

15 contract provisions that quietly cost you.

Data. Leverage. Fair pay.

Built for hospitalists and outpatient IM · 2026

The 15 provisions below are the ones most likely to cost internal medicine physicians — hospitalists, employed outpatient, and private practice — money, mobility, or leverage. Read each item against your contract and mark whether it is present, missing, or unclear. A single CRITICAL finding warrants careful review before signing.

THE 15 RED FLAGS

6 CRITICAL · 7 HIGH · 2 MODERATE

01 | ■ CRITICAL

wRVU rate with no named benchmark

A dollar-per-wRVU multiplier with no reference to 2025 national benchmarks gives the employer full discretion to call any rate “market.”

02 | ■ CRITICAL

Compensation model not specified

If salary vs. wRVU vs. capitation vs. hybrid is ambiguous, the model can shift at renewal — a guarantee silently converting to production-only is the classic pattern.

03 | ■ CRITICAL

Advance draw with no floor

Biweekly advances against projected production without a guaranteed floor mean a year-end production shortfall becomes a clawback you owe back.

04 | ■ CRITICAL

No minimum shift or census guarantee

Per-shift or per-encounter rates with no minimum hand the employer full control of your income — they can cut shifts or redirect admissions and your pay drops without breach.

05 | ■ CRITICAL

Claims-made malpractice, no tail commitment

Silence leaves who pays unresolved. Ask for employer-paid tail in writing for resignation, termination and nonrenewal; confirm the policy terms.

06 | ■ CRITICAL

Stark / self-referral language

Referral-linked pay can put your compensation at risk. Require written terms showing what earns credit and how the arrangement complies with applicable rules before signing.

07 | ■ HIGH

Panel size with no cap or productivity adjustment

An uncapped panel means unpaid workload as it grows — more messages, refills, results, and forms at the same pay. Require a cap or per-patient-above-threshold payment.

08 | ■ HIGH

HEDIS / quality bonus denominator controlled by employer

A bonus tied to system-level metrics or panel mix you didn't choose is structured not to pay out. The denominator, attribution, and physician influence path must be specified.

09 | ■ HIGH

Termination without cause under 90 days

Credentialing alone typically runs 90–120 days. A 30- or 60-day without-cause window leaves no time to credential, relocate, or negotiate the next contract from strength.

10 | ■ HIGH

Non-compete over 10 miles or 2 years

Enforceability varies sharply by state, but litigating an aggressive restriction costs time and money you don't want to spend. Narrow scope and duration before signing.

11 | ■ HIGH

Nocturnist differential below market or missing

The 2025 national benchmark median nocturnist differential is roughly 15%, with top-quartile groups at 20–25%. A missing or below-median differential is below market — anchor it to benchmark data.

12 | ■ HIGH

Ambiguous call coverage language

Specify: in-house vs. remote, number of call days per year, per-call payment rate, and whether call is included in or additive to base. Ambiguity shifts unpaid work onto you.

13 | ■ HIGH

Bonus threshold not tested against your workload

Test the threshold against your credited production, workload and payout period. Model low, expected and high-production payouts before counting the bonus as income.

14 | ■ MODERATE

Moonlighting restriction blocking locum work

A blanket prohibition on outside clinical work eliminates a substantial supplemental income stream. Restrict only true conflicts (same geography, same patient population).

15 | ■ MODERATE

Sign-on clawback over 2 years or full repayment

Standard structure is pro-rata over 24 months. A 3-year clawback or full-repayment-until-year-three is aggressive — negotiate pro-rata and a waiver on without-cause termination.

NEXT STEP

Found a CRITICAL flag?

Run your contract through the Analyzer. Benchmark every term. Get a prioritized list.

clauseline.com/redflags