**PR 100 Adjustment Code**

In US healthcare billing, PR 100 is an adjustment code that represents a contractual obligation adjustment. This code is used by insurance companies to indicate that the provider's charges exceed the amount allowed under the contract between the provider and the insurer.

When a provider bills an insurance company for services rendered to a patient, the insurance company will typically review the claim to determine if the charges are reasonable and within the limits of the contract. If the charges exceed the contracted amount, the insurance company will apply the PR 100 adjustment code to the claim, which reduces the amount paid to the provider.

It's important to note that the amount of the contractual obligation adjustment can vary based on the specific contract between the provider and the insurer, and it may be different for different services or procedures. Providers should review their contracts with insurers to understand the allowed charges for their services and procedures.

**For Example:**

Let's say a patient receives medical services from a provider who is in-network with their insurance company. The provider bills the insurance company $1,000 for the services, but the allowed amount in the provider's contract with the insurance company is only $800. In this case, the insurance company would apply the PR 100 adjustment code to the claim and pay the provider $800 instead of the full $1,000. The provider would then be responsible for writing off the remaining $200, as they have agreed to accept the allowed amount as payment in full.

Another example could be if a patient goes to an out-of-network provider who charges $1,500 for services, but the allowed amount in the insurance company's out-of-network fee schedule is $1,000. In this case, the insurance company would apply the PR 100 adjustment code to the claim and pay the provider $1,000. The provider would then be able to bill the patient for the remaining $500, as they are not obligated to accept the allowed amount as payment in full.

HCFA Claim

HCFA claims, also known as CMS-1500 claims, are a type of standard claim form used by healthcare providers in the United States to bill Medicare and Medicaid programs as well as private insurance companies. HCFA stands for Health Care Financing Administration, which was the agency responsible for managing the Medicare and Medicaid programs until 2001 when it was renamed as the Centers for Medicare & Medicaid Services (CMS).

The HCFA claim form contains standardized fields and codes to help providers accurately bill for their services, including information about the patient, provider, diagnosis, treatment, and charges. The form is used by a wide range of healthcare providers, including physicians, hospitals, clinics, and other healthcare facilities.

The HCFA claim form was first introduced in 1983 and has undergone several revisions since then. The most recent version of the form is the CMS-1500, which was updated in 2014 to accommodate changes in the healthcare industry and to improve the accuracy and efficiency of claims processing.

Submitting HCFA claims is a common practice in US healthcare, and it is important for healthcare providers to accurately complete the form to ensure timely and accurate payment for their services.