IN THE CHANCERY COURT FOR DAVIDSON COUNTY, TENNESSEE

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CLERK & MASTER
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Sean P. Smith,

Petitioner,

v.

TENNESSEE DEPARTMENT OF FINANCE & ADMINISTRATION, DIVISION OF TENNCARE; and

STEPHEN SMITH, DIRECTOR OF TENNCARE, in his official capacity,

Respondents.

Case No. 24-0074-I

Motion for Accommodations to be Granted in the Event of Plaintiff Suffering Incapacitating Injury and/or Death

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Over the course of the past several years, I have sustained numerous injuries and experienced extensive deterioration of both my physical and mental health. This has been happening primarily due to the misconduct of my health plans limiting, interfering, or preventing me from working with the specialists possessing the education, experience, and expertise required to properly diagnose and provide rehabilitative care for the health conditions causing my disabilities. I do not know how to adequately convey how difficult it is for me to try to function and work on things under the physical and mental impairment caused by the health conditions that are causing my disabilities. Under this burden I have to do the best I can with what I have to promote the level of function I will need to effectively study the law and respond to the defendant's filings. My past experience informs me that the options I have to try to accomplish this are limited to using a highly restrictive cyclic ketogenic diet, underfeeding, and fasting alongside a variety of other supportive practices and interventions which when used for an extended period of time has on multiple occasions resulted in injury, further deterioration, increased disability, and periods of incapacitation which varied in their duration and severity.

In the mid to latter part of 2018 I began using a ketogenic diet alongside supportive self-treatment protocols in order to stabilize neurological issues which were severely compromising my digestion, causing uncontrollable weight loss, impairment of my motor control and speech, at times after moving my head the wrong way I would lose control of my body causing me fall and experience severe motor control impairment while lying on the floor, preexisting cognitive dysfunction got much worse, experienced recurrent and progressive episodes of intense mental anguish, and many other debilitating issues. These being caused by neurological dysregulation of my gut and other undefined neurological issues which were induced by a cranial nerve injury. This cranial nerve injury occurred due to my disability-related financial status of indigency limiting me to relying upon Unitedhealthcare Community Plan (UHCCP) as a secondary insurance and because of that dependency UHCCP misconduct was preventing me from *continuing care* with a specialized physical therapist that was in-network with my primary health insurance plan.

The disruption to my care with the specialized physical therapist limited me to self-treatment with physical therapy exercises and manual manipulation techniques I had learned over the years. I was walking at the park next to my house while performing jaw opening and closing exercises when the cranial nerve injury occurred on April 4th 2018. Minutes after the injury I called my PCPs office (Lunceford Family Medicine) and explained my symptoms (mental confusion, speech difficulties, severe numbness on the right side of my jaws, nasal passages, face, and severe paresthesia and ataxia of my hands) asking when I could get an appointment and on that call was given instructions from one of the nurse practitioners to go to the ER as the symptoms I was experiencing sounded like it could be a stroke. It was late in the afternoon, and while the acute symptoms from the injury were very severe, they subsided enough awhile that I believed it better to go to the ER the next day. Especially since prior attempts to get help at ER's had not been successful, and at times had been harmful [Exhibit B2, pg. 6 "2017 Methodist Hospital ER Germantown"] . I had to protect myself by getting what rest I could and seeking help for this new injury the next day.

In 2018 I did not understand the laws or the duties and obligations of my health plans, the importance of making requests in writing, or the need to protect myself by documenting my interactions with my health plans. According to my records, it was not until February 20-29th 2018 that I began to make call notes in an organized manner. As to whether there are hard copies of call notes from prior to Feb 2018 somewhere in a box of folders, I am uncertain. In 2018 I was still just a medically disabled adult communicating my health needs and requesting assistance from my health plans and, as well as I was able to, following the instructions my health plans and its physicians provided in response to my communications, despite observing that I was not getting the help I needed and it seemed what was occurring wasn't 'right'.

I needed help and there were specialists who could help me but I wasn't being allowed to be helped by them; it didn't make sense; I found it very confusing. I often blamed myself thinking that I'm just failing to communicate to doctors or health plan representatives well enough to be understood. I would tell myself I just have to try harder to overcome my impairments and disabilities to provide the information necessary to explain matters. Why else would my health plan keep me sick and make me get hurt except that they just don't have the information they need to understand how to help me?

Sometime between January to February of 2018 I communicated several matters over the phone to UHCCP. I communicated that they had no in-network physical therapists possessing the specialization required to treat a Temporomandibular Disorder (TMD) patient with dry needling and that disrupting ongoing care with my current physical therapist would cause harm and create a medical emergency due to me no longer having access to any efficacious pain management therapy.

I communicated over the phone to UHCCP that the specialized physical therapist I had been seeing since the summer of 2017 and needed to continue seeing was found through a process of complicated consultations and referrals. Throughout 2016-2017 I had tried to find a jaw disorder specialist that was in network with my health plans and found that none were. I attended a series of consultations with jaw disorder specialists, paying for some out-of-pocket while others were free. None of the jaw disorder specialists voiced any ability to get health insurance plans to work with them in good faith for the good of their patients. They provided care for jaw disorders via out of network services.

During a 2017 consultation with Dr. Alan Blanton at a private clinic he operated at the University of Tennessee Health Science Center College of Dentistry in Memphis, he communicated to me that the reimbursement that is offered by UHCCP-TennCare for oral appliances is so inadequate that it does not even cover the cost of paying the dental laboratory that manufactures the oral appliance he needs to provide to patients. Dr. Blanton explained that he has to be able to pay his staff and himself to be able to operate a practice that can provide assistance to patients. Which is just one of the many problems my cold calls and consults had identified which have been preventing jaw and airway specialists from working with health plans to provide care to disabled adult plan beneficiaries throughout Tennessee and other States.

My condition had severely deteriorated during my 2016-2017 efforts to seek care for my jaw disorder and airway issues. I became so impaired and dysfunctional and in such acute intense distress that my need for medical assistance had become desperate; I couldn't hold on any longer. My mom talked to a family friend who was training to be a prosthodontist, Dr. Robinson, and he recommended I see a mentor and instructor of his, Dr. William McHorris, who was a prosthodontist whose private practice and teaching efforts had been focused on jaw disorders for over forty years.

I recall that Dr. McHorris was very specific and adamant that in order to treat my TMD it was required that I see a specialized physical therapist, Dr. Jim Hambrick. Dr. McHorris specifically forbade me from trying to see a physical therapist listed in my health insurance plans provider network. Dr. McHorris made it clear that I did not need a physical therapist, I needed a specialist. Thankfully Dr. Hambrick turned out to be in-network with my primary insurance.

I saw Dr. Hambrick from June 2017 to October 2017, and after observing my response to treatment over multiple appointments he suggested I might benefit more from seeing a colleague of his, Dr. Ken McMahon, who could provide dry needling alongside a more "eclectic" approach to treatment. Dr. Hambrick referred me to Dr. McMahon and I began seeing Dr. McMahon in November of 2017 and was provided dry needling and additional therapies twice a week every week.

In 2017 I had experienced so many problems and seen so many doctors that the primary insurance deductible and out of pocket expense maximum had been met early in the year, which resulted in the primary insurance paying 100% of any submitted claims during 2017. The deductible reset at the start of 2018 and after paying the first set of bills for the services Dr. McMahon provided in Jan-Feb of 2018 I realized I would need to get my secondary insurance to cover the remainder of whatever the primary insurance did not pay for me to continue accessing care at the frequency I needed. For reference, the primary insurance deductible was around $2250, after which the plan paid 70% of claims, leaving the remaining 30% for the secondary insurance to pay, and the out of pocket maximum was $4850 for an individual, or as I recall, $9000 for the 'family'.

Beginning around 2012-2014 my health began to deteriorate at an accelerated rate compared to the past. I suffered injuries, developed significant impairments, became more severely disabled, and with more problems my utilization of healthcare services increased. I saw more and more specialists who, aside from a few out-of-network dentists specialized in jaw disorders that I saw in 2016-2017 via free or mostly or entirely out-of-pocket fee consults, offered little insight or effective therapy to address my complaints or reduce my rate of decline. That is, until the dry needling with Dr. Hambrick and Dr. McMahon; finally I accessed care that really helped me with someone who understood TMD and could provide insight into my complaints and useful patient education.

Sometime in January-February of 2018 I reasoned to UHCCP over the phone that enabling me to continue care in 2018 with Dr. McMahon would not just help me but help reduce costs to the Unitedhealthcare Community Plan. As long ago as 2018 is I remember very specifically communicating to Unitedhealthcare during the phone call that I had spent years trying to work with numerous doctors and physical therapists in their provider network, and that dry needling with Dr. Hambrick and Dr. McMahon was the first time any physician had provided treatment to me which had produced a clear and evident benefit to my jaw related pain and dysfunction.

To this very day, I still remember the room I was in when Dr. Hambrick applied dry needling to my right jaw. That he had a student shadowing him, and how he was using a reference book for trigger points authored by Simons and Travell that he called "the red bible" (it had a red cover). I later learned from Dr. McMahon that Dr. Hambrick really only uses that book to teach because he already has the entire thing practically memorized. I remember how after the dry needling Dr. Hambrick gave me time to recover and asked what I noticed. I noticed that when I spoke or opened my jaw I could feel how the right side of my jaw had changed, was moving different, more freely; it felt like my lower jaw was a swing and suddenly the right side had a longer rope that had become looser and more able to move, which had never happened before. And by observing that change in the right side it became clear, evident, how tight and stuck the left side of my jaws remained.

Needles being jabbed into jaws to hit and release trigger points does not feel good. The needles don't hurt much when jabbed into muscles that don't have trigger points, but when there are trigger points dry needling will produce an intense type of pain and an acute stress to the nervous system. Especially during the initial phase of breaking up trigger points and compensations that have been present for years, sometimes decades. Dr. Hambrick understood this, which is why despite me wanting to proceed right then with more dry needling of my jaws, he told me we'd do more at my next appointment. Dr. Hambrick was a physician, who through specialization and experience understood when to exercise caution while addressing the needs of patients with TMD.

After the pain and stress of the dry needling there is recovery and with it reduced pain and improved function. Something I had never known before. This evident and beneficial change in function and pain made it clear that I needed to continue receiving dry needling with experienced physicians who have a comprehensive understanding of TMD and the musculoskeletal system.

I recall communicating on the phone call to UHCCP during that Jan-Feb 2018 timeframe the many health problems I had been having and the things I was having to do throughout 2016 and 2017 to try to deal with them without having doctors who could help me with them. One of those disclosed health problems and self-treatments being that toward the latter part of 2016 and throughout the first half of 2017 my TMD pain has been so severe and impairing that I had to go to bed with a cooler full of cold packs. When my jaw pain would wake me up I'd have to ice my jaws and head in order to be able to reduce how long it took to get back to sleep, and I'd do that repeatedly throughout the night, until the cold packs stopped being cold, at which point I'd have to try to get back to sleep without them. As a result of the cold packs not being cold enough to fully meet my needs, I did research to try to find a cold pack that would last longer, and ordered "The Coldest" cold pack on February 18th 2017 [Exhibit A2, Invoice for Coldest Pack].

A more detailed corroboration of my chronic use of cold packs and struggles to find care throughout 2016-2018 is provided via excerpts from a March 2018 document summarizing my experiences with providers I had sought care from [Exhibit B2, Provider History v3.3.2018], and a March 2018 letter to Dr. Lauren Reilly who was my PCP at that time [Exhibit C2, Dr. Reilly Dry Needling Letter]. The authenticity and accuracy of these records is corroborated by screenshots of the Google Documents version history and Libre Office document properties in each respective Exhibit. Additionally, an affidavit of the authenticity and accuracy of the documents in the Exhibits is being filed alongside this Motion for Accommodations. I am trying to request medical records to evaluate if I can further corroborate events, should the defendants or the court require it.

Despite communicating all of that information to Unitedhealthcare over the phone I was told I had to find a physical therapist that was in their provider network in order for Unitedhealthcare to pay for my care as a secondary insurance. I recall pleading and asking for the help I knew I needed, but Unitedhealthcare directed me to sort through their list of physical therapy providers with no guidance or indication which if any of the providers in their network had any competency treating TMD let alone were experienced doing so with dry needling. Meaning, either UHCCP did not know if any of their providers could help me, or they withheld that information. Even after having seen multiple PTs at multiple clinics that were in-network between 2014-2017, I was told I had to prove their in-network PTs couldn't help me. They hadn't rendered the care needed, so, why should I have to prove they still can't? I suppose it is pertinent to note at this time that after getting injured in 2018 while trying to prove UHCCP had no in-network PTs to provide the assistance I needed, UHCCP and TennCare continued to engage in misconduct and not help me continue care with Dr. McMahon in 2019 and 2020.

My calendar shows I had appointments scheduled with Dr. McMahon up until February 21st 2018. After February 21st 2018 I went without the specialized care I needed as I tried to get UHCCP to help me. I had cold called multiple physical therapy practices that were in network with Unitedhealthcare Community Plan and only found one which provided dry needling and did not charge patients an out-of-pocket expense for the service. I experienced the April 4th 2018 cranial nerve injury while waiting for an April 23rd 2018 appointment with an UHCCP in-network physical therapist (Dr. Kevin Dorsey).

Dr. Dorsey had very limited experience treating TMD patients and had only gotten his dry needling training and certification last spring. Dr. Dorsey didn’t have an explanation for my injury or the symptoms it produced, and the treatments he provided did not do much to help, and some of the treatments provided would make my cranial nerve injury symptoms worse, particularly the cervical traction machine.

My seeking care for the cranial nerve injury and other ongoing issues resulted in meeting the deductible and out of pocket maximum for my primary insurance in 2018. In December of 2018 I resumed care with Dr. McMahon, and Dr. McMahon’s treatment led to a significant reduction in my cranial nerve injury symptom severity after just two appointments. Symptoms that had remained not merely refractory to all the treatments Dr. Dorsey provided over 13 appointments between April-June, but would many times get worse after appointments. Which is why I stopped seeing Dr. Dorsey in June and having established that there were no other UHCCP physical therapists providing the service needed I had to do the best I could with self-treatment.

I eventually resumed care with Dr. McMahon and then finally received treatment that provided benefit, but the damage caused by the cranial nerve injury remained. I effectively lost the ability to exercise and struggled even more to feed myself. This resulted in experiencing greater cognitive impairment, poorer emotional health, and was the beginning of developing sarcopenia and multiple nutrient deficiencies. These and other issues resulted in me losing 40 lbs of lean muscle mass between April 2018 to 2021 and developing symptoms of nutritional deficiencies that didn't get identified until 2020-2021 [Exhibit D2, Evidence of Sarcopenia and Malnourishment].

I had spent over a decade engaged in intense and regular exercise alongside regimented nutrition to build and maintain my body and mind. I had lost it all in the course of two years as a result of this cranial nerve injury and not being able to get care for it or care for the issues that caused it to occur. I had seen multiple in-network doctors between April to December of 2018, including Orthopedic Spine Specialists, Neurologists, Gastroenterologists, ENTs, a Sleep Doctor, and others, and none knew how to diagnose what happened to cause the neurological injury and my symptoms, let alone render treatment.

Being in ketosis tends to: provoke the ataxia and paresthesia of my hands and jaws-face-head; the neurocognitive impairments caused by my 2018 cranial nerve injury; creates digestive problems; provokes the nerve injury I incurred in 2022 (I was trying to exercise again to fight the sarcopenia; injury was caused by a yoga/physical therapy exercise) which caused me to develop back pain and paresthesia in my right foot, worsens my symptoms of dysautonomia such as brain fog, lightheadedness, fatigue, feeling drained, getting a weird feeling in my chest and having skipped heartbeats, gait issues (staggered gait, struggling to walk, legs giving out on me), impaired digestion, etc; as well as causing other problems. This occurs because being in ketosis results in increased sympathetic tone in the nervous system, which creates more muscle tension, and also disposes the nervous system to promote muscle bracing into established compensatory patterns such as my forward head posture, both of which contribute to the misalignment and dysfunction of my jaws, head, neck, and body, which impinge nerves and veins which causes vascular and neurological dysfunctions. Ketosis also reduces inflammation and metabolic byproducts (i.e. lactic acid buildup in muscles) while also altering how the nervous system perceives pain reducing its impact[1], both of which act to reduce the intensity of myalgia (muscle pain and tenderness), making me less aware of muscles that are being overused and in need of management, resulting in muscles getting tighter and tighter until they get so tight that they get stuck in compensation, causing MSK restrictions and an increased likelihood of experiencing neurological or myofascial injury. Ketosis also causes me to develop electrolyte imbalances that dispose my muscles to tightness, tetany, and spasm. The tetany and spasm can be very painful, keeping me awake in the middle of the night. The acute pain and sleep disruption further increase sympathetic tone and aggravate my TMD and MSK dysfunction and the severity of the neurological issues that they cause. These elevations in sympathetic tone also cause alterations in stress hormones and together these tend to increase the severity of my sleep onset and sleep maintenance insomnia.

Multiple factors make it probable that I could redevelop the nutrient insufficiencies and/or deficiencies I had in 2020-2022. The restrictive nature of a ketogenic diet makes it difficult to get

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[1] Alhadeff, A. L., et al. (2018). A Neural Circuit for the Suppression of Pain by a Competing Need State. *Cell*, *173*(1), 140–152.e15. https://doi.org/10.1016/j.cell.2018.02.057

sufficient vitamins and minerals. My jaw issues limit my ability to chew and thus what I can eat. Managing my Mast Cell Activation Syndrome (MCAS) requires that I avoid trigger foods, which further restricts what foods I can eat. My MCAS also causes me to experience adverse reactions to many common nutritional supplements and my MCAS when provoked compromises my cognitive function. As I would be using a ketogenic diet to promote cognitive function I would also need to limit nutritional supplementation and avoid trigger foods so as not to undermine my efforts to promote cognitive function.

Using a ketogenic diet isn't something I'm looking forward to. I suppose this situation is not all that unlike what occurred in 2018 with UHCCP; I'm communicating that being required to perform a task it should never be necessary for me to perform is going to hurt me, and wishing I would be granted assistance so that I could avoid injury and get help. It's strange to have written all of this, reading and revising it multiple times, before realizing that similarity.

Throughout 2019 I continued to use and modify my ketogenic diet+protocols. Sometime in 2020, my health plans abuse and my neglected health and disability needs had compromised my health and safety to the point that the ketogenic diet+protocols began to cause significant complications resulting in injuries for which I found that no further modification of the ketogenic diet and protocols was able to attenuate. I had to discontinue the strict ketogenic diet and protocols and try to find a different way to compensate for my disabilities so I could function well enough to work productively on 'seeking help'. I have been unable to find an effective substitute.

In the past I could return to using a ketogenic diet and last a few months before experiencing problematic complications. However, the last time I tried to do that was in March of 2023, so that I could travel to St. Louis and consult with some physicians there, and I only lasted three weeks before the injuries became too much. I then spent April-September of 2023 trying to recover and it wasn't until October that I had any ability to resume trying to work on 'getting help'.

I have sought and been unable to find an accessible viable alternative to litigating this legal case on my own. People have through their actions, their agendas and exercise of liberty, organized themselves into a society that passes laws that grant rights and offer protections, but refrains from acting to enforce those laws to protect disabled adults who are being abused, exploited, and injured by private or state operated health insurance plans. As a result, the process of seeking relief and/or justice requires that disabled adults like me must seek out confrontation on that point with little to no assistance even when this means that we destroy ourselves in the process. Thereby making a mockery of the notion of having had rights, or being afforded protections; we are citizens of a "Volunteer State" that volunteers its disabled adult citizens to be abused and exploited for the profit of able-bodied groups and individuals. I must, therefore, expect no forthcoming assistance and apply myself with as much ability as I can, and when injury occurs, I must persist despite that injury, knowing that persisting will lead to more severe injuries.

The possibility that I suffer injuries that will incapacitate me as I try to litigate this case is high, and it is quite possible that upon being incapacitated I will be killed by being unable to function well enough to self treat and stabilize. It is prudent for me to operate under this expectation and plan accordingly. This expectation being formed by having established through many trips to Emergency Rooms (ER), beginning in 2014 as I suffered numerous injuries related to my inadequately diagnosed and unmet health needs, that the physicians at the ERs in Memphis Tennessee do not know how to assist me, will not make a concerted effort to figure out how to assist me, and neither do the majority of in-network specialists that ER physicians discharge me with generic instructions to seek further evaluation from.

Needless to say I've learned to keep to myself when I'm experiencing what most people would consider a medical emergency. When I get broken such that I can't function well enough to figure out what to do to stabilize the health conditions causing my disabilities, there's nowhere in Memphis for me to go to for 'help', and no in-network healthcare facility in Tennessee I have been made aware of which 'might' be able to help.

In the event I could find a way to self treat and stabilize it would, per my health history, be expected to take at least several months to try to recover. Whether or not I could recover is something I cannot predict, as every previous time I've suffered an injury while engaging in prolonged ketosis I did not elect to persist in adherence of the practices that injured me, but immediately sought to discover information and implement changes which would mitigate the injury and help me try to recover.

After the defendants have filed things that I must respond to or when I have to write a brief I will begin utilizing a cyclic ketogenic diet+protocols to promote cognitive function so that I may have the function required to litigate this lawsuit to the best of my ability. When that will be remains unclear to me as I do not understand if I am expected to write a brief prior to the defendants response brief or only afterwards, or both prior to and after.

While a cyclic ketogenic diet and supportive practices can enable a more consistent and effective level of cognitive performance for me, the emotional and physical stresses and injuries it causes is an ordeal to endure. I feel like I'm a cripple denied a wheelchair being forced to crawl on broken glass and nails while people walk over and on top of me in order to get to a court hearing where it will be decided if able bodied people will be allowed to benefit their finances, their careers, and even their social standings by physically and psychologically torturing me to death. Is this hearing going to be part of the process of adjudication, or an execution?

The misconduct of my health plans and their administrators has led to this situation where I will be required to play a game of chicken with disease, disability, and death. As matters currently stand, continuing to engage in misconduct remains in the best interests of my health plans and their administrators as causing me to become incapacitated or killed would stop this pro se lawsuit and limit the public disclosure of the evidence of their misconduct; no 'me' means no more problem. This potential benefit incentivizes my health plans and their administrators to act in bad faith with me both as their beneficiary and as a plaintiff, with the Davidson County Chancery Court, and any other party interested in the integrity of the judicial process or my health and well being. An injunction against the defendants to cease in misconduct would arguably be ineffective, as the potential benefit of causing my incapacitation or death would remain, and where there is a will there's a way, or at least an attempt.

Therefore, a Motion which can grant Accommodations which will remove from the defendants the benefit they could derive from killing or incapacitating me, and also incentivize them to cease in misconduct and do all that they can to provide reasonable accommodations for my disabilities such that I am not incapacitated or killed, seems fitting and in keeping with their established duties as administrators of a State Medicaid program. With these considerations in mind I am submitting this Motion so that the Davidson County Chancery Court may grant the following Accommodations to be implemented in the event that I, Sean Smith a disabled adult Pro Se Plaintiff, while attempting to litigate my case suffer incapacitating injury and/or death due to health plan misconduct having prevented access to needed care in the past or during the proceedings of this case:

1. Summary Judgment in favor of plaintiff against the defendants
    a. I would hope that the court will find my complete incapacitation or corpse sufficient evidence to: (1) substantiate that the misconduct of my health plans and their administrators has prevented me access to needed care and; (2) provide adequate cause <u>to rule against the defendants</u>.
    b. The State of Tennessee and TennCare have extensive resources and capabilities. It is well within their power to communicate and coordinate with my primary health insurance plan that is operated by Unitedhealthcare and Federal Express Corporation. Especially so as Unitedhealthcare is, as of 2024, the third

party administrator of my primary health insurance plan and since at least 2014 has been the TennCare Managed Care Organization/Contractor (MCO/MCC) of my secondary health insurance plan. Furthermore, TennCare, through its division TennCare Oversight, is supposed to protect "the public health and the integrity of the TennCare Program by overseeing, examining and monitoring Managed Care Companies participating in the program." in order to "ensure they [MCCs] are financially sound and operate in compliance with their TennCare contract and applicable laws".[2] TennCare has an obligation to make certain that their contracted partner does not abuse and exploit their plan beneficiary, and failing that has a duty to then intervene so as to try to prevent the beneficiary from being incapacitated or killed. I had attempted to request and failed to receive assistance from TennCare or TennCare Oversight years ago, as outlined and evidenced on page 34 of Exhibit B of my Petition for Judicial Review filed on 1.26.2024. Perhaps with the Chancery Courts judicial oversight it might be possible for TennCare Oversight to find itself able to fulfill its duties and obligations. If UHC-Fedex misconduct or bad faith actions continue to prevent needed care, then TennCare and its plan administrators can document this during their attempts to communicate and coordinate with UHC-Fedex and use that documentation to prove that TennCare and it's administrators conducted themselves in a manner wherein they acted in good faith to make a reasonable and genuine attempt to prevent Mr. Smith's incapacitation or death.

c. I ask the court to exercise discretion to apply more severe penalties against the health plans and their administrators than those requested in my Petition filed on 1.26.2024 or in my 2023 complaint-appeal sent to all of my health plans. *Please make them suffer at least as much as I had to suffer.* Hopefully, then, those other disabled adult plan beneficiaries like me who are yet suffering might be granted the assistance they need by their health plans out of fear of ever having to deal with another situation similar to this one and the penalties that the Chancery Court ordered against the defendants.

2. If for whatever reason Summary Judgment cannot be granted, then:

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[2] TN Dept Comm & Insur. 2024. "Frequently Asked Questions. What do we do?". Retrieved: https://www.tn.gov/commerce/tenncare-oversight/about-us/faq.html
And; https://www.tn.gov/commerce/tenncareoversight.html

    a. Indefinitely suspend these legal proceedings until someone, in good faith with full intent, adequate resources, and the ability to seek justice for the incapacitated or deceased plaintiff, decides to finish litigating this case.
    b. Indefinite meaning a full pause in which there is no statute of limitations or deadline. The litigation of this case after the plaintiffs incapacitation or death will be possible 5, 10, 50, or 150 years from now; the possibility of litigation should hang over the heads of the responsible parties, the health plan administrators and their co-conspirators, for the rest of their natural lives: let the uncertainty and fear of potential legal consequences be their sentence. Hopefully someone someday might seek justice for me. <u>I at least would like the court to grant me the privilege of being able to be killed believing that posthumous justice will remain possible.</u>

3. Determining Cause of Incapacitation or Death Requires Multiple Physicians Who Are Specialized Specialists:
    a. Each of my primary health conditions are one's that most physicians are undereducated on. Even when a physician has education and some degree of specialization with one of the health conditions I have, their understanding and expertise is typically still limited. One needs to not just understand one of the conditions I have, but all of them and how they interrelate with each other. Including the specifics of how these health conditions cause or contribute to each other, particularly with respect to their etiological factors, pathogenesis, pathophysiology, and prognosis. This is why an interdisciplinary approach is needed.
    b. In example, many Sleep Medicine Specialists understand the basics of how underdeveloped facial anatomy contributes to Obstructive Sleep Apnea (OSA), but can have little to no understanding of what causes jaws to become underdeveloped. Which limits their understanding of when during a person's growth and development the issues with their jaws began to negatively affect their airway and the airway issues began to negatively affect the development of their jaws. Most Sleep Medicine Specialists also *tend* to have a poor understanding of how facial anatomy and airway issues can cause jaw disorders, a.k.a. Temporomandibular Disorders (TMD), and how jaw disorders can affect the airway and influence OSA. Dentists specialized in jaws and airways tend to have a more comprehensive and detailed understanding of the relationship

Sleep Medicine Specialists.

Many patients are told that they don't have OSA by a sleep doctor who performed a sleep study scored using insensitive and flawed scoring criteria. Those same patients get identified as being at risk of having OSA by specialized dentists based upon the patient's facial anatomy and health history. Those dentists then refer those patients-at-risk to a sleep doctor who performs a properly scored sleep study, and more often than not, the patient-at-risk previously told they didn't have OSA then gets diagnosed with OSA. Some Sleep Medicine Specialists have just as much or more education related to jaws and airways than the specialized jaw-airway dentist, but most do not.

c. To understand how my untreated OSA contributes to worsening my jaw disorder, chronic pain, mast cell activation syndrome, dysautonomia, gastrointestinal issues, musculoskeletal dysfunction, neurological issues, etc, will require specialists who possess additional specialization specific to the issues I have. Specialized specialists who will work in concert with other specialized specialists. These specialized specialists possess specialization that far exceeds board certification for their speciality.

d. Determining if someone really understands jaws and airways requires the assessor to have a broad but still detailed understanding of the subject matter. To understand which physicians can handle a complex medical case with multiple comorbidities requires understanding the disorders that are present, how they need to be treated, and what an interdisciplinary treatment process requires of physicians and their practice/facility. There are many physicians who are educated in jaws and airways who do not have the experience, education, or practice/facility support to assist a patient with a case as complex as mine is. But some physicians do. Clinicians and educators like Dr Jeff Rouse, Dr. Mark Cruz, Dr. Richard Roblee and many others within that sphere of the jaw-airway focused community. Those physicians teach at continuing education programs and collaborate clinically with a variety of academic researchers and clinical specialists. I would advise the court to seek out these educators, their students who have taken most of or all of their courses, the physicians these educators collaborate with, and ask the educators and students and their collaborators for recommendations as to which of physicians the court is able to call upon might between facial anatomy, OSA, TMD, and comorbid diseases than the majority of have the education and expertise required to competently attend to the task of determining the cause of my incapacitation and/or death.

e. Common misconceptions about who is specialized in jaws and airways.

    i. The physicians who are highly educated with respect to jaws and airways became educated because they pursued continuing education within their field and outside of it in an multi- or interdisciplinary manner. It is generally not part of their training in school, part of their certification for their medical or dental license, or part of becoming board certified for their speciality.

    ii. Many medical doctors and health plans operate under the misconception that Oral Maxillofacial Surgeons and Orthodontists are trained to understand jaw disorders and airway issues. Even some Oral Surgeons and Orthodontists practice under the misconception that they themself understand jaw disorders and airway issues. However, these two specialities are educated under and conduct themselves according to biased orthodoxies while also tending to isolate or silo themselves apart from specialties, disciplines, and communities of professionals who hold views and produce evidence that undermine some of the common orthodoxies within the Orthodontic and Oral Maxillofacial specialities.

        An example of this would be how the field of anthropology has through the fossil record and study of hunter gatherer populations determined what is 'properly developed jaw structure' for human beings, and by and large, anthropologists are in consensus on that point. The Orthodontic and Oral Maxillofacial specialists have remained seemingly ignorant of the extensive data set provided by anthropologists regarding classifying what is an underdeveloped jaw and what causes underdeveloped jaws. Orthodontists and Oral Surgeons have, instead, for decades relied upon esoteric classification schemes about where jaws 'should be' that have little to do with any biological or physiological premise let alone the anthropological models.

        There are some amazingly educated and competent Oral Maxillofacial Surgeons and Orthodontists, who are not only aware of the anthropological models determining what are properly developed jaws, but have been teaching their peers about it for many years now in collaboration with anthropologists[3]. However, the general rule is that the Orthodontic and Oral Surgery specialities have been a hazardous obstacle to patients like myself for many decades, and that legacy, unfortunately, continues as these specialities are generally resistant to adapting their views to be in accordance with the scientific evidence as a whole.

    iii. The Orofacial Pain Speciality knows much about managing pain, but has significant shortcomings when it comes to diagnosing and treating developmental TMD caused by underdeveloped jaws compromising the airway. I have strong criticisms to offer about the shortcomings of the diagnosis and treatment guidelines the Orofacial Pain Specialty espouses, but I do not think it's appropriate for me to voice those criticisms here in detail at this time unless directly requested to. The education that one must acquire in order to be certified as an Orofacial Pain Specialist is significant, but it is not the education that is needed to fully understand and assist with the jaw and airway needs of patients with TMD and OSA/UARS. ·

f. The specialists who can determine if my health conditions have incapacitated or killed me:
    i. General Dentist/Orthodontist/Prosthodontist whose specialization includes:
        I. at least 50% of their practice focused on jaws disorders and airway
        II. practicing that specialization for at least 5-7 years, preferably 10-15+ years, and practicing using an interdisciplinary or at least multidisciplinary diagnostic and treatment process
        III. with relative frequency provides assistance to patients that have medically complex cases and some degree of disability.
        IV. Understands how the structure of the jaws, the function and posture of the tongue, and impact those have on the airway affect the alignment of the cranium, cervical spine, and mandible and how misalignment can cause compensation and dysfunction

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[3] Rose, J. C., & Roblee, R. D. (2009). Origins of dental crowding and malocclusions: an anthropological perspective. Compendium of continuing education in dentistry (Jamesburg, N.J. : 1995), 30(5), 292–300.

throughout the entire musculoskeletal system and create neurological and neuropsychiatric symptoms; how jaws-cranium-cervical-tongue-airway affect mind and body, head to toe.

V. Understands the neurology of the cranial nerves and how they relate to the jaws, tongue, airway, breathing behavior, sleep, cognitive function, pain perception, paresthesias and ataxia of the face-jaws-hands-feet, abnormal gait, digestion, etc.

VI. Understands how airway issues and jaws impact mental health. In example, How OSA causes brain injury that then induces depression or how Sleep Related Disordered Breathing acts as a perpetuating allostatic challenge that sensitizes the limbic system causing anxiety and disposing one to develop chronic stress conditions and/or PTSD.

ii. Mast Cell Activation Syndrome (MCAS) specialist who *at the very least* in their practice of medicine diagnose's MCAS based upon one of the two primary consensus criteria[4], preferably utilizing consensus-2 criteria as espoused by MCAS researchers like Dr. Lawrence Afrin, Dr. Anne Maitland, and Dr. Pradeep Chopra, where the priority is to diagnose based upon symptoms presented in the patient's health history and the patient's response to MCAS therapies. And who understands: (1) how many patients with MCAS get inappropriately directed to psychiatry for their symptoms; (2) cranium-cervical-mandible alignment can contribute to MCAS severity [Dr. Maitland discusses cranium-cervical-vagus contributions in some of her lectures]; (3) the need to accurately diagnose and effectively treat OSA as part of managing MCAS.

iii. Dysautonomia specialist who understands how sleep related breathing disorders contribute to and/or cause dysautonomia, and vice versa, and how each exerts a systemic impact on multiple biological systems; understands many psychiatric symptoms occur because of dysautonomia and can be made worse by psychiatric medications.

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[4] Afrin, L. et al. (2021). Diagnosis of mast cell activation syndrome: a global "consensus-2". *Diagnosis*, *8*(2), 137-152. https://doi.org/10.1515/dx-2020-0005

iv. Sleep Medicine Specialists who understand the difference between OSA and Upper Airway Resistance Syndrome (UARS) and the paramount importance of utilizing the American Academy of Sleep Medicine's recommended 1A scoring criteria for hypopnea[5] as defined in the 2012 update to the 2007 scoring manual, or more sensitive methods and criteria, for persons with TMD or chronic pain, and/or a history of psychiatric or gastrointestinal complaints. Understands how OSA/UARS causes sleep bruxism[6] and a forward head posture and contributes to misalignment of the cranium-cervical-mandible and this in turn creates conditions that can cause TMD.

v. Psychiatrist who understands how severe psychiatric illness is primarily caused by undiagnosed and untreated sleep breathing disorders and that many psychiatric medications commonly prescribed to patients with severe psychiatric illness worsen OSA by compromising airway patency and thereby inducing brain injury and metabolic dysregulation, i.e. atypical antipsychotics[7].

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[5] https://aasm.org/aasm-clarifies-hypopnea-scoring-criteria/

[6] Simmons JH. Neurology of sleep and sleep-related breathing disorders and their relationships to sleep bruxism. J Calif Dent Assoc. 2012 Feb;40(2):159-67. PMID: 22416635.

[7] References to substantiate the OSA-Psych statement:

Prevalence of OSA in People with Severe Psychiatric Disease:

Knechtle, B. et al. (2019). Clinical Characteristics of Obstructive Sleep Apnea in Psychiatric Disease. *Journal of clinical medicine*, *8*(4), 534. https://doi.org/10.3390/jcm8040534

80-90% of people with OSA Undiagnosed:

Chen, L. et al. (2021). Validation of the STOP-Bang questionnaire for screening of obstructive sleep apnea in the general population and commercial drivers: a systematic review and meta-analysis. Sleep & breathing = Schlaf & Atmung, 25(4), 1741–1751. https://doi.org/10.1007/s11325-021-02299-y

Psych meds worsen OSA:

Shirani, A. et al. (2011). The impact of atypical antipsychotic use on obstructive sleep apnea: a pilot study and literature review. *Sleep medicine*, *12*(6), 591–597. https://doi.org/10.1016/j.sleep.2010.12.013

Khazaie, H. et al. (2018). A weight-independent association between atypical antipsychotic medications and obstructive sleep apnea. *Sleep & breathing = Schlaf & Atmung*, *22*(1), 109–114. https://doi.org/10.1007/s11325-017-1537-y

Rohatgi, R. et al. (2018). Is obstructive sleep apnea the missing link between metabolic syndrome and second-generation antipsychotics: Preliminary study. Indian journal of psychiatry, 60(4), 478–484. https://doi.org/10.4103/psychiatry.IndianJPsychiatry_105_18

OSA causes extensive brain injury:

Ronald M. Harper, et al. (2012). Functional Neuroanatomy and Sleep-Disordered Breathing: Implications for Autonomic Regulation. The Anatomical Record. 295; 1385-1395.

See Also, Sean Smith's Petition for Judicial Review, EXHIBIT B, Pg. 37-65 for further review of relevant scientific studies.

vi. Physical therapist who understands TMD and it's relationship to the airway, vision, and ambulation, and how those variables can contribute or cause musculoskeletal dysfunction and how MSK dysfunction can negatively impact the nervous system and how the experience and impact of chronic pain varies between people in general and between males and females. i.e. educator Dr. Ron Hruska at the Postural Restoration Institute.

vii. Pathologist/Coroner who at least understands the basics of OSA, MCAS, and dysautonomia and who will work with the above specialists to understand what it is they need to look for to determine cause of death as it relates to the health conditions that cause my disabilities (TMD, MCAS, OSA, Dysautonomia, MSK dysfunction, history of metal toxicity and malnutrition and sarcopenia and loss of ability to exercise, etc).

Dated March 4th 2024

Sincerely,
Sean Smith
Sean P. Smith 3,4, 2024