
The Evolution of the ANSI ASC X12N 837 format from the UB-92 Flat file format

Bob Davis, January 13, 2004

Introduction

The purpose of this document is to provide background information on the ANSI ASC X12N 837 standard format¹ and to describe similarities and differences between this standard and the UB-92 format.

The goals for this document are:

1. to provide the user with a structural overview of the UB-92 flat file format;
2. to provide the user with a structural overview of the ANSI ASC X12 837 standard; and
3. to discuss the differences (gaps) and congruencies between the two formats.

The document attempts to accomplish these goals using clear and logical language, without excessive technical jargon.

Overall, the ANSI ASC X12 837 format and the UB-92 flat file format are more similar than they are different. Both formats are designed to support data content detailed in the institutional UB-92 Data Specifications document maintained by the National Uniform Billing Committee (NUBC).²

Background

The ANSI ASC X12 837 standard provides the following text describing the purpose of this transaction set.

“This X12 Transaction Set contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This transaction set can be used to submit health care claim billing information, encounter information, or both, from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required or between payers and regulatory agencies to monitor the rendering, billing, and/or payment of health care services within a specific health care/insurance industry segment.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies, and entities providing medical information to meet regulatory requirements. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health

¹ It is not the intent of this document to educate the user on X12-837 transactions. This document must be used in conjunction with published ANSI ASC X12 implementation guides.

² This document is available for a membership fee on the NUBC Web site at www.nubc.org.

maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups. A regulatory agency is an entity responsible, by law or rule, for administering and monitoring a statutory benefits program or a specific health care/insurance industry segment.”³

The Health Care Service Data Reporting Guide (HCSDRG) derives its name from the language above that permits use of the 837 standard for use in reporting health care services. This is the same standard that is used to report institutional claim adjudication information for payment to private and public payers. Separate 837 implementation guides have been developed by the ANSI ASC X12N Task Group 2 Work Group 2 for payment of institutional, professional, and dental health care claims. A fourth implementation guide has been written for the reporting of health care services. It has been given the following name by the ANSI ASC X12N organization: 004050X156.⁴

The existing de facto standard for reporting health services performed in an institutional setting to public and private entities on a mandated and voluntary basis is the UB-92 flat file format.⁵ Though this format has been widely used for this reporting purpose across the country by state and private entities, this standard is a proprietary format maintained by Medicare. Since different states have different reporting requirements, the UB-92 flat file format reserves data elements and record types for individual state assignment. The HIPAA legislation will make the current UB-92 flat file formats maintained by Centers for Medicare and Medicaid Services obsolete once HIPAA transactions and codes are fully implemented. For advocates of standards, the UB-92 flat file format has 3 inherent problems:

1. Changes in the data elements and record types shared with Medicare are subject to the proprietary needs of the Medicare program.
2. Individually defined state data elements and record types promotes a non-standard solution for state data collection systems.
3. After the HIPAA transactions and codes law is implemented, this format will no longer be maintained even for the proprietary Medicare uses.⁶

Format Overview

Both the 837 and the UB-92 formats support the reporting of information referred to here as “what is wrong with the patient, what services did the patient receive, how much does it cost” information. Information in the “what is wrong with the patient” category includes diagnoses and disposition of the patient related to an episode of care. Information in the “what services

³ Scope and Purpose of Health Care Claim Transaction (837) standard.

⁴ This implementation guide is a technical document that can be downloaded from the Washington Publishing Company web site: http://www.wpc-edi.com/HealthCare_40.asp.

⁵ *De facto* standards are those standards that are defined for a specific purpose and then, due to their usefulness, adopted by industries for widespread use. “Tutorial Module 5: Public Health Data Standards.” Web-based Resource Center. Public Health Data Standards Consortium. Available online: <http://phdatastandards.info/knowresources/tutorials/module5.htm>. Accessed on January 13, 2004.

⁶ The Medicare version of this format can be downloaded from the following web site: <http://cms.hhs.gov/providers/edi/edi3.asp>.

did the patient receive” category includes procedures, while information in the “how much does it cost” category includes the charge information related to that same episode of care. Both formats also support the reporting of patient demographics for identifying and statistical purposes. The structure of how each format accomplishes the reporting of this information is different and will be the main topic of discussion for the remaining sections of this paper.

UB-92 Flat File Format Basics

The data content in the UB-92 flat file format is predominately the data defined by the National Uniform Billing Committee in the UB-92 Specifications Document, which is available on the NUBC web site (www.nubc.org). UB-92 flat file is organized by Record Types and data elements within those record types. Each of the record types is a fixed record length of 192 characters of information that is logically arranged by categories of information. It takes several record types to completely report a single episode of care. The record types for a single episode of care are linked together by a patient control number, which is typically the billing number. If the fixed 192 characters of information is not enough to completely report a category of information, the format allows, when appropriate, multiple sequences of those record types for that episode of care. Listed in Exhibit 1 are high level categories included in the UB-92 flat file format. The format rules for a UB-92 formatted submission allow multiple patients to be reported for each provider and it also allows for multiple providers to be reported in the same submission. The indentations are intended to help the reader organize the related record types.

Exhibit 1: UB-92 Format Snapshot

Processor Data	-	Record Type 01
Provider Data	-	Record Type 10
Patient Demographics	-	Record Type 20
Patient Insurance Data	-	Record Type 30 – Sequencing Supported
Patient UB Coded Data	-	Record Type 40 & 41 – Sequencing Supported
Patient Charge Data	-	Record Type 50, 60, & 61 – Sequencing Supported
Patient Medical Data	-	Record Type 70 – Sequencing Supported
Patient Physician Data	-	Record Type 80 – Sequencing Supported
Patient Summary	-	Record Type 90
Provider Summary	-	Record Type 95
Process Summary	-	Record Type 99
Note: The UB-92 format reserves some record types within each category area to be used for local assignment. Listed below are those record types by category.		
Patient Demographics	-	Record Type 25-29
Patient Insurance Data	-	Record Type 35-39
Patient UB Coded Data	-	Record Type 45-49
Patient Charge Data	-	Record Type 55-59 & Record Type 65-69
Patient Medical Data	-	Record Type 79
Patient Physician Data	-	Record Type 85-89

UB-92 Example

Exhibit 2 is an example of a typical UB-92 submission reporting services provided by two providers for a total of 3 patients. In this example Scott Greene and Nancy Best were discharged from Too Good Hospital and Bill Dunnet was discharged from All Right Hospital

Exhibit 2: UB-92 Submission Sample (2 providers, 3 patients)

RT 01 containing Submission information

RT 10 containing identifying information about Too Good Hospital

RT 20 containing demographic information about Scott Greene

RT 30 containing insurance information about Scott Greene

RT 40 containing UB coded information about Scott Greene

RT 41 containing more UB coded information about Scott Greene

RT 50 containing Accommodation Charge information about Scott Greene

RT 60 containing Ancillary Charge information about Scott Greene

RT 70 containing Medical information about Scott Greene

RT 80 containing Physician information about Scott Greene

RT 90 containing Summary information about Scott Greene

RT 20 containing demographic information about Nancy Best

RT 30 containing insurance information about Nancy Best

RT 40 containing UB coded information about Nancy Best

RT 41 containing more UB coded information about Nancy Best

RT 50 containing Accommodation Charge information about Nancy Best

RT 60 containing Ancillary Charge information about Nancy Best

RT 70 containing Medical information about Nancy Best

RT 80 containing Physician information about Nancy Best

RT 90 containing Summary information about Nancy Best

RT 95 containing Summary information about Too Good Hospital

RT 10 containing identifying information about All Right Hospital

RT 20 containing demographic information about Bill Dunnet

RT 30 containing insurance information about Bill Dunnet

RT 40 containing UB coded information about Scott Bill Dunnet

RT 41 containing more UB coded information about Bill Dunnet

RT 50 containing Accommodation Charge information about Dunnet

RT 60 containing Ancillary Charge information about Bill Dunnet

RT 70 containing Medical information about Bill Dunnet

RT 80 containing Physician information about Bill Dunnet

RT 90 containing Summary information about Bill Dunnet

RT 95 containing Summary information about All Right Hospital

RT 99 containing Submission Summary information

ANSI ASC X12 837 Format Basics

The data content in the ANSI ASC X12N 837 format is predominately the data defined by the National Uniform Billing Committee in the UB-92 Specifications Document, which is available on the NUBC web site (www.nubc.org).

The ANSI ASC X12 syntax is organized by loops, segments, and data elements. Loops are made up of segments and segments are made up of data elements. Each data element is variable length with the standard minimum and maximum length. The loops are organized by categories of information. In the 837 format related categories of information are associated by their hierarchy as defined by an HL (hierarchical level) segment. Proper coding of this HL segment allows for information on multiple providers to be reported as well as information for multiple patients for each provider to be reported. The HL segment defines a parent-child relationship. One common situation for use of the HL segment is to define a provider as the parent and each reported patient as the child. This provides the function necessary for a provider to submit multiple claims in a single submission. Related data elements are organized in segments.

Listed in Exhibit 3 are high level categories included in the ANSI ASC X12N 837 format. The format rules for a ANSI ASC X12N 837 formatted submission allow multiple patients to be reported for each provider and it also allows for multiple providers to be reported in the same submission. The indentations are intended to help the reader organize the related record types. The HL segment will show the relationship between that loop and the total submission and the repeats show where multiple reports are permissible. It should be noted that the ANSI ASC X12N 837 format is used for submitting claims to private and public payers as well as for reporting requirements. The subscriber loop (2000B) and the patient loop (2000C) both are reported for an encounter when the patient is DIFFERENT than the person providing the insurance coverage for that episode of care.

Exhibit 3: ANSI ASC X12 Format Snapshots

Header			
Submitter	Loop 1000A		
Receiver	Loop 1000B		
Provider	Loop 2000AHL & Repeat > 1		
Subscriber	Loop 2000B	HL & Repeat > 1	
Patient	Loop 2000C	HL & Repeat > 1	
Claim	Loop 2300	Repeat < 100	
Service Line	Loop 2400	Repeat < 999	
Trailer			

The 837 format supports two segments that can be used to support local data needs. These segments (K3 and NTE) are in the Claim Loop (2300). The narrative in the Health Care Service Data Reporting Guide places parameters on the use of these segments with the understanding that there are situations that require the flexibility to support locally defined data needs.

Exhibit 4 below is an outline representing the hierarchical structure of the X12-837 loops and segments for the ANSI ASC X12N 837 Health Care Service Reporting Guide (004050X156) implementation. The indentations in the outline are intended to represent hierarchical relationships. The numbers in parenthesis in the right hand margin represent permissible repeats of the associated loop.

**Exhibit 4:
837 Loop and Segment Diagram**

HEADER	
ST	Transaction Set Header
BHT	Beginning of Hierarchical Transaction
REF	Transmission Type Identification
LOOP ID	1000A SUBMITTER NAME (1)
NM1	Submitter Name
REF	Submitter Secondary Identification
PER	Submitter EDI Contact Information
LOOP ID	1000B RECEIVER NAME (1)
NM1	Receiver Name
Detail - Provider	
LOOP ID	2000A SERVICE PROVIDER HIERARCHICAL LEVEL (1)
HL	Service Provider Hierarchical Level
LOOP ID	2010AA SERVICE PROVIDER NAME (1)
NM1	Service Provider Name
REF	Service Provider Secondary Identification
Detail - Subscriber	
LOOP ID	2000B SUBSCRIBED HIERARCHICAL LEVEL (>1)
HL	Subscriber Hierarchical Level
SBR	Subscriber Information
PAT	Patient Information
LOOP ID	2010BA SUBSCRIBER NAME (1)
NM1	Subscriber Name
N3	Subscriber Address
N4	Subscriber City/State/Zip Code
DMG	Subscriber Demographic Information
REF	Subscriber Secondary Identification
LOOP ID	2010BC PAYER NAME (1)
NM1	Payer Name
REF	Payer Secondary Identification
Detail - Subscriber	
LOOP ID	2000C PATENT HIERARCHICAL LEVEL (>1)
HL	Patient Hierarchical Level
LOOP ID	2010CA PATIENT NAME (1)
NM1	Patient Name

N3 Patient Address
N4 Patient City/State/Zip Code
DMG Patient Demographic Information
REF Patient Secondary Identification

Claim

LOOP ID 2300 CLAIM INFORMATION (100)

CLM Claim Information
DTP Statement Dates
DTP Discharge Hour
DTP Admission Date / Hour
CL1 Claim Codes
PWK Claim Supplemental Information
AMT Payer Estimated Amount Due
AMT Patient Estimated Amount Due
REF Medical Record Number
REF Mother's Medical Record Number
K3 File Information
NTE Claim Note
HI Principal Dx, Admitting Dx, and E-code
HI Diagnosis Related Group (DRG) Information
HI Other Diagnosis Information
HI Principal Procedure Information
HI Other Procedure Information
HI Occurrence Span Code Information
HI Occurrence Code Information
HI Value Code Information
HI Condition Code Information
QTY Claim Quantity

LOOP ID 2310A ATTENDING PHYSICIAN NAME (1)

NM1 Attending Physician Name
REF Attending Physician Secondary Information

LOOP ID 2310B OPERATING PHYSICIAN NAME (1)

NM1 Operating Physician Name
REF Operating Physician Secondary Information

LOOP ID 2310C OTHER PHYSICIAN NAME (1)

NM1 Other Physician Name
REF Other Physician Secondary Information

LOOP ID 2310D REFERRING PHYSICIAN NAME (1)

NM1 Referring Physician Name
REF Referring Physician Secondary Information

LOOP ID 2320 OTHER SUBSCRIBER INFO (10)

SBR Other Subscriber Information
AMT Payer Prior Payment

LOOP ID 2330A OTHER SUBSCRIBER NAME (1)

NM1 Other Subscriber Name

REF	Other Subscriber Secondary Information
LOOP ID	2330B OTHER PAYER NAME (1)
NM1	Other Payer Name
REF	Other Payer Secondary Information
LOOP ID	2330C OTHER PAYER PATIENT INFO (1)
NM1	Other Payer Patient Information
REF	Other Payer Patient Identification Number
LOOP ID	2400 SERVICE LINE NUMBER (1)
LX	Service Line Number
SV2	Institutional Service Line Information
DTP	Service Line Date
TRAILER	
SE	Transaction Set Trailer

ANSI ASC X12N 837 Example

Exhibit 5 is an example using the ANSI ASC X12 837 for reporting services provided to two providers for a total of 3 patients. In this example Scott Greene and Nancy Best were discharged from Too Good Hospital and Bill Dunnet was discharged from All Right Hospital. In the example below the patient is always the same as the person providing for insurance coverage for these episodes of care.

Exhibit 5: ANSI ASC X12 837 Sample (2 providers, 3 patients)

Header
ST*837*987654~
BHT*0019*00*A12345*20010801*1800~
Loop 1000A - Submitter Name
NM1*41*2*TOO GOOD HOSPITAL*****46*999008888~
Loop 1000B - Receiver Name
NM1*40*2*MY STATE DATA AGENCY*****46*12000~
Loop 2000A - Service Provider Hierarchical Level for Too Good Hospital
HL*1**20*1~
Loop 2010AA - Service Provider Name for Too Good Hospital
NM1*85*2*TOO GOOD HOSPITAL*****24*999008888~
REF*1J*898989~
Loop 2000B - Subscriber (Patient) Hierarchical Level for Scott Greene
HL*2*1*22*1~
SBR*P*****BL~
Loop 2010BA - Subscriber (Patient) Name for Scott Greene
NM1*IL*1*GREENE*SCOTT*A**MI*GRNESSC1234~
N3*1313 MOCKINGBIRD LANE~
N4*ANYTOWN*NY*09090~
DMG*D8*19760706*M*::RET:3::RET:2~
REF*SY*130281234~
Loop 2010BC - Payer Name

NM1*PR*2*EMPIRE BLUE CROSS*****PI*00303~

Loop 2300- Claim Information for Scott Greene

CLM*ABH123456*5015***11:A:1~

DTP*096*TM*1200~

DTP*434*RD8*20010610-20010611~

DTP*435*DT*200106100900~

CL1*2*1*01~

REF*EA*ABHMEDRECMOM~

NTE*UPI*STATE SPECIFIC REQUIREMENTS~

HI*BK:66411*BJ:66411~

HI*BF:66331:::Y*BF:66111:::N*BF:V270:::N~

HI*BR:7569:D8:20010610~

HI*BQ:7309:D8:20010610~

Loop 2310A - Attending Physician Name for Scott Greene

NM1*71*1*DOCTOR*JOE****XX*F88888~

REF*1G*JDUPIN~

REF*0B*JDSTAATE~

Loop 2310B - Operating Physician Name for Scott Greene

NM1*72*1*SURGEON*REALGOOD****XX*F99999~

REF*0B*RSUPIN~

REF*1G*RSSTA

Loop 2320 - Other Subscriber Information for Scott Greene

SBR*S*****CI~

Loop 2330A - Other Subscriber Name for Scott Greene

NM1*IL*1*Greene*Beth*P~

Loop 2400 - Service Line Number for Scott Greene

LX*1~

SV2*001**5015-

LX*2~

SV2*122**2754*DA*2*1377~

LX*3~

SV2*258**15~

LX*4~

SV2*259**68~

LX*5~

SV2*279**59~

LX*6~

SV2*305**38~

LX*7~

SV2*309**39~

LX*8~

SV2*729**2034~

LX*9~

SV2*999**8~

Loop 2000B - Subscriber (Patient) Hierarchical Level for Nancy Best

HL*3*1*22*0~

PAT*****Y~

Loop 2010BA - Subscriber (Patient) Name for Nancy Best

NM1*QC*1*BEST*NANCY*E**MI*BESTNA9999~

N3*1313 MOCKINGBIRD LANE~

N4*ANYTOWN*NJ*0*09090~

DMG*D8*20010610*F*::RET:3::RET:2~

REF*SY*99999999~

Loop 2300- Claim Information for Nancy Best

CLM*ABH1234567*2343***11:A:1~

DTP*096*TM*1600~

DTP*434*RD8*20010610-20010611~

DTP*435*DT*200106100900~

CL1*4*1*01~

REF*EA*ABHMEDRECKID~

REF*MRN*ABHMEDRECMOM~

NTE*UPI*STATE SPECIFIC REQUIREMENTS~

HI*BK:V3000*BJ:V3000~

HI*BF:7625:.....N*BF:V053:.....N~

HI*BR:9604:D8:20010610~

HI*BQ:9955:D8:20010610~

HI*BE:54:::3610~

Loop 2310A - Attending Physician Name for Nancy Best

NM1*71*1*DOCTOR*JOE****XX*F88888~

REF*1G*JDUPIN~

REF*0B*JDSTAATE~

Loop 2310B - Operating Physician Name for Nancy Best

NM1*72*1*SURGEON*REALGOOD****XX*F99999~

REF*0B*RSUPIN~

REF*1G*RSSTATE~

Loop 2320 - Other Subscriber Information for Nancy Best

SBR*S*****CI~

Loop 2330A - Other Subscriber Name for Nancy Best

NM1*IL*1*SAMPLE*TIMOTHY*O~

Loop 2400 - Service Line Number for Nancy Best

LX*1~

SV2*001**2343~

LX*2~

SV2*171**2232*DA*2*1116~

LX*3~

SV2*279**37~

LX*4~

SV2*309**63~

LX*5~

SV2*729**11~

Loop 2000A - Service Provider Hierarchical Level for All Right Hospital

HL*4**20*1~

Loop 2010AA - Service Provider Name for All Right Hospital

NM1*85*2*ALL RIGHT HOSPITAL*****24*999008888~

REF*1J*898989~

Loop 2000B - Subscriber (Patient) Hierarchical Level for Bill Dunnet

HL*5*4*22*1~

SBR*P*****BL~

Loop 2010BA - Subscriber Name (Patient) for Bill Dunnet

NM1*IL*1*DUNNET*BILL*A**MI*DUETBI1234~

N3*1313 MOCKINGBIRD LANE~

N4*ANYTOWN*NY*09090~

DMG*D8*19760706*M*.:RET:3::RET:2~

REF*SY*130281234~

Loop 2010BC - Payer Name

NM1*PR*2*EMPIRE BLUE CROSS*****PI*00303~

Loop 2300- Claim Information for Bill Dunnet

CLM*ABH123456*5015***11:A:1~

DTP*096*TM*1200~

DTP*434*RD8*20010610-20010611~

DTP*435*DT*200106100900~

CL1*2*1*01~

REF*EA*ABHMEDRECMOM~

NTE*UPI*STATE SPECIFIC REQUIREMENTS~

HI*BK:66411*BJ:66411~

HI*BF:66331::::::Y*BF:66111::::::N*BF:V270::::::N~

HI*BR:7569:D8:20010610~

HI*BQ:7309:D8:20010610~

Loop 2310A - Attending Physician Name for Bill Dunnet

NM1*71*1*DOCTOR*JOE****XX*F88888~

REF*1G*JDUPIN~

REF*0B*JDSTAATE~

Loop 2310B - Operating Physician Name for Bill Dunnet

NM1*72*1*SURGEON*REALGOOD****XX*F99999~

REF*0B*RSUPIN~

REF*1G*RSSTA

Loop 2320 - Other Subscriber Information for Bill Dunnet

SBR*S*****CI~

Loop 2330A - Other Subscriber Name for Bill Dunnet

NM1*IL*1*Dunnet*Sue*O~

Loop 2400 - Service Line Number for Bill Dunnet

LX*1~

SV2*001**5015-

LX*2~

SV2*122**2754*DA*2*1377~

LX*3~

SV2*258**15~

LX*4~

SV2*259**68~

LX*5~

SV2*279**59~

LX*6~

SV2*305**38~

LX*7~

SV2*309**39~

LX*8~

SV2*729**2034~

LX*9~

SV2*999**8~

TRAILER

SE*91*987654~

The table below identifies where the basic data categories are reported in the ANSI ASC X12N 837 and UB-92 formats. It should be noted that all categories are reported in both formats.

**Exhibit 6:
ANSI ASC X12 837 and UB Format Category Crosswalk**

<i>Category</i>	<i>ANSI ASC X12N 837</i>	<i>UB-92</i>
Submitter/Receiver	Header & 1000A	RT 01
Provider	2000A	RT 10
Subscriber/Insured	2000B	RT 30
Patient Demographics	2010BA or 2000C	RT 20
Patient UB Coded Data	2300	RT 40 & 41
Patient Medical	2300	RT 70
Patient Charges	2400	RT 50 & 60
Patient Physician	2310 A, B, C	RT 80

UB-92 Format and ANSI ASC X12 Similarities and Differences

There are two primary similarities between the UB-92 format and ANSI ASC X12 format: (1) both are used as transmission vehicles for the same institutional services UB data content; (2) both formats organize the data into similar categories. The syntax and organization of each of the formats is the source of most of the differences, which are summarized in exhibit 7. The ANSI ASC X12 formats, including the 837, have been named as a HIPAA standard. As a HIPAA standard, the 837 is now subject to a national consensus approval and maintenance process. The UB-92 flat file format is a proprietary format maintained by Medicare and adopted by many for reporting health encounters all over the country. Exhibit 7 below summarizes format differences.

**Exhibit 7:
Format Gap Matrix**

<i>Gap Description</i>	<i>ANSI ASC X12 837</i>	<i>UB-92</i>
Category Organization	Logical order as defined in hierarchical loops and in data segments	Physical order as defined by record types
Category Linkage	Records linked by the HL segments and associated information about patient (note order is not significant)	Records linked by repeating patient identifier in each related record type associated with patient specific information (note order is critical)
Format Organization	Loop requirements dependent on situational use	Record Types required based on strict syntax rules
Data Element Format	Variable length with minimum and maximum lengths defined along with a finite list of data types (i.e., numeric, date/time, character)	Fixed length with numeric or alpha-numeric field definitions
Format Maintenance	ANSI ASC X12N consensus process	Medicare internal process
Transmission Medium	Designed as a vehicle for electronic (i.e., machine to machine without human intervention) data transmission	Designed as a vehicle for magnetic (i.e., tape, cartridge, diskette) data transmission

Summary

Discussion of the UB-92 flat file and the ANSI ASC X12N 837 is not a tale of competing formats, rather it is an evolutionary story. Neither format has ever been more than the prologue to a much more robust story. Both formats are designed as vehicles to simply transmit UB data content. Neither format is designed as an application system file structure. It is those application systems that can provide the ways and the means to use the data to improve the quality of health care, not the submission formats alone. The consensus process that is driving the development of the HIPAA final rules has provided the magnifying glass on the data and in so doing the ANSI ASC X12N 837 format is evolving to better meet the needs of a larger cross section of our health delivery system. Data that are used widely are data that are highly valued.

Through better understanding of the transmission vehicles, we hope to promote greater standardization in our core health delivery systems. Through greater understanding we hope to de-mystify some of the technical wrappings of these core data. Through our technology and a growing realization about the necessity of collaboration, the goal of improved data quality needed to make the important health treatment and policy decisions in our complex modern world is more achievable today than ever before.