BOARD OF VETERANS' APPEALS

FOR THE SECRETARY OF VETERANS AFFAIRS

IN THE APPEAL OF [redacted] Docket No. 250318-525729

Represented by
Gordon A. Graham, Agent

DATE: January 5, 2026

ORDER

1. Entitlement to service connection for diabetes mellitus type II (DM II), to include diabetic complications, is granted as secondary to service-connected disabilities.

2. Entitlement to service connection for obstructive sleep apnea (OSA) is granted as secondary to service-connected disabilities.

FINDINGS OF FACT

1. The Veteran's DM II is caused or aggravated by service-connected disabilities.

2. The Veteran's OSA is caused or aggravated by service-connected disabilities.

CONCLUSIONS OF LAW

1. The criteria for service connection of DM II as secondary to service-connected disabilities have been met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.310.

2. The criteria for service connection of OSA as secondary to service-connected disabilities have been met. 38 U.S.C. §§ 1110, 1131, 5107; 38 C.F.R. §§ 3.102, 3.310.

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

The Veteran had active service in the United States Air Force from May 1972 to January 1979, from December 1990 to July 1991, and from October 2000 to March 2001, with military occupation specialties (MOS) of Calibration Specialist, Central Office Repairman, Chief Field Maintenance, Operations Staff Officer, and Security Forces Officer.

This matter comes before the Board of Veterans' Appeals (Board) on appeal from a January 2025 rating decision issued by the Agency of Original Jurisdiction (AOJ), a Department of Veterans Affairs (VA) Regional Office (RO).

In the March 2025 VA Form 10182, Decision Review Request: Board Appeal (Notice of Disagreement), the Veteran elected the Direct Review docket. Therefore, the Board may only consider the evidence of record at the time of the January 2025 AOJ decision on appeal. 38 C.F.R. § 20.301. Any evidence submitted after the AOJ decision on appeal cannot be considered by the Board. 38 C.F.R. §§ 20.300, 20.301, 20.801.

Secondary Service Connection

The Veteran seeks service connection for DM II and OSA as secondary to his service-connected disabilities.

Secondary service connection is appropriate when a service-connected disability causes another disability. 38 U.S.C. §§ 1110, 1131; 38 C.F.R. § 3.310. The three-element test for secondary service connection requires evidence of (1) a current disability; (2) a service-connected disability; and (3) a causal relationship between the current disability and the service-connected disability. Additional disability resulting from the aggravation of a nonservice-connected condition by a service-connected condition is compensable. 38 U.S.C. §§ 1110, 1131; 38 C.F.R. § 3.310; *Allen v. Brown*, 7 Vet. App. 439, 448 (1995).

Causal Relationship

As for the *third element of secondary service connection*, obesity may be an 'intermediate step' between a service-connected disability and a claimed disability that may be otherwise service connected on a secondary basis. *Walsh v. Wilkie*, 32 Vet. App. 300, 303 (2020); VAOPGCPREC 1-2017 (Jan. 6, 2017). When adjudicating a claim for secondary service connection with obesity as an intermediate step, the Board must answer (a) whether the service-connected condition caused the veteran to become obese; (b) if so, whether the obesity as a result of the service-connected disability was a substantial factor in causing the disability for which secondary service connection is sought; and (c) whether the condition for which secondary service connection is sought would not have occurred but for the obesity caused by the service-connected disability. Walsh at 306-7. This inquiry extends both to causation and to aggravation. *Id*. at 305.

1. Entitlement to service connection for DM II, to include diabetic complications, is granted as secondary to service-connected disabilities.

The first element of secondary service connection is met. The Veteran has current diagnoses of DM II and bilateral diabetic peripheral neuropathy. *See* December 2024 VA Diabetes Mellitus and Diabetic Sensory-Motor Peripheral Neuropathy DBQs. Therefore, he has a current disability. The second element of secondary service connection is also met. The Veteran is service connected for hepatitis C (HCV) and right-knee degenerative joint disease. The issue in this appeal is whether the Veteran's DM II is caused or aggravated by his service-connected disabilities with obesity as a determinative intermediate step between the two.

The Board concludes that it is.

In December 2024, a VA contract exam was conducted to assess the etiology of the Veteran's DM II. The exam included a questionnaire, in-person evaluation, records review, and lab studies. The examiner (D.K.) confirmed diagnoses of DM II and bilateral diabetic peripheral neuropathy. DM II was first detected in 2017 during a routine exam, and bilateral diabetic peripheral neuropathy was identified in 2019, also during a routine check-up. The Veteran reported no specific symptoms at the time of diagnosis. He had been treated for DM II with Metformin and Trulicity, and

for neuropathy with Pregabalin. While the course of DM II remained stable, the neuropathy had progressively worsened, causing bilateral lower extremity pain, numbness, and tingling, more severe on the left side. Treatment included Ozempic, Jardiance, diabetic shoes, and socks for DM II, and Pregabalin 300 mg TID for neuropathy. Neuropathy impacted his ability to walk, stand for long periods, and maintain balance. *See* December 2024 VA Diabetes Mellitus DBQ.

D.K. concluded that the current medical literature did not support a *direct causal link* between hepatitis C (including advanced liver disease, F4 fibrosis, cirrhosis) and DM II. They explained that DM II develops primarily due to insulin resistance and beta-cell dysfunction. They noted that increased insulin secretion maintains glucose balance initially, but over time, beta-cell changes lead to inadequate insulin production and hyperglycemia. They further indicated that risk factors for DM II include age over 45, *rising obesity*, *physical inactivity*, and energy-dense diets. They also explained that *most patients are obese or have excess abdominal fat*, which promotes insulin resistance through inflammatory mechanisms (e.g., increased free fatty acid release and adipokine dysregulation). Despite these associations, D.K. emphasized that establishing a secondary-service connection between hepatitis C and DM II is unlikely due to the absence of evidence for a *direct causal relationship*. *See* December 2024 VA Medical Opinion DBQ.

The Board finds D.K.'s opinion probative because it is based on a thorough review of medical literature, explains the pathophysiology and risk factors of DM II in detail, and provides a clear rationale for why a *direct causal link* to hepatitis C is unsupported.

In July 2024, the Veteran submitted an independent medical opinion (IMO) from Dr. M.R. in support of his claim. Dr. M.R. concluded that the Veteran's DM II was caused or aggravated by his service-connected obesity and metabolic syndrome.

First, Dr. M.R. explained that the Veteran's obesity was linked to his service-connected disabilities, particularly chronic pain from his right knee condition and the treatment of HCV with Harvoni. Medical records showed that the Veteran began gaining weight after service, with significant weight gain occurring after 2017 following Harvoni treatment. Dr. M.R. cited peer-reviewed studies indicating that weight gain is common after direct-acting antiviral therapy, even among

patients who were overweight or obese prior to treatment. Additionally, they found that chronic knee pain contributed to physical inactivity, further exacerbating weight gain and leading to obesity. *See* July 2024 IMO.

Second, Dr. M.R. indicated that obesity was a substantial factor in causing DM II. The opinion emphasized that obesity is a major risk factor for metabolic syndrome, which includes conditions such as hypertension and DM II. Dr. M.R. referenced medical literature showing a strong association between metabolic syndrome and the development of DM II, concluding that the Veteran's obesity, aggravated by his service-connected conditions, was a significant contributor to his current disability. *See id.*

Finally, Dr. M.R. opined that the Veteran's DM II would not have occurred but for the obesity caused or aggravated by his service-connected disabilities. The opinion stressed that the Veteran's weight gain and subsequent obesity were directly linked to Harvoni treatment and chronic knee pain. Therefore, Dr. M.R. concluded that DM II was clearly and unmistakably aggravated by service-connected obesity and metabolic syndrome. *Id.*

The Board finds Dr. M.R.'s opinion probative because it provides a detailed, well-supported rationale linking the Veteran's service-connected conditions to obesity and metabolic syndrome and explains how these factors substantially contributed to the development and aggravation of DM II.

Although D.K. stated that medical literature does not support a direct causal link between hepatitis C and DM II, their opinion reinforces Dr. M.R.'s conclusion. D.K. explained that DM II develops primarily due to insulin resistance and beta-cell dysfunction and highlighted that obesity and physical inactivity are major risk factors for DM II. They noted that most patients with DM II are obese and that abdominal fat promotes insulin resistance through inflammatory mechanisms. D.K. also identified hypertension, dyslipidemia, and metabolic changes as contributing factors (i.e., conditions central to metabolic syndrome).

This analysis aligns with Dr. M.R.'s opinion that the Veteran's service-connected disabilities caused or aggravated his obesity, which then substantially contributed to DM II. Thus, while D.K. rejected a *direct* nexus, their discussion of obesity and

metabolic pathways *indirectly* supports Dr. M.R.'s conclusion that DM II resulted from obesity linked to service-connected disabilities. *Compare* December 2024 VA Medical Opinion DBQ *with* July 2024 IMO.

Upon review of the record, the Board concludes that the relevant medical evidence persuasively weighs in favor of finding that the Veteran's DM II was caused or aggravated by his service-connected disabilities. The third element of service connection is met. Accordingly, entitlement to service connection for DM II, to include diabetic complications, is granted on a secondary basis.

2. Entitlement to service connection for OSA is granted as secondary to service-connected disabilities.

The first element of secondary service connection is met. The Veteran was formally diagnosed with mild OSA, confirmed by a July 2011 VA sleep study. Therefore, he has a current disability. The second element of secondary service connection is also met. The Veteran is service connected for HCV and right-knee degenerative joint disease. The issue is whether the Veteran's OSA is caused or aggravated by his service-connected disabilities with obesity as a determinative intermediate step between the two.

The Board concludes that it is.

As discussed, the probative medical evidence weighs in favor of finding that the Veteran's obesity is caused or aggravated by medication used to treat his service-connected HCV and inactivity resulting from his service-connected chronic right knee pain. *See* July 2024 IMO.

In December 2024, D.K. opined that the Veteran's OSA was less likely due to his service-connected HCV with residuals, including advanced liver disease, F4 fibrosis, and cirrhosis. D.K. reviewed the claims file and relevant medical literature and found no evidence of a *direct* causal relationship between HCV and OSA. The rationale explained that pharyngeal narrowing and airway collapse during sleep are complex processes influenced by multiple factors, including reduced ventilatory drive, neuromuscular changes, and anatomical risk factors such as large neck circumference and surrounding soft tissue. These factors were said to increase

pressure on the upper airway, leading to collapsibility and obstruction during sleep. D.K. noted that the most common causes of OSA in adults are *obesity*, male sex, and advancing age, *with severity often related to body mass index*. The opinion emphasized that anatomical and neuromuscular factors, rather than HCV or its residuals, drive the pathogenesis of OSA. Therefore, D.K. concluded that establishing a secondary-service nexus was unlikely because medical literature does not support a *direct* causal link between HCV and OSA. *See* December 2024 VA Medical Opinion DBQ.

The Board finds D.K.'s opinion probative because it is based on a comprehensive review of the Veteran's medical records and relevant medical literature, and it provides a clear, well-supported rationale explaining that OSA is primarily caused by anatomical and neuromuscular factors (e.g., obesity, male sex, age).

In July 2024, Dr. M.R. opined that the Veteran's OSA was caused or worsened by his service-connected obesity. The Veteran was initially diagnosed with mild OSA before 2020 following a sleep study and was not prescribed CPAP at that time. Due to persistent symptoms of sleep fragmentation and snoring, a second sleep study was conducted in July 2021, which revealed moderate OSA with an Apnea-Hypopnea Index (AHI) of 26.4 and episodes of hypoxia with oxygen saturation below 80 percent. These findings improved with CPAP therapy, which was subsequently prescribed and alleviated the Veteran's symptoms. *See* July 2024 IMO.

Dr. M.R. emphasized that obesity is a significant risk factor for OSA, citing medical studies that demonstrate a strong association between body weight and OSA risk. The opinion explained that obesity contributes to increased fat deposits in the neck, which narrow the airway and promote obstruction during sleep. The IMO documented the Veteran's BMI progression over time: 27.4 in 2011 and 29.1 in 2012, both in the overweight range; a gap in data until 2020, when BMI remained at 29; and a marked increase to 33 in 2021, classifying him as Stage 1 obese. This increase coincided with his referral to the VA MOVE program for weight management. Although BMI slightly decreased to 32 in 2022, the Veteran remained in the Stage 1 obesity category. Dr. M.R. concluded that this progression in BMI and the associated anatomical changes substantially contributed to the development and worsening of OSA. *See id.*

The Board finds Dr. M.R.'s opinion probative because it is grounded in a comprehensive review of the Veteran's medical history, supported by clinical data and medical literature, and provides a clear, logical rationale linking service-connected obesity to the development and worsening of OSA. Dr. M.R. explained that obesity is a well-established risk factor for OSA due to increased fat deposits in the neck that narrow the airway and promote obstruction during sleep. Importantly, the opinion is consistent with the Veteran's historical BMI progression, which demonstrates a correlation between weight gain and the severity of OSA. The Veteran's BMI increased from 27.4 in 2011 and 29.1 in 2012 (overweight range) to 33 in 2021 (Stage 1 obesity), coinciding with the progression of OSA from mild to moderate severity as confirmed by sleep studies. This temporal relationship between rising BMI and worsening OSA symptoms strengthens Dr. M.R.'s conclusion that obesity substantially contributed to the Veteran's OSA, making the opinion well-supported, persuasive, and highly probative.

Upon review of the record, the Board concludes that the relevant medical evidence persuasively weighs in favor of finding that the Veteran's OSA was caused or aggravated by his service-connected disabilities. The third element of service connection is met. Accordingly, entitlement to service connection for OSA is granted.

D. C. JOHNSON
Acting Veterans Law Judge
Board of Veterans' Appeals

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The Board's decision in this case is binding only with respect to the instant matter decided. This decision is not precedential and does not establish VA policies or interpretations of general applicability. 38 C.F.R. § 20.1303.