RATEMYVSO RESEARCH SHEET

SECONDARY SERVICE CONNECTION • 38 C.F.R. § 3.310

SLEEP APNEA SECONDARY TO DEPRESSION & ANXIETY

Three diagnoses. Three datasets. One evidence framework.

PRIMARY DISABILITY
SERVICE-CONNECTED DEPRESSION OR ANXIETY

CAUSES OR AGGRAVATES →

SECONDARY • DC 6847
SLEEP APNEA

BOARD RESEARCH SNAPSHOT

Production shards generated August 10, 2026

KEEP EACH DIAGNOSIS IN ITS OWN DATA LANE

DC 9434 MAJOR DEPRESSIVE DISORDER

64% GRANTED AMONG DECIDED ISSUES

438 ÷ (438 granted + 242 denied)

438	Granted	26.8%
922	Remanded	56.4%
242	Denied	14.8%
34	Other	2.1%

1,636 total published issues

DC 9435 DEPRESSIVE DISORDER

77% GRANTED AMONG DECIDED ISSUES

162 ÷ (162 granted + 48 denied)

162	Granted	51.3%
104	Remanded	32.9%
48	Denied	15.2%
2	Other	0.6%

316 total published issues

DC 9400 ANXIETY DISORDER

56% GRANTED AMONG DECIDED ISSUES

63 ÷ (63 granted + 50 denied)

63	Granted	29.6%
96	Remanded	45.1%
50	Denied	23.5%
4	Other	1.9%

213 total published issues

DO NOT ADD THESE TOTALS TOGETHER. They are separate diagnostic-code pairings and have not been deduplicated across decisions. Each merits percentage uses only that lane's granted and denied issues. Remands are not losses.

CAUSED VERSUS AGGRAVATED

WHAT THE CLASSIFIED GRANTS SAY

PAIRING	CLASSIFIED COVERAGE	CAUSED	AGGRAVATED
MAJOR DEPRESSIVE DISORDER	437 of 438 • 99.8%	371 84.9%	66 15.1%
DEPRESSIVE DISORDER	162 of 162 • 100%	135 83.3%	27 16.7%
ANXIETY DISORDER	53 of 63 • 84.1%	51 96.2%	2 3.8%

Classification coverage matters: 1 major-depression grant and 10 anxiety grants were not classified as caused or aggravated from the available decision text.

THE LEGAL FRAMEWORK

THE FILE STILL NEEDS ALL THREE ELEMENTS

01 CURRENT SLEEP APNEA
A clinician-confirmed diagnosis supported by a sleep study.

02 SERVICE-CONNECTED MENTAL HEALTH CONDITION
The exact primary diagnosis and diagnostic code should match the veteran's award and medical record.

03 CASE-SPECIFIC MEDICAL NEXUS
A qualified opinion explains causation or aggravation in this veteran, not merely an association.

SHARED SYMPTOMS ARE NOT PROOF. Fatigue, poor sleep, concentration problems, and depressed mood can overlap. The diagnosis and nexus must distinguish the conditions.

POTENTIAL MEDICAL PATHWAYS

Theory is not evidence until it is applied to the record

NAME THE CHAIN, THEN SUPPORT EVERY LINK

1 MEDICATION AND WEIGHT
Some psychiatric medications are associated with weight gain. A provider must identify the medication, timing, documented change, and its role in this veteran's OSA.

2 FUNCTION AND ACTIVITY
Symptoms may affect activity, eating, or weight. The record must show the actual sequence rather than assume it from the diagnosis.

3 SLEEP AND AIRWAY EFFECTS
Sleep disruption and sedating effects may be discussed, but the opinion must explain how they relate to obstructive airway collapse.

4 AGGRAVATION
If OSA already existed, the provider should identify whether the mental health condition or its treatment produced measurable worsening.

CLINICAL CONTEXT
Research supports substantial coexistence and a potentially bidirectional relationship among OSA, depression, and anxiety. Evidence about direction and mechanism is not uniform. Population findings support clinical evaluation, not an automatic nexus.

BUILD THE INDIVIDUAL RECORD

MAKE THE MEDICAL SEQUENCE VISIBLE

1 MENTAL HEALTH BASELINE
Diagnosis, service connection, symptom history, functioning, activity, and weight before treatment.

2 TREATMENT CHANGES
Medication names, dates, doses, side effects, weight change, sedation, and adherence.

3 OSA SYMPTOM ONSET
Dated reports of snoring, gasping, breathing pauses, fatigue, and witnessed changes.

4 OBJECTIVE DIAGNOSIS
Sleep study, apnea type, AHI or REI, oxygen findings, PAP prescription, and follow-up.

5 MEDICAL NEXUS
Correct facts, competing risk factors, literature applied to the veteran, and separate answers for causation and aggravation.

NEXUS QUALITY CHECK

THE OPINION SHOULD ANSWER SIX QUESTIONS

1. What is the exact service-connected diagnosis and code?
2. Did sleep apnea begin before or after the mental health condition and its treatment?
3. What specific pathway connects the two conditions in this record?
4. How were BMI, anatomy, age, smoking, diabetes, and other risks considered?
5. Does the evidence support causation, aggravation, or neither?
6. If aggravation is claimed, what evidence shows worsening beyond ordinary progression?

COMMON BREAK POINTS

WHY SIMILAR CLAIMS PRODUCE DIFFERENT OUTCOMES

STRONGER RECORD

- Exact mental health diagnosis is identified
- Medication, activity, weight, and symptoms form a dated timeline
- Sleep study confirms current OSA
- Opinion addresses competing risk factors
- Causation and aggravation receive separate analysis

WEAKER RECORD

- Depression and anxiety are treated as interchangeable
- Opinion relies only on coexistence or shared symptoms
- Medication or weight pathway is asserted without records
- Generic literature is not applied to the veteran
- Alternative causes or aggravation are ignored

READ THE RECORD, NOT THE ODDS
These are descriptive patterns in published Board decisions. Board decisions are not binding precedent, remands are not final merits decisions, and the data does not predict any individual claim.

Clinical context: Garbarino et al., Behav Sleep Med. 2020, PMID 30453780; Du et al., J Psychiatr Res. 2024, PMID 38430795; Bak et al., Obes Rev. 2019, PMID 31524318. Educational use only. Not legal or medical advice.

MENTAL HEALTH PAIRINGS