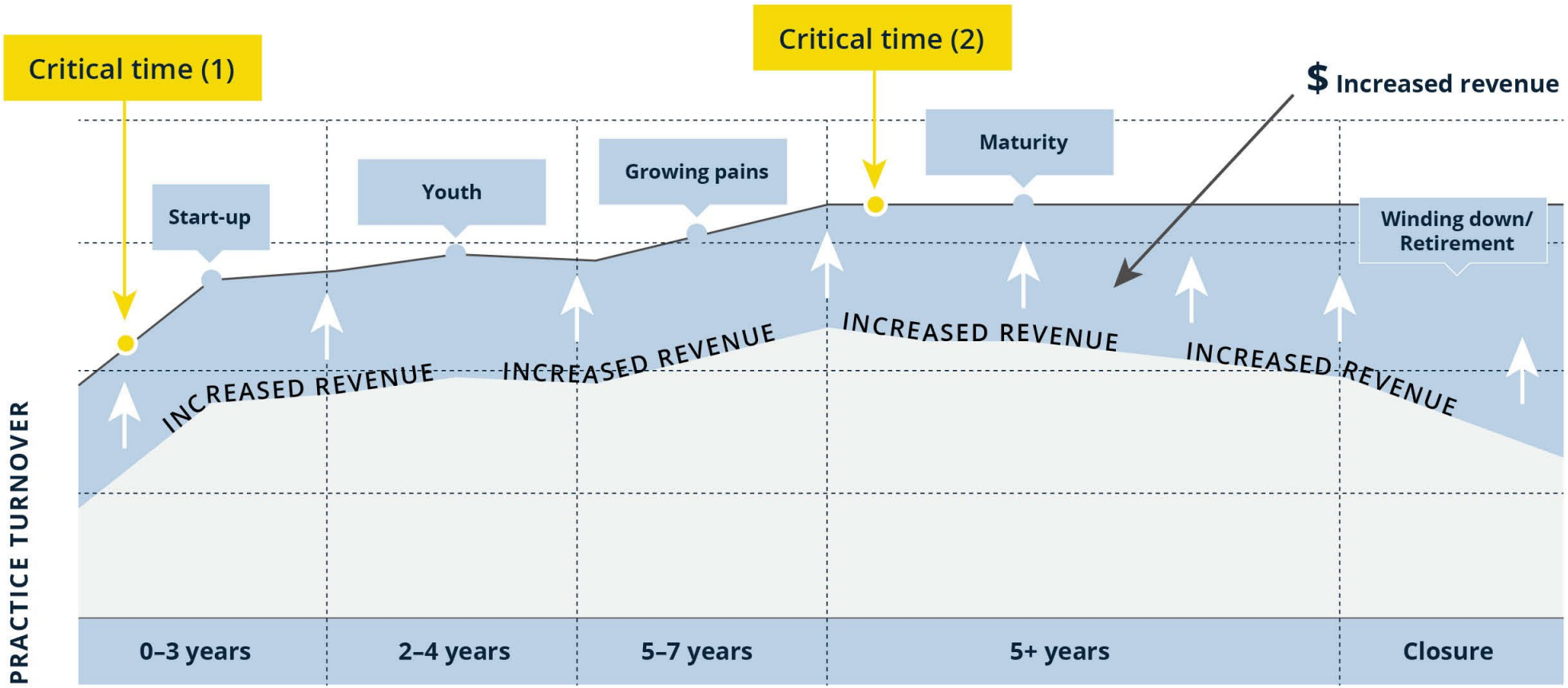
> It means building good relationships with your referrers that will last you for your time in private practice.



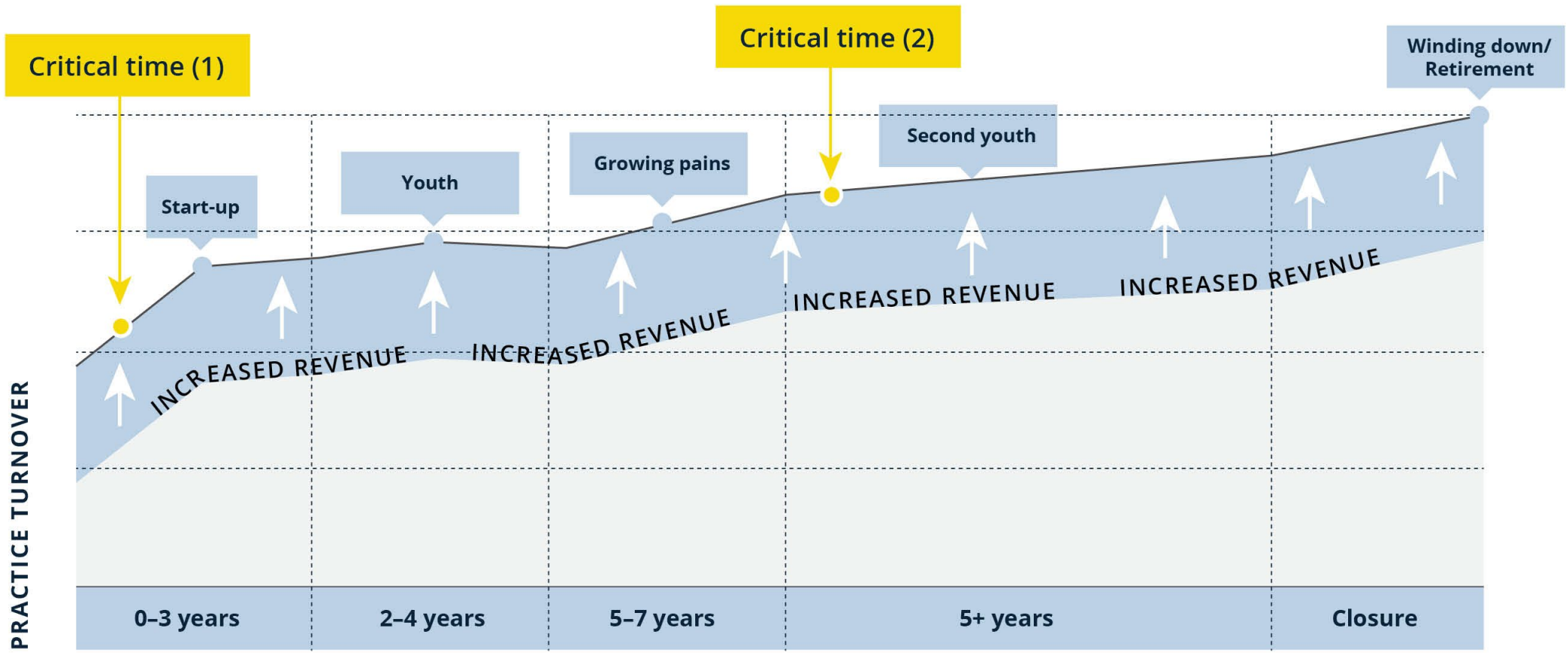
A lesson on what happens in most private practices



Marketing to referrers stops the dip



Second youth can stimulate additional revenue.



Lessons to be learned:

- What you do at the start matters at the end
- Prioritise staying in touch with referrers
- Relationship marketing works



Where to set up, what to consider?



Example of a good set up

Golden rules:

> Don't consult at too many locations; you'll waste all your time in the car

> Make sure you like the demographic; the type of patients you will see

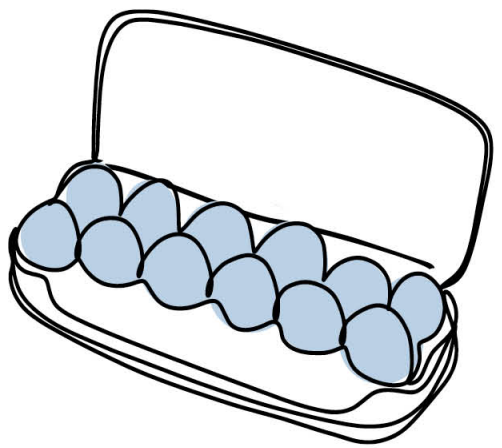
> Consideration to where your competitors are

> Politics that may influence your decision

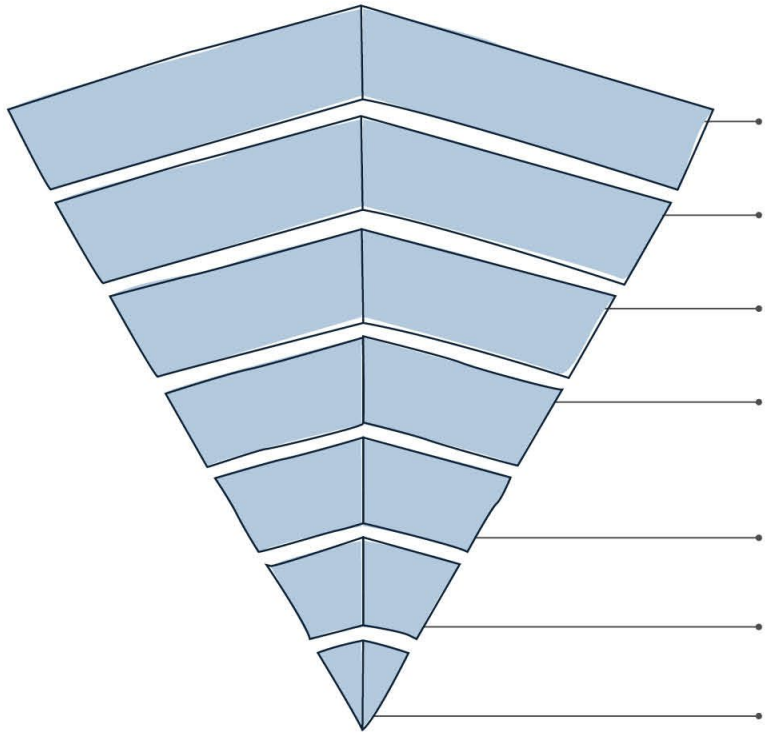
** Remember your colleagues may now be your competitors, private practice can be lonely*

Give them what they want, make it personal to them

- You don't need to 'win' every one
- Think *'The Dirty Dozen'*



Marketing touches



Base Marketing:

- Letter
- Phone call
- Fax
- Appointment

Bespoke Marketing:

- Thank you letter
- Information sheet
- Podcasts



- **Referrals!**

Relationship marketing works

Referrers will

‘Choose with emotion, then justify with logic.’

Referrers choose

Who they like

Who makes them feel safe

Who makes them feel valued



DO ask about them

DON'T give your resume



DO do follow AHPRA guidelines

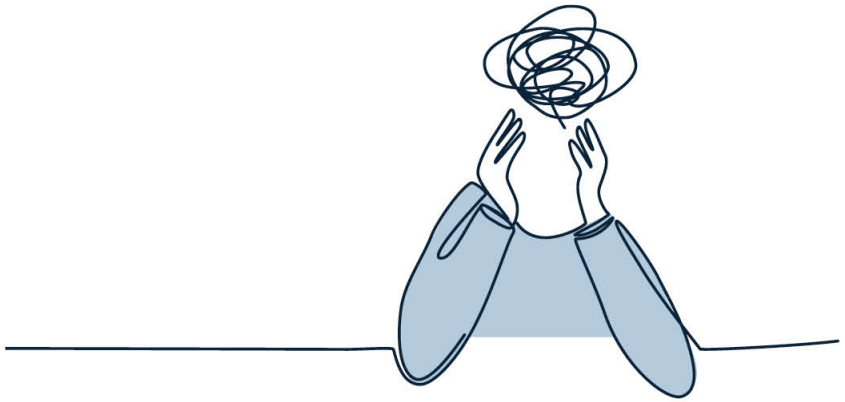
DON'T exaggerate your skills



AIM FOR...
Professional relationships built on trust and dependability that will last for your time in private practice!

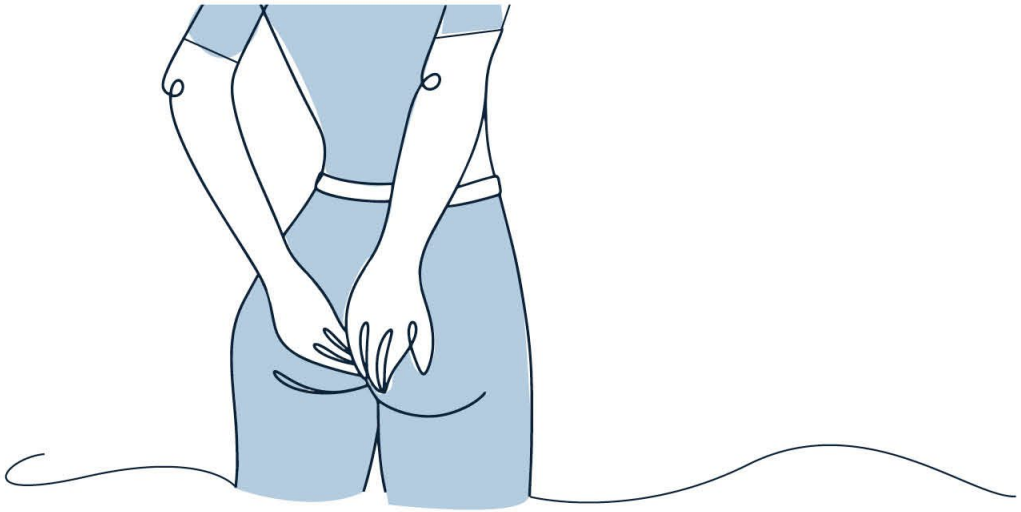
DO talk in language they use with their patients

DON'T make the language too medically technical



DO talk about conditions they see all the time

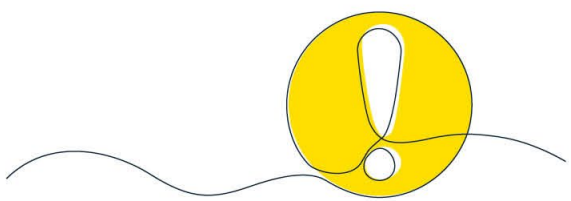
Don't talk about conditions they rarely see



*Focus on what **they** need – not what **you** need*

The reasons GPs refer

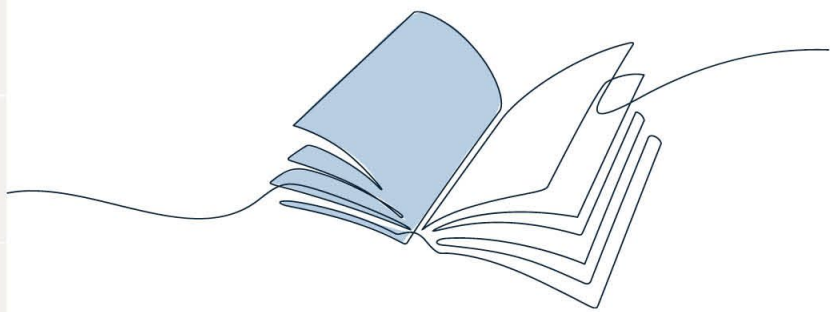
- You are an advocate for their patients
- You make them feel safe
- You are not risky
- You make them feel an equal (“Not just a GP” billboard)
- They feel a connection with you
- You help them (e.g. answer their calls, provide education, show concern for their welfare)



A clinical reason is never mentioned first, when they say why they refer!

Let’s read between the lines

The reasons:	What it really means:
Advocate	I know my patient is okay and I won’t get grief
Safe	I can show my underbelly and say I don’t know
Not risky	I won’t get sued
Equal	I feel respected
Connection	I will buy on emotion and justify with logic
Help	I feel listened to and when I call you will prioritise me



Tell the market who you are

or the market will decide



Example marketing touches

Letters to referrers



Professional profile



Clinical podcasts



Example marketing touches

Professional profile



Educational sessions

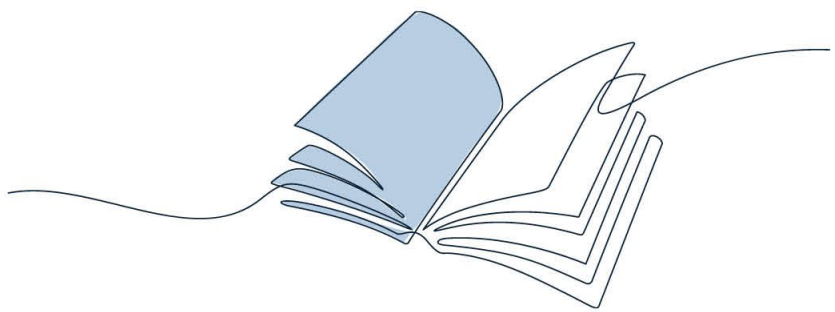


Christmas cards



Take home messages

- Concentrate on marketing that builds relationships
- Attract work that gives meaning and purpose to your life
- Abide by AHPRA
- Give your referrers what they need! (Not what you need)
- Own your fears – we all have them
- Don’t worry about competition. Do you!
- What you do at the start will influence the end



Thank you

P. 1300 073 239

E. admin@roomswithstyle.com.au

www.roomswithstyle.com.au

RWS

practice | marketing | staff | rooms

PROFMED
BY PROFCOVER

TAILORED INSURANCE SOLUTIONS FOR MEDICAL PRACTICES

General Advice Warning

- This presentation does not take into account your current objectives, financial situation or needs.
- Because of this you should consider the appropriateness of the cover/advice provided having regard for your current objectives, needs and financial situation.



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Comprehensive Solutions for Medical Practices



MEDICAL INDEMNITY INSURANCE

Specialised Medical Indemnity Insurance for medical practitioners

All doctors working in private clinics need medical indemnity insurance!

PRACTICE INDEMNITY INSURANCE

Protects practices, clinics and healthcare institutions from malpractice, negligence or errors

CYBER INSURANCE

Protects against data breaches, ransomware and liability from compromised patient information

COMMERCIAL/ OFFICE INSURANCE

Covers clinic property and equipment, loss of income from specified events, and can include public liability

MANAGEMENT LIABILITY INSURANCE

Protects owners, directors and managers from risks like mismanagement, regulatory breaches, employment practices and crime

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From Patients to Practice: Building a Safety Net Against Modern Risks

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Comprehensive Solutions for Medical Practices



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Practice Indemnity Insurance

Common Misconception:

Professional indemnity only protects doctors for individual mistakes

The Reality:

A medical practice also carries risk through:

- Patient Interactions
- Staff (Nurses ,admin, allied health)
- Systems and processes that support care

The Safeguard:

Practice Indemnity Insurance

Practice Indemnity Protects Who?

- The Business (entity)- Primary Purpose!
- Employees (eg nurses, admin staff, allied health)
- Doctors (may extend if gap in personal policy or where practice itself is held vicariously liable)
- Contractor doctors (limited basis)



Common Risks in Medical Practice

Clinical Errors

- Misdiagnosis or delayed diagnosis
- Medication errors (wrong drug/dose)
- Procedural errors during minor surgeries or injections
- Failure to obtain informed consent
- Failure to refer to a specialist

Admin Errors

- Appointment & scheduling mistakes
- Failure to communicate test results
- Incorrect patient records entered
- Breaches of confidentiality/privacy
- Billing and Medicare claiming errors
- Poor triage or failure to escalate urgent cases

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Practice Indemnity Insurance Covers...

Medical Malpractice

- Covers claims for **bodily injury** arising from unintended errors, mistakes, or malpractice in healthcare services.
- Includes cover for:
  - Negligent advice or misrepresentation.
  - Defamation (libel/slander).
  - Breach of confidentiality or privacy.
  - Infringement of intellectual property rights.
- **Defence costs & settlement expenses**

Key Extensions:

- Abuse liability, complaints & investigations, Medicare/private health audits.
- Good Samaritan acts, telehealth, mandatory reporting.
- Vicarious liability for medical practitioners & locums.

Practice Indemnity Insurance Covers...

Errors and omissions

- Covers claims for **errors or omissions** in professional services (e.g.admin, advisory, training).
- Covers claims for **bodily injury** arising from unintended errors, mistakes, or malpractice in healthcare services.
- Includes cover for:
  - Negligent advice or misrepresentation.
  - Defamation (libel/slander).
  - Breach of confidentiality or privacy.
  - Infringement of intellectual property rights.
- **Defence costs & settlement expenses**

Key Extensions:

- Employee dishonesty, complaints & investigations.
- Loss of documents, statutory liability, contamination clean-up.
- Media management crisis costs, continuous cover.

When is Practice Indemnity Required?

- **Sole Trader (100% owned by one doctor)**

  May only need the doctor's individual indemnity policy

- **Partnership, Trust, or Company**

  Generally requires separate practice indemnity insurance



General Liability (Public & Products Liability)

Covers broader risks of running a business

- **Public Liability** – injuries or property damage on premises
- **Products Liability** – harm caused by products supplied, sold, or modified



Cyber Liability

"There are only two types of companies: Those that have been hacked and those that will be hacked."

– Robert S. Mueller, III, former Director of the FBI

Cyber Liability: The Stats

20% of all Australian data breaches in 2024 came from **healthcare**

48% of healthcare organisations reported a **cyber attack in 2025**

12.9M Australians had health data stolen in the **MediSecure breach (2024)**

Top 4 Cyber Risks for Medical Practices

1. **Phishing & Email Compromise**

Fake emails trick staff

2. **Ransomware**

Systems locked until ransom is paid

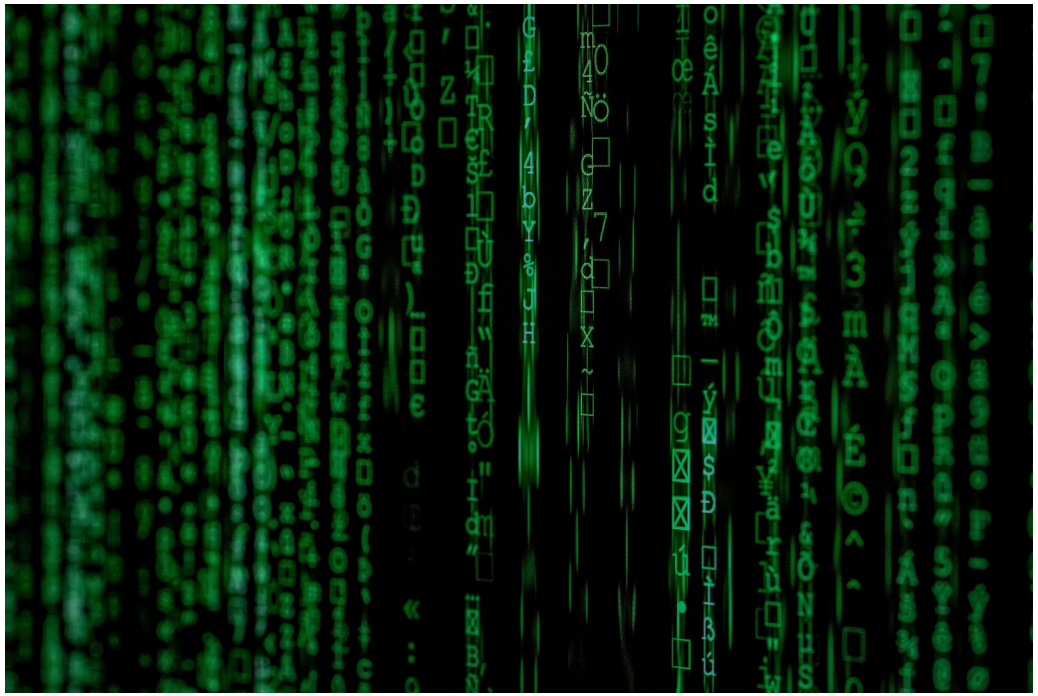
3. **Human Error**

Mistakes expose data (wrong email, misconfigured system)

4. **Third-Party Vendor Breaches**

External providers (labs, billing, prescriptions) hacked

What are the Ramifications for Practices?



- Cyber incidents aren't just IT problems - they are **patient care** problems
- Disruption to practice: cancelled appointments, delayed treatments or a closed practice
- Loss of trust: patients expect their records to be safe
- Legal & financial exposure: OAIC reporting, fines, lawsuits
- Every clinic, large or small, is a potential target!

Without Cyber Insurance (Before)

❌ Confusion about what to do after a breach

❌ Out-of-pocket costs for IT forensics & legal advice

❌ Must notify patients & regulators alone

❌ Lost income if systems are offline

❌ Risk of lawsuits with no support

With Cyber Insurance (After)

✅ Immediate access to IT & cyber response experts

✅ Legal & regulatory guidance

✅ Patient notifications, credit monitoring & PR support included

✅ Business interruption losses reimbursed

✅ Defence costs & settlements covered

Digital Healthcare

Rapid Growth

The digital healthcare sector is evolving at unprecedented speed

Opportunities

Innovations like AI, remote patient monitoring, and telemedicine are transforming patient care and driving medical breakthroughs.

Risks

But with this progress comes exposure to **new risks** that many practices have not yet considered.



Management Liability

Management Liability – The Business Side of Medicine



As an employer…

- Risk of claims for **unfair dismissal, bullying, discrimination**

As a manager...

- Must comply with **WHS laws, privacy, Fair Work**
- Simple oversights can trigger **penalties or investigations**

As a director...

- Carry **personal accountability**
- Financial decisions, regulatory breaches, or employment issues can put **assets at risk**

Management Liability – What it includes

- **Directors & Officers Liability** – Protects personal assets if accused of mismanagement.
- **Employment Practices Liability** – Covers unfair dismissal, bullying, or harassment claims.
- **Statutory Liability** – Responds to breaches of legislation.
- **Crime/Fraud Cover** – Protection against employee dishonesty or theft.
- **Tax Audit Cover** – Supports certain ATO investigations.

FWC Statistic!

Fair Work Commission Applications – FY 2023/24

- 40,188 applications received (unfair dismissal, bullying, harassment, etc.)
- Highest annual number since the Fair Work Act 2009

EPL Risk Trends in Australia

- Increasing disputes around workplace conduct:
  - Harassment & discrimination
  - Return-to-work policies
  - COVID-19 vaccine mandates
- Growing awareness of employee rights leading to more claims

Management Liability Pays For:

- Legal defense costs
- Tribunal and inquiry representation
- Settlements and compensation
- Regulatory investigations

Management Liability Claims

- Employment Claim (Fair Work)
  - Settlement and defense costs exceeded $150,000
- Workplace Harrassment/ Discrimination
  - Total legal and settlement costs $237,000
- Employee Theft
  - Loss and investigation re-imbursed $150,000
- ATO Audit Costs
  - Professional fees $40,000



Commercial Insurance

Commercial Insurance

- Property and Assets Damage
- Business Interruption – Income Protection for a Business
- Theft
- Money
- Machinery/Equipment Breakdown
- Public & Products Liability
- Glass
- General Property
- Employee Dishonesty
- Tax Audit



Business Interruption – Key Features

- **Indemnity Period**
  Covers until the practice is realistically back to pre-loss levels.
- **Gross Profit vs. Revenue**
  Cover is based on gross profit (turnover minus variable costs).
- **Increased Cost of Working (ICOW)**
  Covers the additional expenses incurred to keep the business operating and reduce the loss of income
  Examples: renting temporary rooms, outsourcing services.

Business Interruption- Key Features

- **Trends & Adjustments Clause**
  Claims adjusted for actual business conditions at time of loss.
  Ensures fairness (e.g. if practice was growing).

- **Extensions Beyond the Premises**
  Cover can extend to:
  - ❑Utility failures (power, water, telecoms)
  - ❑Access issues (road closures, etc.)

Property and Business Interruption – Claim

- **Medical practice –Day Surgery**
- **Event: Electrical fire - smoke & water damage.**
- **Closure: 4 Days for repairs.**
- **Immediate Impact**
  - ❑ Loss of reputation – procedures cancelled
  - ❑ No patient consultations → loss of reve
  - ❑ Staff & rent still pa
  - ❑ Da

$180,000 settlement

Costs of immediate Remediation to make safe

- Electrical contractor – inspect, reconnect, Test and Tag
- Air conditioning filter cleaning and servicing
- IT support – Test/assess IT and office equipment for smoke damage.

ful particles,

leaned carpets/ chairs

leaning of all surfaces

- Disposed of consumables
- Check AIR quality assessment prior to restarting practice
- Costs of replacing Carpets/blinds /consumables/ stock
- **Loss of Profits Claim**
- **ACOW – Staff Overtimes/ Generator**
- **Accounting Fees CPC**

Insurance Protects, But Good Practice Prevents!



- **Practice Indemnity** – Stay trained, document well, follow guidelines
- **Cyber** – Strong passwords, updates, staff awareness
- **Commercial** – Safe premises, maintained equipment, safety compliance
- **Management Liability** – Clear HR policies, up-to-date handbooks, fair processes



Protecting Your Practice: Building a Safety Net for the Risks You Can't Afford to Ignore

PROFMED
BY PROFCOVER

Medical mentor panel

Dr. Amber Hart

Director / GP / Lactation Consultant
Maternal & Infant Wellbeing Melbourne

Associate Professor Chun Yew Fong

Co-Director / Haematologist
Eastern Haematology Oncology Group

Dr. Dan Bates

Director / Sports and Exercise Physician | Back, Neck and Joint