RATEMYVSO RESEARCH SHEET

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

SLEEP APNEA SECONDARY TO DIABETES

Identify the pathway first. Then document every link in the chain.

PRIMARY • DC 7913	CAUSES OR AGGRAVATES	SECONDARY • DC 6847
SERVICE-CONNECTED DIABETES MELLITUS	→	SLEEP APNEA

BOARD RESEARCH SNAPSHOT

DC 7913 » DC 6847 • shard generated August 10, 2026

744 PUBLISHED ISSUES ON THIS EXACT PAIRING

DECIDED ISSUES

49%

GRANTED

207 ÷ (207 granted + 216 denied)

GRANTED	207 issues	27.8%
REMANDED	308 issues	41.4%
DENIED	216 issues	29.0%
OTHER	13 issues	1.7%

TWO DIFFERENT DENOMINATORS: 27.8% is granted among all 744 issues. 49% is granted among the 423 issues decided granted or denied. Remands are shown separately and are not losses.

HOW THE CLASSIFIED GRANTS WON

206 of 207 grants classified • 99.5% coverage

CAUSATION LED, BUT AGGRAVATION REMAINS SEPARATE

180 GRANTS	CAUSED BY DIABETES	87.4%

26 GRANTS	AGGRAVATED BY DIABETES	12.6%

1 GRANT UNCLASSIFIED — 206 of 207 grants were identified as caused or aggravated from available decision text. The nexus opinion should answer both legal paths separately.

CHOOSE THE MEDICAL ROUTE

Do not mix them into one vague theory

THREE PATHWAYS REQUIRE THREE DIFFERENT RECORDS

1 OBESITY AS AN INTERMEDIATE STEP

DIABETES OR TREATMENT → WEIGHT → OSA

Document how diabetes or its treatment caused or aggravated obesity, then explain how obesity was a substantial factor in causing or worsening obstructive sleep apnea.

Every link needs medical and factual support

2 DIRECT NEUROPATHY THEORY

NEURAL CONTROL OR AIRWAY REFLEXES

A specialist may discuss diabetic autonomic or peripheral neuropathy and breathing control. The opinion must identify findings in this veteran rather than rely on a general association.

Obesity is not the only possible theory

3 AGGRAVATION OF EXISTING APNEA

MEASURABLE WORSENING

If apnea already existed, the opinion should identify whether diabetes, treatment, neuropathy, or weight change worsened it beyond ordinary progression.

Causation and aggravation are separate questions

ASSOCIATION IS NOT A NEXUS. Diabetes and OSA commonly coexist. The claim still needs an individualized explanation connecting the service-connected diabetes to the diagnosed apnea.

THE EVIDENCE CHAIN

Use the pathway that actually fits the veteran

MAKE EACH STEP TESTABLE AGAINST THE RECORD

01 DIABETES BASELINE
Diagnosis, service connection, duration, glycemic control, complications, and treatment history.

02 INSULIN OR MEDICATION TIMELINE
Names, dates, doses, treatment changes, documented effects, and clinical reasoning.

03 WEIGHT OR NEUROPATHY EVIDENCE
Use dated measurements, counseling records, neurological findings, and specialist assessments.

04 SLEEP APNEA ONSET
Symptoms, sleep study, apnea type, AHI or REI, oxygen findings, PAP treatment, and progression.

CLINICAL CONTEXT

A large BMI-matched cohort found a 48% higher adjusted rate of incident OSA in people with type 2 diabetes. Reviews describe a potentially bidirectional relationship and possible roles for diabetic neuropathy. These findings support evaluation and a medical rationale, not automatic causation.

BUILD THE INDIVIDUAL FILE

SIX RECORD GROUPS SHOULD TELL ONE STORY

1 DIABETES RECORDS
Diagnosis, rating decision, A1C history, complications, and longitudinal treatment.

2 MEDICATION HISTORY
Insulin and other therapies, timing, dose, side effects, and documented weight effects.

3 WEIGHT TIMELINE
Dated measurements, counseling, diet, activity, functional limitations, and alternative causes.

4 NEUROPATHY FINDINGS
Autonomic or peripheral neuropathy diagnoses, testing, symptoms, and specialist interpretation.

5 SLEEP STUDY
Apnea type, AHI or REI, oxygen findings, interpretation, PAP prescription, and follow-up.

6 NEXUS OPINION
Correct facts, individualized mechanism, literature applied to the file, and both legal paths.

NEXUS QUALITY CHECK

CAN THE OPINION ANSWER THESE QUESTIONS?

1. **Which exact pathway is being claimed: weight, neuropathy, or aggravation?**
2. **Did the opinion use the veteran's actual medication, weight, and symptom timeline?**
3. **If obesity is intermediate, were both causal links analyzed?**
4. **Does the sleep study identify obstructive, central, or mixed apnea?**
5. **Were anatomy, age, activity, diet, and other competing risks addressed?**
6. **Were causation and aggravation answered separately with full rationales?**

COMMON BREAK POINTS

WHAT SEPARATES A COMPLETE CHAIN FROM A GUESS

STRONGER RECORD

- Diabetes is already service connected
- Sleep study confirms current apnea and type
- The medical pathway is stated precisely
- Every intermediate link has dated evidence
- Alternative risks and aggravation are addressed

WEAKER RECORD

- Diabetes and sleep apnea merely coexist
- Weight gain is assumed without a treatment timeline
- Neuropathy is discussed without individual findings
- Generic literature replaces case-specific reasoning
- 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: Subramanian et al., Diabetes Care. 2019, PMID 30626657; Reutrakul and Mokhlesi, Chest. 2017, PMID 28527878; Pontiroli et al., Diabetes Obes Metab. 2011, PMID 21645159.