AUTO INSURANCE UTILIZATION REVIEW
SUPPLEMENTAL IPPS CALCULATION FORM

Submit this form to:
DIFS-URAppeals@michigan.gov

This form is REQUIRED as part of an appeal involving reimbursement made pursuant to the Medicare Inpatient Prospective Payment System. Please complete the form in its entirety.

I. PROVIDER/INSURER INFORMATION

Provider/Insurer Name:
Provider/Insurer Point of Contact (First and Last Name):
Email Address:
NPI:
Assigned Utilization Review Case Number:
Name of IPPS Software/Grouper Used to Calculate Expected Reimbursement:

II. DETAILED CALCULATION OF EXPECTED PAYMENT (PROVIDER) OR ACTUAL REIMBURSEMENT (INSURER)

Please complete each field below. Please note that any factors or payments not listed below are excluded from calculation of a provider's reimbursement under the IPPS, pursuant to MCL 500.3157. Excluded items are payments or adjustments for: readmission, value based purchasing, HAC, bad debts, and sequestration.

DRG		
	DRG Relative Weight	
CAPITAL AMOUNTS		
	Standard Federal Rate	
	Geographic Adjustment Factor	
	Adjusted Rate	
	MS-DRG Weight	
	Capital Federal Specific Portion	
	Capital Disproportionate Share Hospital Factor	
	Capital Disproportionate Share Hospital Payment	
	Capital Indirect Medical Education Factor	
	Capital Indirect Medical Education Payment	

OPERATING AMOUNTS		
	Labor-Related Share	
	Area Wage Index	
	Wage Adjusted Labor Share	
	Non-Labor Share	
	Standard Operating Rate	
	MS-DRG Weight	
	Operating Federal Specific Portion	
	Operating Disproportionate Share Hospital Factor	
	Operating Disproportionate Share Hospital Payment	
	Operating Indirect Medical Education Factor	
	Operating Indirect Medical Education Payment	
	Uncompensated Care	
	Total Operating Payment with DSH/IME/UCC	
	Outlier Payment	
	New Technology Add-On Payment	
	Total Capital, Operating, Outlier & New Technology Payment	
PASS-THROUGH ADJUSTMENTS		
	Graduate Medical Education Pass-Through Adjustment	
	Nursing and Allied Health Pass-Through Adjustment	
	Ancillary Pass-Through Adjustment	
	Total Pass-Through Payments	
OTHER (please describe)		

III. CERTIFICATION AND ACKNOWLEDGEMENTS

By signing this form, I understand and acknowledge that I will respond to the Michigan Department of Insurance and Financial Services' inquiries regarding this appeal, and I certify that the information included on this form is correct and complete to the best of my knowledge and belief. I also understand and acknowledge that submitting false or misleading information is cause for rejection of the appeal and may subject me and/or the provider to penalties as provided by law.

Authorized Signature:	Date:
Printed Name / Title:	Email Address: