MEMORIAL THORACIC & PULMONARY CENTER
Center for Advanced Thoracic Surgery
500 Medical Plaza Drive, Suite 400 • Chicago, IL 60611
Tel: (312) 555-7800 • Fax: (312) 555-7801

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PRIOR AUTHORIZATION REQUEST

Administrative & Demographic Information

REQUEST SUMMARY

This prior authorization request is submitted for post-service review of emergency surgical services provided to Mr. Robert J. Thompson on January 15, 2026. The patient presented to the Emergency Department with acute respiratory distress secondary to foreign body aspiration (dental crown). Emergency bronchoscopy was performed with subsequent conversion to open thoracotomy for foreign body removal. The patient was stabilized and admitted to the Surgical Intensive Care Unit.

Total charges submitted: $12,550.00 • Primary CPT: 32100 (Thoracotomy) • Global Period: 090 days

SECTION A: PATIENT IDENTIFICATION

Patient Last Name	THOMPSON	**First Name**	ROBERT
Middle Initial	J	**Suffix**	
Date of Birth	08/22/1963	**Age**	62 years
Sex	☑ Male ☐ Female ☐ Other		
Social Security Number	XXX-XX-4521 (last 4 digits)		
Patient Address	1847 Lake Shore Drive, Unit 12A		
City	Chicago	**State**	IL
ZIP Code	60614	**County**	Cook
Home Phone	(312) 555-4421	**Mobile Phone**	(312) 555-4422
Email Address	rthompson1963@email.com		
Emergency Contact	Linda Thompson (Spouse) - (312) 555-4423		

SECTION B: INSURANCE / PAYER INFORMATION

Primary Insurance Carrier	BlueCross BlueShield of Illinois		
Plan Name	PPO Corporate Select		
Member ID	BCB-998877665	**Group Number**	GRP-CORP-2250
Policy Holder Name	Robert J. Thompson	**Relationship**	Self
Policy Effective Date	01/01/2024	**Policy Term Date**	12/31/2026
Plan Type	☑ Commercial PPO ☐ Commercial HMO ☐ Medicare ☐ Medicare Advantage ☐ Medicaid ☐ Other		
Payer Address	P.O. Box 805107, Chicago, IL 60680-5107		
Payer Phone	(800) 538-8833	**Payer Fax**	(312) 938-4500
Prior Auth Phone/Portal	(800) 635-4580 / provider.bcbsil.com		

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SECTION C: ENCOUNTER INFORMATION

Date of Service	01/15/2026	**Admission Date**	01/15/2026
Admission Time	18:47	**Discharge Date**	01/19/2026
Type of Service	☑ Elective ☐ Urgent ☐ Emergent		
Place of Service	☑ Office (11) ☐ Outpatient Hospital (22) ☐ ASC (24) ☐ Inpatient Hospital (21) ☐ Emergency Room (23)		
Admission Source	Emergency Department - Direct Admit to OR		
Patient Status at DC	☑ Discharged Home ☐ Transferred ☐ Expired ☐ Still Inpatient		

SECTION D: REQUESTING / RENDERING PROVIDER

Provider Name	James R. Ahmad, MD, FACS, FCCP		
Credentials	Board Certified: Thoracic Surgery, General Surgery		
NPI (Individual)	1122334455	**State License #**	036-085421 (IL)
Practice Name	Chicago Thoracic Surgery Associates, LLC		
Practice NPI	1987654321	**Tax ID (TIN)**	36-7788990
Practice Address	500 Medical Plaza Drive, Suite 420, Chicago, IL 60611		
Phone	(312) 555-7850	**Fax**	(312) 555-7851
Contact Person	Maria Santos, Billing Coordinator - msantos@chicagothoracic.com		

SECTION E: FACILITY / SERVICE LOCATION

Facility Name	Memorial Thoracic & Pulmonary Center		
Facility Type	☑ Acute Care Hospital ☐ Specialty Hospital ☐ ASC ☐ Clinic		
Facility NPI	9988776655	**Medicare Provider #**	14-0234
Facility Address	500 Medical Plaza Drive, Chicago, IL 60611		
OR/Procedure Room	OR Suite 4	**ICU Unit**	SICU Bed 12

SECTION F: REQUEST TYPE & TRACKING

Request Type	☐ Pre-Service Authorization ☐ Concurrent Review ☑ Post-Service Review ☐ Appeal		
Reason for Post-Service	Emergency/Urgent services rendered - prior authorization not feasible		
Claim Number	CLM-2026-01-887456	**Date Submitted**	01/22/2026
Prior Auth # (if any)	N/A - Emergency	**Retro Auth Requested**	☑ Yes

SECTION G: PROCEDURE & BILLING SUMMARY

⚠ **CRITICAL BILLING INFORMATION FOR RULE EVALUATION**

All procedures performed by SAME PROVIDER (NPI: 1122334455) on SAME DATE (01/15/2026) under EMERGENT conditions

CPT	Description	Modifier	Global	Billed	Status
99223	Hospital E&M, high complexity	57	N/A	$285.00	Decision for Surgery
32100	Thoracotomy with exploration	None	090	$8,450.00	Primary Procedure
31500	Emergency intubation	None	000	$485.00	Emergency - documented
31622	Diagnostic bronchoscopy	None	000	$625.00	Findings → open surgery
31635	Surgical bronchoscopy, FB removal	None	000	$1,285.00	Converted to open
32551	Tube thoracostomy	59	010	$520.00	Contralateral (LEFT)
31231	Nasal endoscopy, diagnostic	None	000	$285.00	Access evaluation
30901	Control nasal hemorrhage	None	000	$175.00	Intraoperative
92502	Otolaryngologic exam under GA	None	XXX	$195.00	
30801	Ablation, inferior turbinates	None	010	$245.00	

Modifier Legend: 57 = Decision for Surgery | 59 = Distinct Procedural Service | 25 = Significant, Separately Identifiable E&M | 24 = Unrelated E&M During Postop Period

SECTION H: ATTESTATION & SIGNATURE

I certify that the information provided in this authorization request is true and accurate to the best of my knowledge. I understand that any falsification of information may result in denial of claims and potential legal consequences. I attest that the services described were medically necessary and were provided in accordance with accepted standards of care.

Provider Signature: *[Electronically Signed] James R. Ahmad, MD, FACS*
Date Signed: January 22, 2026 at 2:15 PM CST

Submitted by: Maria Santos, Billing Coordinator

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PATIENT MEDICAL HISTORY

Clinical Intake Documentation

Patient Name	THOMPSON, ROBERT J.	**DOB**	08/22/1963 (Age 62)
MRN	2026-TPC-88456	**Encounter Date**	01/15/2026
Member ID	BCB-998877665	**Attending Physician**	James R. Ahmad, MD

CHRONIC CONDITIONS & COMORBIDITIES

Condition	COPD, moderate (GOLD Stage II)	**ICD-10**	J44.1
Clinical Notes	Diagnosed 2018. Stable on Symbicort maintenance. FEV1 65% predicted.		
Condition	Essential Hypertension	**ICD-10**	I10
Clinical Notes	Diagnosed 2012. Well-controlled on Lisinopril 20mg daily. Most recent BP 128/78.		
Condition	Hyperlipidemia	**ICD-10**	E78.5
Clinical Notes	Diagnosed 2015. Controlled on Atorvastatin 40mg. LDL 92 mg/dL.		
Condition	Type 2 Diabetes Mellitus	**ICD-10**	E11.9
Clinical Notes	Diagnosed 2019. Well-controlled on Metformin 1000mg BID. HbA1c 7.1%.		
Condition	LEFT Pleural Effusion (chronic, small)	**ICD-10**	J90
Clinical Notes	PRE-EXISTING small LEFT-sided pleural effusion, first identified on CT 09/2023. Followed conservatively. Most recent imaging (12/2025) shows stable small effusion, LEFT hemithorax. This is CONTRALATERAL to the current right-sided pathology.		
Condition	Seborrheic Keratosis (back)	**ICD-10**	L82.1
Clinical Notes	Multiple lesions noted on back. One lesion showing recent changes - scheduled for removal.		
Bleeding History	NO BLEEDING DISORDERS	**Coagulation**	Normal
Clinical Notes	No history of bleeding disorders, coagulopathy, or anticoagulant use. PT/INR and PTT within normal limits. Any intraoperative bleeding would be incidental to procedure, not due to underlying condition.		

PRIOR SURGICAL / PROCEDURAL HISTORY

Respiratory / Thoracic Procedures

Procedure	Diagnostic Bronchoscopy	**Date**	03/2022
CPT Code	31622	**Facility**	Northwestern Memorial
Indication / Findings	Evaluation of chronic cough. Findings: Mild chronic bronchitis, no malignancy.		
Procedure	Diagnostic Thoracoscopy	**Date**	09/2023
CPT Code	32601	**Facility**	Rush University Medical Center
Laterality	LEFT thorax	**Operative Report**	Available
Indication / Findings	Left pleural effusion evaluation. THE FINDINGS OF THE DIAGNOSTIC THORACOSCOPY LED DIRECTLY TO THE DECISION TO PERFORM chest tube placement for drainage. Findings: Benign reactive pleuritis, 400mL serous fluid		

	drained.		
Minor Procedures (Same-Day)			
Procedure	Skin Lesion Biopsy	**Date**	11/05/2025
CPT Code	11102	**Global Period**	000 days
E&M Same Day	99213 with Modifier 25	**Indication**	Suspicious seborrheic keratosis
Documentation	SIGNIFICANT AND SEPARATELY IDENTIFIABLE E&M service performed for UNRELATED hypertension medication management during same visit. Blood pressure was 158/95, requiring adjustment of Lisinopril dosage from 20mg to 40mg. This E&M service was UNRELATED to the decision to perform the skin biopsy.		
Other Surgical History			
Procedure	Laparoscopic Cholecystectomy	**Date**	2017
Procedure	Appendectomy	**Date**	1998

CURRENT MEDICATIONS

Medication	Symbicort 160/4.5 mcg	**Dose/Frequency**	2 puffs BID
Medication	Lisinopril 40mg	**Dose/Frequency**	Once daily (increased 11/2025)
Medication	Atorvastatin 40mg	**Dose/Frequency**	Once daily at bedtime
Medication	Metformin 1000mg	**Dose/Frequency**	Twice daily with meals
Medication	Albuterol HFA inhaler	**Dose/Frequency**	2 puffs PRN
Medication	Aspirin 81mg	**Dose/Frequency**	Once daily

ALLERGIES & ADVERSE REACTIONS

Allergen	Codeine	**Reaction**	Nausea, vomiting
Allergen	Latex	**Reaction**	Contact dermatitis
Anesthesia History	No prior adverse reactions to general anesthesia		

HISTORY OF PRESENT ILLNESS

Mr. Thompson is a 62-year-old male with a history of moderate COPD who presented to the Emergency Department on January 15, 2026 at approximately 18:30 with acute onset of severe respiratory distress.

Per the patient and his wife, he was eating dinner at home when he suddenly began choking. The patient had recently had dental work and reports that a dental crown became dislodged and was aspirated during the meal. He immediately experienced severe coughing, gagging, and progressive difficulty breathing.

En route, the patient's respiratory status continued to deteriorate. On arrival to the ED, the patient was in moderate to severe respiratory distress with audible stridor and accessory muscle use.

Onset	Acute - during meal, ~18:00	**Duration**	~45 minutes prior to ED arrival
Severity on Arrival	Severe (SpO2 88% on RA)	**Progression**	Rapidly deteriorating

INITIAL PHYSICAL EXAMINATION

Vital Signs on ED Arrival (18:47)

Blood Pressure	158/92 mmHg	**Heart Rate**	112 bpm
Respiratory Rate	28/min	**SpO2**	88% on room air
Temperature	98.6°F (37.0°C)	**SpO2 on O2**	92% on 4L NC

General Assessment

General	Alert, anxious male in moderate respiratory distress. Sitting upright, tripoding.
HEENT	Audible stridor. Oropharynx clear, no visible foreign body. Trachea midline.
Respiratory	Tachypneic with accessory muscle use. Decreased breath sounds over right lower lung field.
Cardiovascular	Tachycardic, regular rhythm. No murmurs.

DIAGNOSTIC STUDIES

Imaging

Study	Chest X-Ray (portable AP)	**Date/Time**	01/15/2026 18:55
Findings	Radiopaque foreign body in right bronchus intermedius. Right lower lobe atelectasis. Small LEFT pleural effusion (known, stable).		
Study	CT Chest (non-contrast)	**Date/Time**	01/15/2026 19:10
Findings	12mm metallic foreign body in right bronchus intermedius. Distal RLL atelectasis. Left pleural effusion, stable from prior imaging.		

Laboratory (01/15/2026)

WBC	11.2 K/uL	**Hemoglobin**	14.8 g/dL
Platelets	245 K/uL	**BMP**	Within normal limits
ABG (on 4L NC)	pH 7.38, pCO2 42, pO2 68	**Lactate**	1.8 mmol/L

POSTOPERATIVE FOLLOW-UP VISIT

Visit Date	01/29/2026	**Visit Type**	Post-surgical follow-up
CPT Code	99213	**Modifier**	24 (Unrelated E&M in postop period)
Days Post-Op	14 days	**Global Period**	Within 090-day global
Chief Complaint	Routine postop follow-up AND unrelated dermatology concern		

UNRELATED E&M SERVICE DOCUMENTATION (Modifier 24)

During this postoperative visit, patient requested evaluation of a new skin lesion on his left forearm that appeared 1 week ago. This is UNRELATED to the thoracotomy surgical diagnosis (foreign body aspiration). Examination revealed a 6mm papule suspicious for basal cell carcinoma. Patient referred to dermatology for biopsy. This E&M service for the UNRELATED dermatologic condition is separately reportable with Modifier 24 as it is NOT related to recovery from the surgical procedure and NOT related to a complication of surgery.

Surgical Site Status	Incision healing well, no signs of infection, staples removed
Respiratory Status	Breathing comfortably on room air, SpO2 97%

DIAGNOSIS SUMMARY			
Primary Diagnosis	Foreign body in bronchus	**ICD-10**	T17.508A
Secondary Diagnosis	Acute respiratory failure	**ICD-10**	J96.00
Additional Diagnosis	COPD with acute exacerbation	**ICD-10**	J44.1
Additional Diagnosis	Left pleural effusion (chronic)	**ICD-10**	J90
Foreign Body	Dental crown, porcelain-fused-to-metal, ~12mm diameter		
Location	Right bronchus intermedius → Right lower lobe bronchus		

DOCUMENTATION COMPLETED

History obtained by: Sarah Chen, RN • 01/15/2026 18:52
Reviewed by: James R. Ahmad, MD, FACS • 01/15/2026 19:05
Postop note by: James R. Ahmad, MD, FACS • 01/29/2026 10:30

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Department of Thoracic Surgery • 500 Medical Plaza Drive • Chicago, IL 60611

OPERATIVE REPORT

Dictated Report - Emergency Thoracic Surgery

Patient: THOMPSON, ROBERT J. **DOB:** 08/22/1963 **MRN:** 2026-TPC-88456 **DOS:** 01/15/2026

PREOPERATIVE DIAGNOSES	POSTOPERATIVE DIAGNOSES
1. Foreign body in bronchus (T17.508A) 2. Acute respiratory failure (J96.00) 3. COPD with acute exacerbation (J44.1)	1. Foreign body in bronchus, removed (T17.508A) 2. Acute respiratory failure, resolved (J96.00) 3. COPD with acute exacerbation (J44.1) 4. Hemoptysis, post-procedural (R04.2)

PROCEDURES PERFORMED

1. Emergency endotracheal intubation (CPT 31500)
2. Diagnostic nasal endoscopy (CPT 31231)
3. Diagnostic flexible bronchoscopy (CPT 31622)
4. Surgical bronchoscopy with attempted foreign body removal (CPT 31635) - CONVERTED
5. Right posterolateral thoracotomy with bronchotomy and foreign body removal (CPT 32100)
6. Right tube thoracostomy (CPT 32551)

Surgeon	James R. Ahmad, MD, FACS	**Assistant**	Michael Torres, MD (PGY-4)
Anesthesia	General endotracheal	**EBL**	350 mL
IV Fluids	2,500 mL LR	**Urine Output**	450 mL

OPERATIVE DESCRIPTION

EMERGENCY INTUBATION:

The patient was brought to the operating room in acute respiratory distress. Due to the patient's rapidly deteriorating respiratory status with oxygen saturation dropping to 84% despite supplemental oxygen and evidence of impending respiratory failure, EMERGENT endotracheal intubation was performed. Direct laryngoscopy revealed no foreign body in the hypopharynx. A 7.5mm endotracheal tube was placed atraumatically on the first attempt. Breath sounds were confirmed bilaterally with diminished sounds on the right. THE INTUBATION WAS PERFORMED AS AN EMERGENCY PROCEDURE IN A RAPIDLY DETERIORATING PATIENT WHO REQUIRED IMMEDIATE AIRWAY CONTROL AND MECHANICAL VENTILATION.

NASAL ENDOSCOPY:

Prior to bronchoscopy, a diagnostic nasal endoscopy was performed to evaluate the nasal passages and nasopharynx as part of the airway assessment for bronchoscopic access. The nasal mucosa appeared mildly erythematous. Minor epistaxis was noted from the right nasal passage, likely related to the emergent intubation. This was controlled with topical oxymetazoline. This nasal endoscopy was performed as part of the standard access evaluation for the bronchoscopy procedure.

DIAGNOSTIC BRONCHOSCOPY:

The flexible bronchoscope was advanced through the endotracheal tube. The trachea appeared normal. The carina was sharp. The left mainstem bronchus and all left-sided bronchi were examined and found to be free of obstruction. On the right side, a metallic foreign body was visualized lodged in the bronchus intermedius, causing near-complete obstruction. The foreign body appeared to be a dental crown (porcelain-fused-to-metal) approximately 12mm in diameter. Significant mucosal edema and erythema were noted surrounding the foreign body. THE FINDINGS OF THIS DIAGNOSTIC BRONCHOSCOPY WERE CRITICAL IN DETERMINING THE EXACT LOCATION, SIZE, AND

DEGREE OF IMPACTION OF THE FOREIGN BODY. THESE FINDINGS LED DIRECTLY TO THE DECISION THAT SURGICAL THORACOTOMY WOULD LIKELY BE REQUIRED IF ENDOSCOPIC REMOVAL FAILED.

SURGICAL BRONCHOSCOPY WITH ATTEMPTED FOREIGN BODY REMOVAL:

Multiple attempts were made to extract the foreign body endoscopically using various retrieval instruments including optical grasping forceps, retrieval baskets, and balloon catheters. The smooth metallic surface of the dental crown prevented adequate purchase with the forceps. The wedged position and surrounding mucosal edema made manipulation extremely difficult. After approximately 25 minutes of attempted extraction, a small bronchial mucosal laceration was noted with minimal bleeding. Given the inability to safely extract the foreign body endoscopically and the risk of further airway trauma, the decision was made to proceed with open thoracotomy. THE SURGICAL BRONCHOSCOPY WAS CONVERTED TO AN OPEN PROCEDURE.

RIGHT POSTEROLATERAL THORACOTOMY:

The patient was positioned in the left lateral decubitus position. A right posterolateral thoracotomy incision was made in the 5th intercostal space. The chest was entered and the lung was retracted. The hilum was identified and the bronchus intermedius was exposed. A longitudinal bronchotomy was performed and the dental crown was visualized and carefully extracted intact using DeBakey forceps. The bronchial mucosa was inspected and the laceration from the bronchoscopic attempt was identified. This was repaired with interrupted 4-0 Vicryl sutures. The bronchotomy was closed in two layers. Air leak testing was negative. The lung was re-expanded.

TUBE THORACOSTOMY:

A 32-French chest tube was placed in the LEFT hemithorax through a separate stab incision in the 8th intercostal space at the midaxillary line and connected to a Pleur-evac drainage system. The tube thoracostomy was placed on the LEFT (CONTRALATERAL) side - the opposite side from the right thoracotomy - due to a small left-sided pleural effusion noted on preoperative imaging that required drainage. The thoracotomy incision was closed in layers. Sponge, needle, and instrument counts were correct.

MODIFIER 57 DOCUMENTATION - DECISION FOR MAJOR SURGERY

This E&M service (99223) involved the evaluation and management of the patient's acute condition and directly led to the decision to perform emergent thoracotomy (CPT 32100), which is a major surgical procedure with a 090-day global period. The decision for this major surgery was made during this encounter based on the clinical findings and failed endoscopic attempts. Modifier 57 is appended to the E&M code to indicate that the service resulted in the decision to perform a major surgical procedure.

Specimens	1. Foreign body (dental crown) - to patient/family 2. Bronchial mucosal tissue - to pathology
Drains	32Fr right chest tube to Pleur-evac, -20 cm H2O suction
Complications	Bronchial mucosal laceration (repaired); Minor epistaxis (controlled)
Disposition	Extubated in OR. Transferred to SICU in stable condition on supplemental O2.

ATTENDING SURGEON ATTESTATION

I personally performed or directly supervised all key portions of the above procedure(s). This operative report accurately reflects the procedures performed and the clinical findings.

Electronically Signed: *James R. Ahmad, MD, FACS, FCCP*
Date/Time: 01/15/2026 at 22:45 CST
Dictated: 01/15/2026 22:30 • **Transcribed:** 01/15/2026 23:15 • **T#:** OR-2026-01-15-0847

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Surgical Services • 500 Medical Plaza Drive • Chicago, IL 60611

OPERATIVE PROCEDURE LOG

Technical Documentation & Procedure Sequencing

Patient: THOMPSON, ROBERT J.	DOB: 08/22/1963	MRN: 2026-TPC-88456	DOS: 01/15/2026

CASE NARRATIVE SUMMARY

Mr. Robert Thompson, a 62-year-old male with a history of moderate COPD, was brought to the operating room emergently on the evening of January 15, 2026 following aspiration of a dental crown during dinner. The patient arrived in the operating room in moderate respiratory distress with oxygen saturations in the mid-80s despite supplemental oxygen. Given the critical nature of his respiratory compromise, the surgical team mobilized rapidly to secure his airway and attempt foreign body removal.

The operative approach proceeded in a stepwise fashion, beginning with emergent airway management, followed by diagnostic assessment via bronchoscopy, attempted endoscopic retrieval, and ultimately conversion to open thoracotomy when endoscopic methods proved unsuccessful. Throughout the procedure, the surgical team maintained close communication with anesthesiology regarding the patient's hemodynamic and respiratory status. The following log documents each procedural step in chronological sequence.

PROCEDURE SEQUENCE

#	CPT	Procedure Description	Start	End	Dur	Outcome
1	**31500**	Emergency endotracheal intubation	19:02	19:05	3 min	Successful - 7.5 ETT
2	**30901**	Control nasal hemorrhage, anterior	19:06	19:08	2 min	Controlled w/ topical
3	**31231**	Nasal endoscopy, diagnostic	19:08	19:12	4 min	Airway assessment
4	**92502**	Otolaryngologic exam under GA	19:10	19:14	4 min	
5	**30801**	Ablation, soft tissue inferior turbinates	19:07	19:09	2 min	
6	**31622**	Bronchoscopy, diagnostic, flexible	19:15	19:28	13 min	FB identified R bronchus
7	**31635**	Bronchoscopy, surgical, FB removal	19:32	19:58	26 min	Unsuccessful - converted
8	**32100**	Thoracotomy with exploration	20:15	21:42	87 min	FB removed, bronchotomy
9	**32551**	Tube thoracostomy	21:38	21:42	4 min	32Fr placed, L side (contralat)

DETAILED PROCEDURE NARRATIVES

Procedure #1: Emergency Endotracheal Intubation (CPT 31500)

The patient arrived in the operating room with oxygen saturations of 84% on high-flow nasal cannula, exhibiting signs of respiratory distress including tachypnea, accessory muscle use, and audible stridor. Recognizing the emergent nature of the situation, the decision was made to proceed immediately with endotracheal intubation. The anesthesiologist performed rapid sequence induction. Direct laryngoscopy was performed with a Macintosh 3 blade, revealing a Grade 1 view of the vocal cords. No foreign body was visualized at the level of the hypopharynx or glottis. A 7.5mm cuffed endotracheal tube was placed atraumatically on the first attempt. Tube position was confirmed by direct visualization, capnography, and bilateral breath sounds. The patient was placed on mechanical ventilation. This intubation was performed as an EMERGENT procedure due to the patient's rapidly deteriorating respiratory status.

Procedures #2-5: Nasal and Upper Airway Assessment

Following successful intubation, attention was turned to evaluating the upper airway in preparation for bronchoscopy. Minor epistaxis was noted from the right nasal passage, likely resulting from trauma during the emergent intubation process. This was controlled with topical oxymetazoline applied via nasal pledgets. Diagnostic nasal endoscopy was performed using a flexible nasopharyngoscope to evaluate the nasal passages and nasopharynx. The nasal mucosa appeared mildly erythematous but without significant pathology. This examination was performed as part of the standard access evaluation for the planned bronchoscopy procedure.

Procedure #6: Diagnostic Flexible Bronchoscopy (CPT 31622)

The flexible bronchoscope (Olympus BF-1TH190) was introduced through the endotracheal tube adapter and advanced into the trachea. The tracheal mucosa appeared normal with intact cartilaginous rings. The carina was sharp and mobile with respiration. The left mainstem bronchus was entered first and examined thoroughly - all left-sided bronchial segments were patent and free of obstruction or foreign material.

Attention was then directed to the right bronchial tree. Upon entering the right mainstem bronchus, the bronchus intermedius was visualized. A metallic foreign body, consistent with a dental crown (porcelain-fused-to-metal), was identified lodged within the bronchus intermedius. The foreign body was causing near-complete obstruction of the airway lumen, with only a small crescent of patency remaining anteriorly. Significant mucosal edema, erythema, and mild hemorrhage were noted surrounding the impacted foreign body. The right lower lobe segmental bronchi could not be visualized distal to the obstruction.

The findings of this diagnostic bronchoscopy were critical in determining the exact location, size, shape, and degree of impaction of the foreign body. The metallic nature and smooth surface of the crown were noted, which would have implications for retrieval attempts. Based on these findings, the decision was made that surgical thoracotomy would likely be required if endoscopic removal failed. This diagnostic procedure directly informed the surgical plan.

Procedure #7: Surgical Bronchoscopy with Attempted Foreign Body Removal (CPT 31635)

Following the diagnostic bronchoscopy, surgical bronchoscopy with foreign body removal was attempted. Multiple retrieval instruments were employed over the course of approximately 26 minutes:

• Optical grasping forceps (multiple attempts) - unable to achieve adequate purchase due to smooth metallic surface
• Dormia basket retrieval device - could not pass basket beyond foreign body due to degree of impaction
• Fogarty balloon catheter - attempted to pass catheter distal and inflate to extract; unsuccessful
• Alligator forceps - achieved partial grip but foreign body dislodged each time traction was applied

During the final extraction attempt with alligator forceps, a small mucosal laceration occurred at the junction of the bronchus intermedius and right lower lobe bronchus. Bleeding was minimal but the decision was made at this point to cease endoscopic attempts to avoid further airway trauma. THE SURGICAL BRONCHOSCOPY WAS CONVERTED TO AN OPEN PROCEDURE. The bronchoscope was withdrawn and the patient was prepared for thoracotomy.

Procedure #8: Right Posterolateral Thoracotomy with Bronchotomy (CPT 32100)

The patient was repositioned in the left lateral decubitus position with appropriate padding and safety measures. The right chest was prepped and draped in standard sterile fashion. A posterolateral thoracotomy incision was made, extending from the posterior axillary line to the anterior axillary line, along the course of the 5th rib. The latissimus dorsi and serratus anterior muscles were divided. The chest was entered through the 5th intercostal space. Rib spreaders were placed.

The lung was retracted anteriorly and inferiorly to expose the hilum. The pulmonary ligament was divided. The bronchus intermedius was identified and isolated. Stay sutures were placed and a longitudinal bronchotomy was performed. The dental crown was immediately visualized and carefully extracted intact using DeBakey forceps. The specimen was handed off the field and confirmed to be a porcelain-fused-to-metal dental crown measuring approximately 12mm in diameter.

The bronchial lumen was inspected. The mucosal laceration from the bronchoscopic attempt was identified and measured approximately 5mm. This was repaired with interrupted 4-0 Vicryl sutures. The bronchotomy incision was closed in two layers - the mucosa with running 4-0 Vicryl and the outer layer with interrupted 3-0 Vicryl. Air leak testing was performed with the bronchus submerged under saline while positive pressure was applied to the airway - no air leak was identified. The lung was re-expanded and ventilation confirmed.

Procedure #9: Tube Thoracostomy (CPT 32551)

A 32-French chest tube was placed in the LEFT hemithorax through a separate stab incision made in the 8th intercostal space at the midaxillary line. The tube was directed posteriorly and superiorly and connected to a Pleur-evac drainage system at -20 cm H2O suction. Immediate drainage of approximately 150mL of serous fluid was noted. The tube was secured with 0-silk suture and a sterile dressing applied. Note: This tube thoracostomy was placed on the LEFT (CONTRALATERAL) side - the opposite side from the right thoracotomy. This was performed to drain a pre-existing left pleural effusion identified on preoperative CT imaging. The right thoracotomy incision was then closed in layers with excellent hemostasis. Final sponge, needle, and instrument counts were correct x3.

SURGICAL TEAM

Role	Name / Credentials	NPI / ID
Primary Surgeon	James R. Ahmad, MD, FACS, FCCP	NPI: 1122334455
First Assistant	Michael Torres, MD (PGY-4 Thoracic Surgery)	NPI: 2233445566
Anesthesiologist	Patricia Wong, MD (Board Certified Anesthesiology)	NPI: 3344556677
CRNA	David Martinez, CRNA	NPI: 4455667788
Scrub Nurse	Jennifer Adams, RN, CST	Employee ID: MTPC-4521
Circulating Nurse	Robert Kim, RN	Employee ID: MTPC-3892

ANATOMICAL SITE & LATERALITY

Primary Surgical Site	Right bronchus intermedius → Right lower lobe bronchus
Laterality	RIGHT (Modifier: RT)
Thoracotomy Approach	Right posterolateral thoracotomy, 5th intercostal space
Chest Tube Placement	LEFT hemithorax, 8th intercostal space, midaxillary line (CONTRALATERAL to thoracotomy)
Foreign Body	Dental crown (porcelain-fused-to-metal), approximately 12mm diameter, removed intact

OPERATIVE TIME SUMMARY

Anesthesia Start	18:58	**Anesthesia End**	22:15
Surgery Start	19:02	**Surgery End**	21:47
Total OR Time	3 hr 17 min	**Total Surgical Time**	2 hr 45 min
EBL	350 mL	**IV Fluids**	2,500 mL LR
Urine Output	450 mL	**Disposition**	SICU, stable

SURGEON ATTESTATION

I certify that this operative procedure log accurately reflects the procedures performed, their sequence, duration, and the clinical circumstances including the conversion from endoscopic to open surgical approach. I personally performed or directly supervised all key portions of the above procedure(s).

Surgeon: *[Electronically Signed] James R. Ahmad, MD, FACS, FCCP*
Date/Time: 01/16/2026 at 08:15 AM CST

MEMORIAL THORACIC & PULMONARY CENTER

Claims & Supporting Documentation

Claim & Evidence Package

SECTION A: MEMBER CLAIM HISTORY (36 Months)

Summary of respiratory/thoracic claims for Thompson, Robert J. (Member ID: BCB-998877665)

DOS	Claim #	Service	CPT	Billed	Paid	Status
03/15/22	IL22-334521	Diagnostic bronchoscopy	31622	$580.00	$342.80	PAID
03/15/22	IL22-334521	Office visit, established	99214	$145.00	$85.60	PAID
09/22/23	IL23-556892	Diagnostic thoracoscopy	32601	$1,850.00	$1,093.60	PAID
09/22/23	IL23-556892	Hospital E&M, subsequent	99232	$115.00	$67.85	PAID
06/10/24	IL24-112233	Pulmonary function test	94010	$225.00	$132.75	PAID
11/05/25	IL25-445566	Office visit, established	99213	$95.00	$56.05	PAID
11/05/25	IL25-778899	Skin biopsy (000 global)	11102	$185.00	$109.15	PAID
11/05/25	IL25-778899	Office E&M (Mod 25) - HTN mgmt	99213-25	$95.00	$56.05	PAID
01/15/26	**IL26-887456**	**CURRENT CLAIM (see detail below)**	Multiple	**$12,550.00**	Pending	REVIEW
01/29/26	IL26-889900	Postop E&M (Mod 24) - unrelated derm	99213-24	$95.00	$56.05	PAID

CLAIM HISTORY SUMMARY (36 months)

Total Claims: **7** • Paid: **6** • Denied: **0** • Under Review: **1** • Total Billed: **$15,560.00**

⚠️ Note: Claim IL23-556892 (CPT 32601 - thoracoscopy) missing laterality documentation

MEMORIAL THORACIC & PULMONARY CENTER

Claims & Supporting Documentation

SECTION B: INSURANCE VERIFICATION

BlueCross BlueShield — **PPO** Corporate Select

Member: **ROBERT J THOMPSON**

Member ID: **BCB-998877665** Group: **GRP-CORP-2250**

Effective: **01/01/2024** Plan Code: **PCS-500**

PCP: **$25** Specialist: **$50** ER: **$250** Deductible: **$1,500**

— CARD FRONT —

IMPORTANT NUMBERS

Member Services: **1-800-538-8833** Prior Auth: **1-800-635-4580**

Claims: P.O. Box 805107, Chicago, IL 60680

PHARMACY

RxBIN: **003858** RxPCN: **A4** RxGrp: **BCBSRX**

— CARD BACK —

SECTION C: EMPLOYMENT VERIFICATION

MIDWEST ENGINEERING SOLUTIONS, INC. — **EARNINGS STATEMENT** Pay Period: 01/01 - 01/15/2026

Employee: **THOMPSON, ROBERT J** ID: EMP-XXX-4521 Dept: Engineering

Description	Current	YTD
Regular Salary	$6,250.00	$6,250.00
Federal Tax / State Tax / FICA	-$1,631.26	-$1,631.26
Health Insurance - BCBS PPO (Emp+Spouse)	-$312.50	-$312.50
Dental / Vision / 401k (8%)	-$533.25	-$533.25
NET PAY	**$3,772.99**	**$3,772.99**

Annual Salary: $150,000.00 • Pay Frequency: Semi-Monthly • Direct Deposit: Checking XXXX4892

MEMORIAL THORACIC & PULMONARY CENTER

Claims & Supporting Documentation

SECTION D: EXPLANATION OF BENEFITS - CURRENT CLAIM

BlueCross BlueShield
of Illinois

EXPLANATION OF BENEFITS
This is not a bill

Member: THOMPSON, ROBERT J
Member ID: BCB-998877665

Claim #: IL26-887456-001
Date of Service: 01/15/2026

⚠️ **CLAIM STATUS: PENDING MEDICAL REVIEW**
Some services require additional clinical documentation review.

Service	CPT	Billed	Allowed	Plan Paid	You Owe	Status
Thoracotomy w/ exploration	32100	$8,450	$6,245	$4,996	$1,249	Processed
Emergency intubation	31500	$485	$359	$287	$72	Processed
Diagnostic bronchoscopy	31622	$625	$462	$370	$92	Processed
Hospital E&M (Mod 57)	99223	$285	$211	$169	$42	Processed
Tube thoracostomy (L side)	32551	$520	$385	$308	$77	Processed
Surgical bronchoscopy FB	31635	$1,285	--	--	--	Under Review
Nasal endoscopy, dx	31231	$285	--	--	--	Under Review
Hemorrhage control, nasal	30901	$175	--	--	--	Under Review
ENT exam under GA	92502	$195	--	--	--	Pend - No Docs
Turbinate ablation	30801	$245	--	--	--	Pend - No Docs

Processed (5 services)	**$10,365.00**	**$6,130 paid**
Under Review (3 services)	**$1,745.00**	**Pending**
Documentation Required (2 services)	**$440.00**	**Info Needed**

CHICAGO THORACIC SURGERY ASSOCIATES, LLC
James R. Ahmad, MD, FACS, FCCP • Board Certified Thoracic Surgery
500 Medical Plaza Drive, Suite 420 • Chicago, IL 60611 • (312) 555-7850

January 22, 2026

BlueCross BlueShield of Illinois
Medical Review Department
P.O. Box 805107, Chicago, IL 60680-5107

RE: Post-Service Medical Necessity - Claim IL26-887456-001

Patient: Robert J. Thompson • DOB: 08/22/1963 • Member ID: BCB-998877665

Dear Medical Review Committee:

I am writing to provide clinical documentation for the emergency surgical services provided to Mr. Thompson on January 15, 2026. The patient presented with acute respiratory distress from foreign body aspiration (dental crown). He was hypoxic (SpO2 88%) with impending respiratory failure.

Emergency endotracheal intubation (31500) was performed in a RAPIDLY DETERIORATING PATIENT requiring mechanical ventilation. Diagnostic bronchoscopy (31622) identified the foreign body location and THESE FINDINGS LED DIRECTLY TO THE DECISION for surgical intervention. Attempted endoscopic removal (31635) was CONVERTED TO OPEN THORACOTOMY after 26 minutes when retrieval proved impossible. The chest tube (32551) was placed on the LEFT (CONTRALATERAL) side for a pre-existing pleural effusion.

The E&M service (99223) with Modifier 57 was the decision-making encounter that led to the major surgical procedure (32100 - 090 day global). The patient was discharged home on January 19, 2026 in stable condition.

Respectfully,

[Electronically Signed]

James R. Ahmad, MD, FACS, FCCP

Enclosures: Operative Report, Procedure Log