IRS/SSA/CMS Data Match Guide on Instructions from CMS

Data Match is a program coordinated by the Internal Revenue Service (IRS), Centers for Medicare & Medicaid Services (CMS), and the Social Security Administration (SSA) to identify Medicare beneficiaries who received Medicare benefits with Medicare as the primary payer when Medicare should have been the secondary payer. Employers are required to complete the Data Match report within 30 days of receipt of the Data Match Personal Identification Number (PIN), unless an extension has been requested and approved.

The letter directs employers to the Data Match Secure Website, where the questionnaire can be accessed after entering the employer identification number and PIN.

Submission Options

Two submission options are available on the Secure Web site for Data Match questionnaire responses: Direct Entry and Electronic Media Questionnaire (EMQ).

Direct Entry is an option designed for employers with less than 50 workers. This option allows an employer to complete all Data Match questionnaires directly online without downloading or uploading any files. The information is validated for accuracy and completeness as it is entered directly online.

The EMQ program is designed to assist larger employers with at least 50 workers. Employers will download a file of the workers on the Secure Web site and then they will upload the data upon completion of the questionnaire.

Alternative to Data Match

The Employer Voluntary Data Sharing Agreement is an alternative way to satisfy the data match requirement. Under this agreement, an employer shares group health plan coverage information with CMS. In exchange, CMS agrees to provide the employer with Medicare eligibility information for identified Medicare individuals.

Questionnaire

The Data Match questionnaire has four parts. Please see the diagrams below for further instructions on completing each part.

Questionnaire Part I

Question 1a – Did you offer a health plan to any employee at any time since [pre-printed date]? (full or part-time)

No   **Yes**   **Yes**

Question 1b – Did your organization make contributions on behalf of any employee who was covered under a collectively bargained Health and Welfare Fund (e.g., a union plan) since [pre-printed date]?

No   **No**   **Yes**

You DO NOT have to answer any other questions in Part I. **Proceed to Part IV**

Question 2 – In the following years, did you have 20 or more employees for 20 or more calendar weeks (this includes full time, part-time, intermittent and/or seasonal employees)?

No   **Yes**   **Yes**

Question 3 – In the following years, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 20 or more employees for 20 or ore calendar weeks (this includes full time, part-time, intermittent and/or seasonal employees)?

No   **No**   **Yes**

You DO NOT have to answer questions 4 and 5. **Proceed to Part IV**

Question 4 – In the following years, did you have 100 or more employees during 50% of your business days full or part-time?

No   **Yes**

Question 5 – In the following years, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 100 or more employees during 50% of their business days (this includes full time, part-time, intermittent and/or seasonal employees)?

No   **Yes**

Proceed to Part II

Questionnaire Part II

Complete this section only if you answered YES to any year listed in Part I, Questions 2 through 5, and you have offered a group health plan (GHP) to any worker identified in Part III.

You must include all GHPs under which a worker identified in Part III has or has had coverage during the time period identified for that worker.

STEP 1

Determine Worker Employment Status in order to establish those workers that should be included in the search.

STEP 2

Compile Listing of Group Health Plans

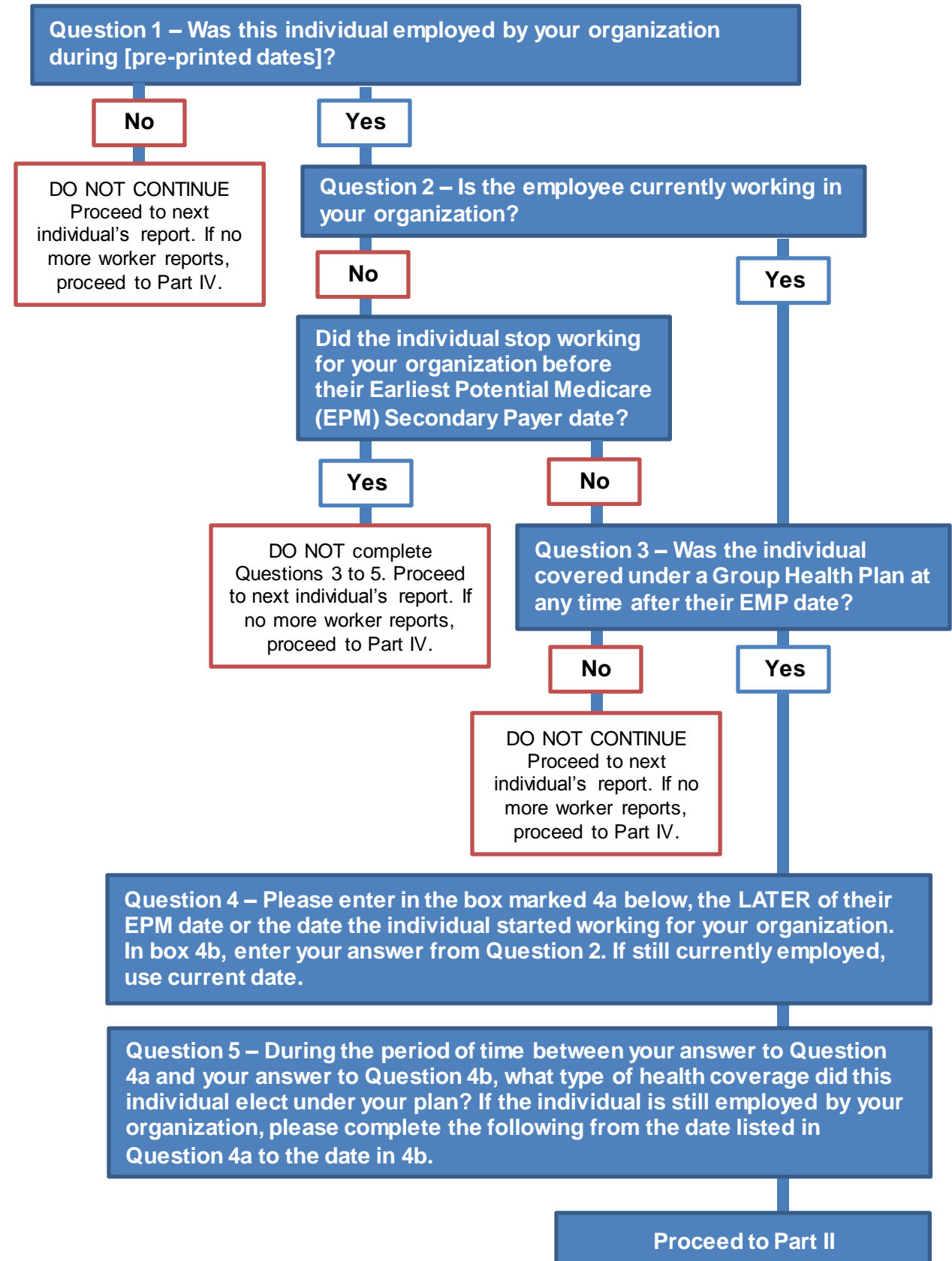You must provide the following for each GHP listed:

- Complete GHP Name
- GHP Address (street name/number, city, state, and ZIP Code)
- Group Identification Number or Code
- GHP Taxpayer Identification Number (TIN)
- Insurer/Third Party Administrator (TPA) Tax identification number
- Pharmacy Benefit International Identification Number (Rx BIN)
- Pharmacy Benefit Processor Control Number (Rx PCN)
- Rx Group Policy Number
- Only 1 GHP type

For EMQ Submitters only:

- Each GHP identified must be given a single and unique report number, which cannot be used again in this section of the report.
- For each GHP Report Number, identify the type of plan (by a letter from the table below) that best describes the GHP arrangement provided by your organization.
    - A   Insurance (Medical and Hospital)
    - J   Hospitalization only plan – A plan which covers ONLY inpatient hospital services
    - K   Medical Services only plan – A plan which covers ONLY non-inpatient medical services
    - U   Prescription Drug Only (in network)
    - V   Prescription Drug with Major Medical (non-network)
    - W   Comprehensive (Hospital, Medical, and Drug [in-network])
    - X   Hospital and Drug (in network)
    - Y   Medical and Drug (in network)
    - 4   Comprehensive (Hospital, Medical, and Drug [non-network])
    - 5   Hospital and Drug (non-network)
    - 6   Medical and Drug (non- network)

Questionnaire Part III

Question 1 – Was this individual employed by your organization during [pre-printed dates]?

No

DO NOT CONTINUE
Proceed to next individual's report. If no more worker reports, proceed to Part IV.

Yes

Question 2 – Is the employee currently working in your organization?

No

Yes

Did the individual stop working for your organization before their Earliest Potential Medicare (EPM) Secondary Payer date?

Yes

No

DO NOT complete Questions 3 to 5. Proceed to next individual's report. If no more worker reports, proceed to Part IV.

Question 3 – Was the individual covered under a Group Health Plan at any time after their EMP date?

No

Yes

DO NOT CONTINUE
Proceed to next individual's report. If no more worker reports, proceed to Part IV.

Question 4 – Please enter in the box marked 4a below, the LATER of their EPM date or the date the individual started working for your organization. In box 4b, enter your answer from Question 2. If still currently employed, use current date.

Question 5 – During the period of time between your answer to Question 4a and your answer to Question 4b, what type of health coverage did this individual elect under your plan? If the individual is still employed by your organization, please complete the following from the date listed in Question 4a to the date in 4b.

Proceed to Part II

Questionnaire Part IV

Employers must verify that the information provided is complete and correct to the best of their knowledge. The name and title of the individual who is certifying the document must be indicated.

Further Research

[CMS Instructions for Completing the Group Health Plan Report for the IRS/SSA/CMS Data Match](#)

[IRS/SSA/CMS Data Match Project XVII - Electronic Media Questionnaire Specifications for Employers](#)