RATEMYVSO RESEARCH SHEET

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

SLEEP APNEA SECONDARY TO TBI RESIDUALS

The apnea type, injury history, and medical mechanism must line up.

PRIMARY • DC 8045	CAUSES OR AGGRAVATES	SECONDARY • DC 6847
SERVICE-CONNECTED TBI RESIDUALS	→	SLEEP APNEA

BOARD RESEARCH SNAPSHOT

225 PUBLISHED ISSUES ON THIS EXACT PAIRING

DC 8045 » DC 6847 • shard generated September 23, 2026

DECIDED ISSUES

58%

GRANTED

59 ÷ (59 granted + 42 denied)

GRANTED	59 issues	26.2%
REMANDED	123 issues	54.7%
DENIED	42 issues	18.7%
OTHER	1 issue	0.4%

TWO DIFFERENT DENOMINATORS: 26.2% is granted among all 225 issues. 58% is granted among the 101 issues decided granted or denied. Remands are shown separately and are not losses.

HOW THE GRANTS WON

ALL 59 GRANTS WERE CLASSIFIED

54 GRANTS	CAUSED BY TBI RESIDUALS	91.5%

5 GRANTS	AGGRAVATED BY TBI RESIDUALS	8.5%

100% CLASSIFICATION COVERAGE

59 of 59 grants were identified as caused or aggravated. The nexus opinion should still answer both legal paths separately.

THE DIAGNOSTIC FORK

START WITH THE TYPE OF SLEEP APNEA

The sleep study controls this question

CSA CENTRAL SLEEP APNEA

BREATHING SIGNAL

The brain temporarily does not send the expected breathing signal. A neurological theory must identify injury findings and explain why they affect respiratory control.

Focus: neurological control and apnea classification

OSA OBSTRUCTIVE SLEEP APNEA

UPPER AIRWAY

The airway narrows or collapses during sleep. The opinion must explain how TBI residuals, treatment, activity, weight, or another documented pathway affects airway obstruction.

Focus: airway mechanism and intermediate steps

MIX MIXED OR COMPLEX PATTERN

BOTH COMPONENTS

If both central and obstructive events appear, the specialist should identify which component is medically linked to TBI and which alternative factors remain relevant.

Focus: distinguish each component

DO NOT BUILD THE THEORY FROM THE LABEL ALONE. The sleep study, its interpretation, and the diagnosing clinician's records should establish the apnea type.

POTENTIAL MEDICAL PATHWAYS

THE OPINION MUST TRACE A SUPPORTED CHAIN

Clinical association is not automatic secondary service connection

01 NEUROLOGICAL CONTROL
For central events, identify the affected neurological system and connect the documented injury to disordered breathing control.

02 ACTIVITY AND WEIGHT
If TBI residuals reduced activity or contributed to weight change, document every step and address other causes.

03 MEDICATION EFFECTS
Identify the medication, indication, dose, timing, and medically supported effect rather than referring to treatment in general.

04 AGGRAVATION
If apnea predated the TBI or residuals, identify measurable worsening beyond ordinary progression and explain the mechanism.

CLINICAL CONTEXT

A 2025 scoping review found OSA prevalence ranging from 20% to 77% across TBI cohorts, but the limited comparison studies did not show significant differences from non-TBI groups. A large VA cohort found TBI associated with increased later sleep-apnea diagnoses. These findings support screening and evaluation, not automatic causation.

BUILD THE INDIVIDUAL RECORD

MAKE SIX ANCHORS EASY TO FOLLOW

1. **INJURY** — Date, mechanism, severity, loss or alteration of consciousness, imaging, and acute treatment.
2. **TBI RESIDUALS** — Service-connection decision, neurological findings, cognition, function, headaches, and rehabilitation.
3. **MEDICATIONS** — Names, dates, doses, sedating effects, weight effects, and treatment changes.
4. **SLEEP SYMPTOMS** — Onset of snoring, gasping, breathing pauses, hypersomnia, fatigue, and witnessed observations.
5. **SLEEP STUDY** — Apnea type, AHI or REI, central-event index, oxygen findings, interpretation, and PAP plan.
6. **NEXUS OPINION** — Correct facts, individualized mechanism, literature applied to the file, alternative risks, and both legal paths.

NEXUS QUALITY CHECK

CAN THE OPINION ANSWER THESE QUESTIONS?

1. **What exact TBI residual is claimed to affect breathing during sleep?**
2. **Does the sleep study show obstructive, central, mixed, or treatment-emergent events?**
3. **Did the opinion distinguish sleep disturbance from sleep apnea?**
4. **How were BMI, anatomy, age, medications, PTSD, and other risk factors considered?**
5. **Was general research applied to this injury, timeline, and testing?**
6. **Were causation and aggravation answered separately with full rationales?**

COMMON BREAK POINTS

WHAT SEPARATES A THEORY FROM A SUPPORTED CLAIM

STRONGER RECORD

- TBI residuals are already service connected
- Sleep study identifies the apnea type
- Injury, residuals, symptoms, and diagnosis form a dated sequence
- Opinion explains the physiology in this veteran
- Alternative risks and aggravation are addressed

WEAKER RECORD

- TBI and sleep apnea merely coexist
- Sleep problems are treated as proof of apnea
- Central and obstructive apnea are confused
- Generic literature replaces individualized reasoning
- Weight, anatomy, medications, or other risks 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: Wickwire et al., Laryngoscope. 2025, PMID 40637502; Leng et al., Neurology. 2021, PMID 33658328.

NEUROLOGICAL PAIRING