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Dept. Of Veterans Affairs
Board of Veterans Appeals
Litigation and Support Group
P.O. Box 27063
Washington, DC 20038

July 25, 2022

Re: [redacted]

Extra Pages for VAF 10182

The Veteran, through counsel, now files his Notice of Disagreement with the rating decision (RD) dated variously on April 21, 2021, March 28, 2022, the Higher Level of Review (HLR) decision dated 4/25/2022 and the latest confirmed and continued denial of July 15, 2022.

The Appellant has continuously appealed his denial of service connection for Obstructive Sleep Apnea (OSA) under 38 CFR §4.97 DC 6847 since the original September 17, 2020, filing of his VA Form 21-526.

A short history of the claim is summarized here for the trier of fact.

History of the Instant Appeal

9/17/2020—Veteran files for sleep apnea and sleep disturbances not otherwise specified secondary to PTSD under . §3.310(a).

10/09/2020—VA c&p exam for sleep apnea (entered in VBMS 4/20/2021).

4/20/2021—VA Independent Medical Opinion by Peter D. Morris, M.D. diagnoses OSA with progression from mild to moderate. Clinician diagnoses OSA as "disease with a clear and specific etiology" but not related to a specific toxic environmental exposure event in Southwest Asia-i.e., MUCMIs.

4/21/2021—RD denies entitlement to SC for OSA on a direct basis under §3.303(a) but does not reach a determination under §3.310(a).

1/28/2022—Veteran files supplemental claim disagreeing with 4/21/2021 RD and submits private subject matter expert IMO diagnosing OSA on a secondary basis to PTSD with AUD.

2/02/2022—VA 21-2507 requests IMO as to whether it is at least as likely as not that the diagnosed OSA is related to or caused by the sleep apnea diagnosed in service.

2/25/2022—Clinician (NP) diagnoses OSA several years after separation and opines there is no diagnosis linking OSA to Active Duty on a direct basis only.

3/23/2022—ACE review on 3/11/2022 with restatement of opinion as to whether it is at least as likely as not the OSA is proximately due to PTSD with AUD. NP clinician opines "medical literature does not support an association between OSA and PTSD.

3/28/2022—RD confirms and continues denial of OSA secondary to PTSD with AUD.

3/29/2022—Veteran files VA 20-0996 request for Higher Level of Review.

5/16/2022—VA 21-2507 exam request for ACE review to determine if OSA is due to secondary service connection via obesity as contended by the Veteran's representative and/or private IMO subject matter expert.

5/31/2022—ACE review of records by nurse practitioner opines that "medical records fail to show that conditions of PTSD and allergic rhinitis aggravated the veteran's OSA w/ obesity. Medical records fail to show the association of these conditions during AD [active duty] with OSA".

7/15/2022—RD confirms and continues denial of OSA secondary to PTSD with AUD on a direct basis. RD attributes OSA thusly: " Given Veteran is obese, this is the majority cause of sleep apnea."

Legal Standard of Review

The Court of Appeals for Federal Claims (CAFC) held in **Shedden v. Principi,** 381 F.3d 1163, 1166 -67 (Fed. Cir. 2004) that service connection may be granted for disability resulting from disease or injury incurred in or aggravated by active service. 38 U.S.C. §§1110, 1131, 5107; 38 C.F.R. §3.303. The three-element test for service connection requires evidence of: (1) a current disability; (2) in-service incurrence or aggravation of a disease or injury; and (3) a causal relationship between the current disability and the in-service disease or injury.

These tenets were reaffirmed in succeeding Courts to include, inter alia, ***Martinez-Bodon v. Wilkie***, 32 Vet.App. 393, 397 (2020) and ***Romanowsky v. Shinseki*** , 26 Vet.App.289,293 (2013). The new Appeals Improvement Management Act (AMA) has in no way, shape, or form altered the strictures of principles of service connection.

The credibility and weight to be attached to medical opinions is within the providence of the Board as adjudicators. ***Guerrieri v. Brown***, 4 Vet. App. 467, 470-71 (1993). Greater weight may be placed on one physician's opinion over another depending on factors such as reasoning employed by the physicians and the extent to which they reviewed prior clinical records and other evidence. ***Gabrielson v. Brown***, 7 Vet. App. 36, 40 (1994).

Nieves-Rodriguez v. Peake, 22 Vet. App. 295, 301 (2008) held that a medical examination report must contain not only clear conclusions with supporting data, but also a reasoned medical explanation connecting the two); see also ***Stefl v. Nicholson***, 21 Vet. App. 120, 124 (2007) (stating that a medical opinion must support its conclusion with an analysis that the Board can consider and weigh against contrary opinions).

A VA medical examination report is entitled to no weight if it contains only data and conclusions. ***Id.*** at 304. Ludella Brown, DNP, NP-C opined on May 31, 2022, that medical records "fail to show that PTSD and allergic rhinitis aggravated the Veteran's OSA w/ obesity. Medical records fail to show the association of these conditions during AD [active duty] with OSA." This is the incorrect legal standard of review. §§3.303(a); 3.310(a).

The Decision Review Officer is limited by law to review an appeal based on the facts found. Undoubtedly, further medical inquiry can be undertaken with a view towards further developing the claim. However, in this regard, the Court has cautioned VA against seeking an additional medical opinion where favorable evidence in the record is unrefuted, and indicated that it would not be permissible to undertake further development if the sole purpose was to obtain evidence against an appellant's claim. See ***Mariano v. Principi***, 17 Vet. App. 305, 312 (2003). See also ***McLendon v. Nicholson***, 20 Vet.App. 79, 85 (2006 (In any event, the lack of medical evidence in service does not constitute substantive negative evidence).

Summary of Independent Medical Opinions

An in-person c&p examination dated 10/09/2020, (entered into VBMS on April 20, 2021), was completed by Peter D. Morris, M.D., Dr. Morris diagnosed the Appellant with OSA as of July 24, 2020. The Doctor opined the date of onset of the OSA was "10-15 years ago" which falls within the time of the Veteran's active duty service. Dr. Morris further noted a sleep study was accomplished on March 13, 2021, which confirmed a progression of the diagnosis from mild to

moderate OSA. However, when asked for a medical opinion as to whether the etiology of the OSA was due to MUCMI, Dr. Morris opined **only** that

"a specific, toxic, environmental exposure event in Southwest Asia would not cause OSA."

At no time was a medical condition of obesity noted, implied or diagnosed in the evidence of record (STRs). Appellant has never contended his OSA is due to a medically unexplained chronic multisymptom illness (MUCMI). Nowhere in the four corners of the VA's requested IMO did Dr. Morris opine on the relationship between OSA as being secondary to the Veteran's PTSD with AUD. For this reason, the IMO is of little probative value beyond acknowledging the favorable finding of fact that the Veteran began to suffer OSA before separation from active duty. See 38 USC §5110.

The Veteran, now represented by counsel and apprised of the need for a supportive medical nexus per ***Shedden*** *supra,* obtained his own opinion from a subject matter expert. [redacted], M.D., a board certified Internal Medicine specialist, opined that the Veteran's OSA was secondary to his service connected PTSD. Dr. [redacted]'s rationale was well-supported by no less than nineteen cites to peer-reviewed studies supporting the correlation between PTSD and the post-service OSA diagnosis. More importantly, on page three of her IMO, Dr. [redacted] points the Veterans Health Administration's VHA) very own peer-reviewed study which clearly and convincingly links OSA to PTSD. Dr. Rivero's cites clearly rebut a later VA clinician's medical opinion that avers there is no medical literature whatsoever linking the two comorbidities together. See ***Bell v. Derwinski,*** 2 Vet. App. 611, 613 (1992) (records generated by VA facilities that may have an impact on the adjudication of a claim are considered constructively in the possession of VA adjudicators during the consideration of a claim, regardless of whether those records are physically on file).

A second VA c&p medical exam and opinion was completed on February 18, 2022 by Ludella Brown, N.P. The VA 21-2507 instructions for the c&p exam were to clarify whether the current OSA claimed by the Appellant "is/are

at least as likely as not (50% or greater probability) incurred in or caused by the sleep apnea **during** service." The Nurse Practitioner opined that:

"medical records show that the Veteran was diagnosed with OSA several years **after** AD [active duty]; there is no nexus established."

This medical opinion completely ignores a prior favorable finding of fact by Dr. Peter Morris in his October 9, 2020, medical opinion that the Veteran suffered OSA *during* active duty on a direct basis. The date of the diagnosis is irrelevant.

A third VA March 11, 2022, Acceptable Clinical Evidence (ACE) IMO, again by Ludella Brown, NP, answered a clarification as to :

"whether any currently diagnosed condition(s) related to the Veteran's claimed sleep apnea, is/are at least as likely as not (50% or greater probability) proximately due to or the result of the Veteran's service connected post-traumatic stress disorder with alcohol use disorder."

Nurse Brown opined that:

"Medical literature does not support an association between OSA and PTSD-OSA results from a collapse of the upper airways during sleep-there is no nexus established. Records reviewed from Dr. [redacted]-obstructive sleep apnea due to post-traumatic stress disorder and DBQ 2/2022."

A May 16, 2022, VA 21-2507 request for yet a fourth c&p cited its precept now was to entertain a theory of remote etiology to include obesity in service:

"The POA raised the theory of entitlement that sleep apnea is secondary to or aggravated by the now SC allergic rhinitis. Although actual service connection for allergic rhinitis and this theory of entitlement occurred after the closed record, the POA is entitled to raise a new theory during the IC. In order to ensure that we have

fulfilled our full duty to assist this Veteran, please also request secondary and aggravation opinions as related to the allergic rhinitis. The claim for allergic rhinitis was received on 11/09/2021. Therefore it is conceivable that this is part of the record.

Medical opinion 1of 2) Please complete section four and state whether the Veteran's medical records support that claimed sleep apnea **with obesity**, is/are at least as likely as not (50% or greater probability) proximately due to or the result of the Veteran's Service connected disabilities…"

On May 31, 2022, VA completed its fourth request for "clarification" as to whether obstructive sleep apnea-*with obesity*- might be the proximate cause of OSA. Again, Ludella Brown, NP opined for the third time that:

"Medical records are insufficient to support a determination of baseline level of severity." And:

"Medical records fail to show that the conditions of PTSD and allergic rhinitis aggravated the veteran's OSA w/ obesity. Medical records fail to show the association of these conditions during AD [active duty] with OSA."

With regards to the above c&p IMO, Appellant points to the private IMO authored by Dr. [redacted] The VA examiner in the July 15, 2022, RD would have the trier of fact believe Appellant's counsel has alleged that the Veteran's current obesity may be the root cause of the OSA. Alternately, the Examiner would have the adjudicator believe the private IMO implies obesity as the probable culprit. There is only one reference discussing OSA in the setting of obesity(or, no obesity). On page 4, the peer-reviewed discussion states:

"There is a statistically significant association between PTSD symptoms and OSA in Veterans ***with and without*** obesity, per one peer-reviewed study of OEF/OIF/OND Veterans."

This representative has never implied or averred verbally, or in writing, that the Veteran's OSA might have an obesity etiology. The clinician and the Examiner have manufactured this finding of fact out of whole cloth. See ***Colvin***

v. Derwinski, 1 Vet.App. 171, 175 (1991) holding the Board is not required to accept the medical authority supporting a claim, it must provide its reasons for rejecting such evidence and, more importantly, must provide a medical basis other than its own unsubstantiated conclusions to support its ultimate decision. In the absence of a finding of fact that the Veteran was obese at any time during his active duty service, the rationale for the July 15, 2022, VA examiner's conclusions are unsupported and nothing more than post hoc rationalizations. See ***Martin v. Occupational Safety &Health Review Comm'n,*** 499 U.S. 144, 156 (1991) (explaining that "litigating positions' are not entitled to deference when they are merely appellate counsel's 'post hoc rationalizations' for prior agency action"). However, the Secretary's impermissible post-hoc rationale cannot make up for shortcomings in the Board's assessment of the medical opinion. See ***Doty v. United States***, 53 F.3d 1244, 1251 (Fed. Cir. 1995) ("'Courts may not accept appellate counsel's post hoc rationalizations for agency action. It is well established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself.'" (quoting ***Motor Vehicle Mfrs. Ass'n of the U.S., Inc., v. State Farm Mut. Auto. Ins. Co***., 463 U.S. 29, 50, 103 S. Ct. 2856, 77 L. Ed. 2d 443 (1983))); ***Evans v. Shinseki,*** 25 Vet.App. 7, 16 (2011) (explaining that "it is the Board that is required to provide a complete statement of reasons or bases" for its decision and "the Secretary cannot make up for [the Board's] failure to do so" by providing his own reasons or bases on appeal).

Discussion

It would appear the VA examiner, on May 31, 2022, somehow suddenly extrapolated that the Veteran was obese- both currently as well as during his active duty. As mentioned above, a longitudinal review of the entire claims file and especially the military's STRS show no evidence of diagnosed obesity at any time during active duty service which the Secretary has conceded as the beginning of the OSA disability. As this clarification diagnosing obesity bases its premise on a fact that is incorrect, the requested clarification is devoid of probative value for rating purposes. Likewise, the July 15, 2022, RD relies solely on an incorrect premise that Appellant's OSA is directly attributable to his *current* obesity. Appellant has never alleged this theory of entitlement.

Assuming, arguendo, that the Veteran was indeed obese during his active duty service as alleged by the clinician and VA examiner, it stands to reason that this evidence of record would be dutifully recorded in the military STRs. Moreover, if the Veteran had been obese, it would have been entered into the record and judicial punishment would have been meted out for failure to comply with a direct order to lose weight. The clinician attempts to attribute obesity in 2022 with a medical disorder (PTSD with OSA) incurred directly in service in the absence of obesity. Absent any evidence of obesity in service, this argument fails.

A careful inspection of the September 2020 claim filing for OSA shows the Veteran averred it was due to his PTSD for which he is service connected. The Veteran is not a medical doctor nor does he have any medical training. Thus, his opinion cannot be granted any probative value. He can, however, attest to what comes to him via his five senses. See ***Layno v. Brown***, 6 Vet. App. 465, 470 (1994)(a Veteran is competent to report on that of which he or she has personal knowledge). See also ***Clemons v. Shinseki***, 23 Vet. App. 1, 5 (2009) A claimant "[does] not file a claim to receive benefits only for a particular diagnosis, but for the affliction his . . . condition, whatever that is, causes him." Consequently, VA "should construe a claim based on the reasonable expectations of the non-expert, self-represented claimant and the evidence developed in processing that claim," taking into consideration "the claimant's description of the claim; the symptoms the claimant describes; and the information the claimant submits or that the Secretary obtains in support of the claim."

Here, the Veteran contended his OSA was, or might be, due to his PTSD which included a sleep disorder. Dr. Morris linked the Veteran's diagnosed OSA to OSA suffered on a direct basis while in service. For two years, the Secretary has opined on everything the Appellant's OSA is *not* related to while studiously avoiding a concession that his very own VA-contracted studies confirm the correlation between OSA and PTSD. This is error. ***Bell*** *supra*.

Conclusion

In sum, the VA has produced four VA opinions- none of which address the Veteran's contention that his OSA is secondary to his PTSD. We know it is not related to a MUCMI. We know it is not related to the SC rhinitis. We do not know that it is related to undiagnosed obesity in service as there is no evidence to support the contention that the Veteran was indeed obese. That is merely subjective conjecture on the part of a VA-contracted clinician with no evidentiary proof. The legal standard of review doesn't permit an endless parade of VA-requested IMOs in search of a supportive denial logic. ***Mariano*** *supra.* §3.104(c) states:

"(c) Development. The development of evidence in connection with claims for service connection will be accomplished when deemed necessary but it should not be undertaken when evidence present is sufficient for this determination. In initially rating disability of record at the time of discharge, the records of the service department, including the reports of examination at enlistment and the clinical records during service, will ordinarily suffice. Rating of combat injuries or other conditions which obviously had their inception in service may be accomplished pending receipt of copy of the examination at enlistment and all other service records.". §3.104(c) (2022).

Here, the trier of fact is left with little more than a probative, rational opinion which is well-supported- not with just peer-reviewed cites-but by a VA-contracted, peer-reviewed study which unequivocally supports the Appellant's argument. §3.104(c). Appellant benefits from the simplicity of his argument and the VA's wealth of supportive medical literature.

In the instant case, under 38 USC §5104(b)(4), the Secretary has conceded a favorable finding that the Appellant suffers from OSA. See RD dated July 15, 2022, page 3 of 4 Favorable findings of fact. In addition, the appellant has an aggravating factor of PTSD. Lastly, the Veteran has a medical opinion linking his OSA to his PTSD on a secondary basis under §3.310(a) (2022). These three "elements" have been held to be the prerequisite since the Caluza

decision of 1995. See ***Caluza v. Brown***, 7 Vet.App. 498, 506 (1995). See also ***Shedden v. Principi***, 381 F.3d 1163, 1166 -67 (Fed. Cir. 2004).

Appellant feels he has more than met his requirement of showing his legal entitlement to service connection. He has provided a clear and convincing Independent Medical Opinion (IMO) from a Board certified subject matter expert medical doctor which provided a well-reasoned rationale with supportive peer-reviewed medical studies which support the IMO.

A longitudinal review of the Veteran's service treatment records (STRs) at no time shows him as overweight, out of compliance with body mass index (BMI) parameters or admistrative admonitions for failure to comply with physical standards during his entire military service. The Secretary provides nothing to substantiate there has ever been a finding of fact that the Veteran was held to be obese or supportive peer-reviewed medical literature that his alleged obesity has anything medically to do with his OSA. See ***McLendon v. Nicholson***, 20 Vet.App. 79, 85 (stating that a speculative medical opinion as to causation cannot establish a medical nexus to service); ***Tirpak v. Derwinski,*** 2 Vet.App. 609, 611 (1992) (holding that medical opinions are speculative and of little or no probative value when a physician makes equivocal findings such as "the veteran's death may or may not have been averted"); 38 C.F.R. §3.102 (2008).

Appellant feels the March 11, 2022, IMO is severely deficient and presents nothing more than data and conclusions absent any supportive rationale. ***Nieve-Rodriguez*** *supra.* The quoted medical rationale merely parrots (and contradicts) the VHA's very own sponsored study's authors. Again. Absent any discussion other than bald assertions of a lack of medical studies on the subject when presented with same is little more than data and subjective conclusions with no supportive rationale. The Nurse Practitioner's lack of familiarity with the evidence of record cannot be treated as substantive negative evidence. In other words, the mere absence of evidence does not necessarily equate to unfavorable evidence. There are a long line of precedential cases supporting this proposition. See, e.g., ***Horn v. Shinseki,*** 25 Vet. App. 231, 239 (2012); ***Buczynski v. Shinseki***, 24 Vet. App. 221, 224 (2011); ***Buchanan v. Nicholson***, 451

F.3d 1331, 1336 (Fed. Cir. 2006). See also ***Forshey v. Principi,*** 284 F.3d 1335, 1358 (Fed. Cir. 2002) (en banc) (cautioning that negative evidence, meaning actual evidence weighing against a party, must not be equated with the absence of substantive evidence). To the extent the opinions were premised on an inaccurate history, the Board could conclude that they were of no probative value. See ***Kowalski v. Nicholson,*** 19 Vet.App. 171, 179 (2005).

Appellant asks for the time-honored canon first articulated by the Supreme Court in ***Boone v. Lightner*** to reflect the sound policy that we must "protect those who have been obliged to drop their own affairs to take up the burdens of the nation." 319 U.S. 561, 575 (1943). This same policy underlies the entire veterans benefit scheme.

Most recently, in ***Lynch v. McDonough,*** WL 20-2067 (Fed. Cir. 2021), the CAFC held that the evidence need only be in approximate balance which means nearly equal as stated in 38 USC §5107(b). See also ***Ortiz v. Principi***, 274 F.3d 1361,1364 (Fed. Cir. 2001). Ortiz held "nearly equal implies approximate which includes equipoise". The pro-Veteran canon instructs that provisions providing benefits to veterans should be liberally construed in the veterans' favor, with any interpretative doubt resolved to their benefit. See, e.g., ***King v. St. Vincent's Hosp.,*** 502 U.S. 215, 220 (1991).

Wherefore, Appellant asks for the benefit of the doubt as the evidence, taken in concert with the required medical nexus, preponderates in his favor, or, if not preponderating, surely argues for equipoise. ***Shedden*** *supra.*

Respectfully submitted,

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