No. AT/IV/O/ECHS-III
Office of the CGDA
Ulan Batar Road, Palam
Delhi Cantt.-110010.
Dated: 10.04.2015.

To

PCsDA/CsDA

Subject: Regarding ECHS Circulars

Copies of Central Organisation ECHS following letters have been uploaded on the website of CGDA. Please download the same for information and necessary action:

Sl No	Letter No. and date	Subject
1.	B/49773/AG/ECHS/Rates Policy dated 20.02.2015	Revision of rates for various treatment procedures under ECHS
2.	B/49773/AG/ECHS/Rates Policy dated 24.02.2015	Revision of ceiling rates and guidelines for various coronary/vascular stents for ECHS beneficiaries.
3.	B/49761/AG/ECHS/Policy dated 19.01.2015	Implementation instruction: Issue of medical equipment prescribed for ECHS members.
4.	B/49773/AG/ECHS/Rates Policy dated 20.01.2015	Unlisted cardiac implants: MRI safe pacemaker and ICDs.

Sr. Accounts Officer (AT-IV)

Tele: 25683476
ASCON: 36833

Central Organisation, ECHS
Adjutant General's Branch
Integrated Headquarters
Ministry of Defence (Army)
Maude Lines
Delhi Cantt-110010

B/49773/AG/ECHS/Rates/Policy

20 Feb 2015

IHQ of MoD (Navy)/Dir ECHS (N)
Air HQ (VB)/DPS
HQ Southern Command (A/ECHS)
HQ Eastern Command (A/ECHS)
HQ Western Command (A/ECHS)
HQ Central Command (A/ECHS)
HQ Northern Command (A/ECHS)
HQ South Western Command (A/ECHS)
HQ Andaman & Nicobar Command (A/ECHS)

REVISION OF RATES FOR VARIOUS TREATMENT PROCEDURES UNDER ECHS

1. Ref this office letter No B/49773/AG/ECHS/Rates/Policy dt 07 Oct 2014 and B/49773/AG/ECHS/Rates/Policy dt 19 Nov 2014

2. CGHS has revised the rates for various treatment procedures vide their OM No S-11011/48/2014-CGHS (HEC) dt 18 Feb 2015. The rates of under mentioned treatment procedures alongwith their CGHS code are as under:-

S No	CGHS Code	Treatment Procedure	Current Rate		Revised Rates	
			Non-NABH	NABH	Non-NABH	NABH
Gynae & Obst						
(i)	648	RVF Repair	14000	16100	18975	21821
(ii)	1590	USG for Obstetrics – Anomalies scan	323	380	770	886
Nephrology & Urology						
(i)	793	Epididymectomy	8000	9200	15938	18750
(ii)	888	Lithotripsy Extra Corporeal shock wave	19000	21850	19550	22483
(iii)	746	Ureteric Catheterization	690	794	8278	10950
(iv)	807	Kidney Transplant (Related)	3500	4025	200000	230000
(v)	808	Kidney Transplant (unrelated) including immunosuppressant therapy	143000	164450	300000	345000
General Surgery						
(i)	372	Secondary Suture of wounds	290	334	3400	4000
(ii)	390	Haemorrhoidectomy	2500	2875	20720	24375
(iii)	391	Stappler Haemorrhoidectomy	4025	4629	38000	43700
(iv)	393	Varicose vein surgery; Tendelenburg operation with suturing or ligation	8625	9919	10000	11500
(v)	18	Catheterization	83	95	425	500
(vi)	477	Fissure in Ano- Fissurectomy	5750	6613	13800	15870
(vii)	506	Laproscopic Paraumbilical Hernia Repair	12580	14800	17500	20125

-----2/-

Ophthalmology						
(i)	32	Pterygium Surgery	86	99	5500	6325
(ii)	34	Conjunctival wound repair or exploration following blunt trauma	115	132	3300	3795
Imaging Investigations						
(i)	150	CT-orbit and brain	173	199	1600	1840
(ii)	991	Foramen magnum decompression for Chari Malformation	1100	1265	93750	107813
Cardiology						
(i)	534	DVR	53000	60950	155422	178735

2. Reimbursement to beneficiaries/ empanelled hospitals shall be limited to ceiling rate or as per actuals, whichever is lower. The other terms and conditions as regards to CGHS package rates remain unchanged.

3. The revised rates shall come into force for ECHS from the date of issue and shall be in force till further orders and are applicable in all cities.

(Vijay Anand)
Col
Dir (Med)
for MD ECHS

Copy to:-

MoD (DoESW) - for info alongwith copy of CGHS OM No S-11011/48/2014-CGHS (HEC) dt 18 Feb 2015.

DGAFMS-DG-3A
DGMS (Army)/DGMS-5(B)
DGMS (Navy)/Dir ECHS (Navy)
DGMS (Air Force) (Med-7)
Office of the CGDA
Ulan Batar Road
Palam, Delhi Cantt-10 - for info please.

UTI-ITSL
1533/1, Above Farico Show Room
1st Floor, Old Madras Road
Halasuru, Bangalore,
Karnataka-560008 - for info.

(_____) - Request confirm receipt and intimate the new rates have been implemented.
All Regional Centres

Internal

Ops & Coord, P & FC, Claim Sec - for info.
Stats & Automation Sec - for uploading on ECHS website.

Tele: 25683476
ASCON: 36833

Central Organisation, ECHS
Adjutant General's Branch
Integrated Headquarters
Ministry of Defence (Army)
Maude Lines
Delhi Cantt-110010

B/49773/AG/ECHS/Rates/Policy

24 Feb 2015

IHQ of MoD (Navy)/Dir ECHS (N)
Air HQ (VB)/DPS
HQ Southern Command (A/ECHS)
HQ Eastern Command (A/ECHS)
HQ Western Command (A/ECHS)
HQ Central Command (A/ECHS)
HQ Northern Command (A/ECHS)
HQ South Western Command (A/ECHS)
HQ Andaman & Nicobar Command (A/ECHS)

REVISION OF CEILING RATES AND GUIDELINES FOR VARIOUS CORONARY/VASCULAR STENTS FOR ECHS BENEFICIARIES

1. Ref this office letter No B/49773/AG/ECHS/Rates/Policy dt 26 Apr 2013.

2. Para 2 (b) (iii) is hereby deleted as the same is covered as under:-

For : (ii) Cobalt Sents.

Read: (ii) Cobalt Stents (including coated and other Stents)

(Vijay Anand)
Col
Dir (Med)
for MD ECHS

Copy to:-

MoD (DoESW) - for info please.

DGAFMS-DG-3A
DGMS (Army)/DGMS-5(B)
DGMS (Navy)/Dir ECHS (Navy)
DGMS (Air Force) (Med-7) - for info please.

Office of the CGDA
Ulan Batar Road
Palam, Delhi Cantt-10

UTI-ITSL
1533/1, Above Farico Show Room
1st Floor, Old Madras Road
Halasuru, Bangalore,
Karnataka-560008 - for info.

( ) - Request confirm receipt and intimate the new rates have been implemented.
All Regional Centres

Internal

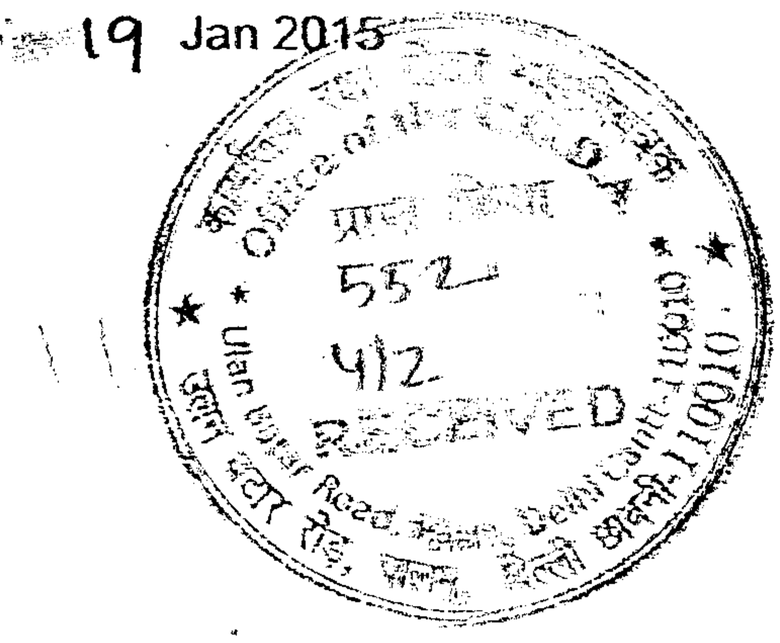
Ops & Coord, P & FC, Claim Sec - for info.
Stats & Automation Sec - for uploading on ECHS website.

Tele: 011-25683476
Tele Fax: 011-25682392
dirmedechs-mod@nic.in

Central Organisation ECHS
Adjutant General Branch
Integrated HQ of MoD (Army)
Maude Lines
Delhi Cantt-110 010

B/49761/AG/ECHS/ Policy

19 Jan 2015



IHQ of MoD (Navy)/Dir ECHS (N)
Air HQ (VB)/DPS
HQ Southern Command (A/ECHS)
HQ Eastern Command (A/ECHS)
HQ Western Command (A/ECHS)
HQ Central Command (A/ECHS)
HQ Northern Command (A/ECHS)
HQ South Western Command (A/ECHS)
HQ Andaman & Nicobar Command (A/ECHS)

IMPLEMENTATION INSTR: ISSUE OF MEDICAL EQPT PRESCRIBED FOR ECHS MEMBERS

1. Ref
   (a) GOI/MoD letter No 24(8)/ 03/ US(WE)/ D(Res) dated 19 Dec 03.
   (b) Cent Org ECHS Letter No B/49773/AG/ECHS dated 05 Apr 04.
   (c) CGHS OM No S11011/ 4/ 2014-CGHS(P) dated 05 Mar 14.

2. The issue of medical equipment prescribed for ECHS members is governed by GOI/MoD letter under reference 1(a). The procedure for issue has been implemented vide Central Org ECHS letter under reference 1(b). MH& FW OM No 24-2/ 96/R&H/ CGHS/ Part-I/ CGHS(P) dt 26 Jun 01 governs the type of equipment to be issued and its ceiling rates. This OM has been updated by CGHS OM under reference 1(c). However, this OM has authorized additional types of equipment without formulating the prescription criteria for the same. The matter has been considered by this Central Org in consultation with O/o DGAFMS and Consultant, Respiratory Medicine, AH R&R. and this implementation letter is being issued suitably modified to cater for the needs and procedures of ECHS and its members.

3. The following guidelines have been framed for issue of Oxygen Concentrator/BIPAP/CPAP etc. to ECHS beneficiaries:
   (a) The items will be procured by Polyclinic and issued to beneficiary as per procedure and conditions outlined in Central Org letter under reference 1(b).

   (b) Statement of case should be accompanied with the relevant Proforma for the machine, duly filled up by the treating physician (specimen copy of Proforma attached). The treating physician should carefully read the laid down guidelines before filling up the respective columns of the Proforma. Actual value of the parameters mentioned in Proforma should invariably be entered and complete basic investigation reports must be attached.

0-6/9
11/2/15

(c) The maximum ceiling limit for procurement will be as following:

(i)	Oxygen Concentrator	Rs. 60,000/-
(ii)	CPAP	Rs. 50,000/-
(iii)	Bi-level CPAP	Rs. 80,000/-
(iv)	Bi-level Ventilatory system	Rs. 1,20,000/-

(d) The above ceiling limits include cost of maintenance with spare parts for a period of five years. Humidifiers, if prescribed should be an integral part of the PAP system rather than being supplied separately.

4. Reimbursement is NOT permitted as of date. Instr for reimbursement are being issued separately. This office letter No B/ 49761/AG/ ECHS/ Policy dated 27 Jan14 maybe treated as cancelled.

5. These instructions and rates shall take effect from the date of issue of this letter. This letter is issued with approval of competent authority empowered vide GOI/Mod letter No.22(1)/ 01/ US(WE)/ D(Res) dated 30 Dec 02 amended vide GOI/Mod letter No.22(1)/ 01/ US(WE)/ D(Res) dated 29May 03.

Vijay Anand

(Vijay Anand)
Col
Dir (Med)
For MD ECHS

Encl: 1. Proforma for prescription
2. Notes to Prescribers

Copy To:

DOESW - for info.

DGAFMS-DG-3A
DGMS (Army)/DGMS-5(B)
DGMS (Navy)/Dir ECHS (Navy) - for info please.
DGMS (Air Force) (Med-7)

UTI-ITSL
1533/1, Above Farico Show Room - for info.
1st Floor, Old Madras Road Halasuru,
Bangalore, Karnataka-560008

Office of the CGDA - for info of PCDAs and CDAs please.
Ulan Batar Road, Palam, Delhi Cantt-10

(_____)
All Regional Centres -Request confirm receipt and ensure action.

Internal
Ops & Coord, P &FC, Claim Sec
Stats & Automation Sec - for uploading on ECHS website of said letter.

NOTE FOR PRESCRIBERS
(For diagnostic as well as for titration)

Only whole night manually validated Level-I polysomnography including channels for sleep, breathing, pulse oxymetry, leg EMG, ECG, snoring & BI-LEVEL titration will be accepted for consideration of BI-LEVEL CPAP / BI-LEVEL ventilator support system. Screening studies such as Level III, Level IV (Cardio pulmonary sleep studies) shall not be acceptable. Auto titrated CPAP studies shall also not be acceptable.

DEFINITIONS

1. Apneas Absence of airflow on the nasal cannula and < 10% baseline fluctuations on the thermistor signal, lasting for > 10 s.

2. **Flow limitation Events:** Any series of two or more breaths (lasting > 10s) that had a flattened or nonsinusoidal appearance on the inspiratory nasal cannula flow signal and ended abruptly with a return to breaths with sinusoidal shape.

3. **Hypopneas** American Academy of Sleep Medicine (AASM) hypopneas: As proposed by the AASM Task Force (10), these events include both flow Hypopneas and any flow limitation event associated with 3% desaturation or associated with an AASM arousal.

4. RERA **(respiratory effort-related arousal)** is defined as a event characterized by increasing respiratory effort for $\geq$ 10 seconds leading to arousal from sleep but which does not fulfill the criteria for hypopnea or apnea. A RERA is detected with nocturnal esophageal catheter pressure measurement, which demonstrates a pattern of progressive negative esophageal pressures terminated in a change in pressure to a less negative pressure level associated with an arousal.

5 RDI (respiratory distress index) is defined as the number of obstructive apneas, hypopneas and RERA's per hour (based on a minimum of 2 hours of sleep in case of split-NPSG) recorded by polysomnography using actual recorded hours of sleep (i.e. the RDI may not be extrapolated or projected).

6. AHI (Apnea Hypopnea Index) The AHI is equal to the average number of episodes of apnea and hypopnea per hour and must be based on a minimum of two hours of sleep recorded by polysomnography using actual recorded hours of sleep. (i.e., the AHI may not be extrapolated or projected).
Note: For the purposes of this recommendation, the terms apnea hypopnea index (AHI) and respiratory disturbance index (RDI) are interchangeable, although they may differ slightly in clinical use; an AHI/RDI greater than 30 is consistent with severe obstructive sleep apnea. In some cases, respiratory effort-related arousals (or RERAS) are included in the RDI value. These RERA episodes represent EEG arousals associated with increased respiratory efforts but do not qualify for apneic or hypopneic episodes because of the absence of their defining air flow changes and/or levels of oxygen saturation.

7. Upper airway **resistance syndrome (UARS):** is an abnormal breathing pattern during sleep that is associated with isolated daytime sleepiness not explained by

any other cause, including the obstructive sleep apnea/hypopnea syndrome. Essential features include (a) the clinical complaint of excessive daytime sleepiness; (b) an elevated EEG arousal index (more than ten per hour of sleep) with arousals related to increased respiratory efforts as measured by continuous nocturnal monitoring of esophageal pressures; (c) a normal RDI of less than 5 events per hour of sleep. Supportive features include (a) the clinical complaint of snoring (b) an increase in snoring intensity prior to EEG arousals and (c) clinical improvement with a short term trial of nasal CPAP therapy.

8. **Split-Night Study NPSG:** Patients with a RDI of > 40 events per hour during the first 2 hours of a diagnostic NPSG receive a split-night study NPSG, of which the final portion of the NPSG is used to titrate CPAP; split-night study may be considered for patients with RDI of 20-40 events per hour, based on clinical observations, such as the occurrence of obstructive respiratory events with a prolonged duration or in associated with severe oxygen desaturation: a minimum of 3 hours of sleep is preferred to adequately titrate CPAP after this treatment is initiated; split-night studies require the recording and analysis of the same parameters as a standard diagnostic NPSG; on occasion, and additional full-night CPAP titration NPSG may be required if the split-night study did not allow for the abolishment of the vast, majority of obstructive respiratory events or prescribed CPAP treatment does not control clinical symptoms.

INDICATIONS

1. **CPAP treatment Is indicated in the following situations:**

The treatment of obstructive sleep apnea (OSA) in adults is considered medically necessary for patients who meet either of the following criteria on polysomnography:

(a) Apnea Hypopnea Index (AHI) or a respiratory disturbance index (RDI) greater than or equal to 15 events per hour;

OR

(b) AHI (or RDI) greater than or equal to 5, and less than 15 events per hour with documentation demonstrating any of the following symptoms:

(i) Excessive daytime sleepiness, as documented by either a score of greater than 10 on the Epworth Sleepiness scale or inappropriate daytime napping (e.g., during driving, conversation or eating) or sleepiness that interferes with daily-activities; or

(ii) Impaired cognition or mood disorders; or

(iii) Hypertension; or

(iv) Ischemic heart disease or history of stroke; or

(v) Cardiac arrhythmias, or

(vi) Pulmonary hypertension.

2. **BI-LEVEL CPAP is indicated in the following conditions:**

BI-LEVEL CPAP is a device used mainly for severe cases of OSA.

Bi-level CPAP (with IPAP 4-22 cm water and EPAP 4-22 cm water)

(a) When CPAP pressure requirement is greater than 16 cm

(b) Oral leaks become uncontrollable at sub-therapeutic pressure after trying humidifier, chin strap & positive pressure therapy.

(c) Pressure of central apneas due to too high pressures.

(d) When patient cannot tolerate CPAP after ensuring the problem is not due to oral leaks, dryness, nasal congestion, interface problem or claustrophobia.

(e) Patients with persistent hypoxia and / or hypercapnia after treatment with CPAP.

3. **BI-LEVEL Ventilatory support system is indicated in the following conditions:**

Bi-level CPAP (with IPAP 4-30 cm water and EPAP 4-30 cm water)

(a) **Restrictive Thoracic Disease** : (e.g. sequelae of polio, spinal cord injury, neuropathies, myopathies and dystrophies, amyotrophic lateral sclerosis, chest wall deformities and kyphoscoliosis, post thoracoplasty for TB) with symptoms (such as fatigue, dyspnea, morning headaches etc) and one of the following: (a) PaCO2 $\geq$ 45 mmHg on room air or PaCO2 $\geq$ 52 mmHg, done while awake and breathing the patient's usual FiO2, (b) sleep oxymetry demonstrating oxygen saturation $\leq$ 88% for at least than 5 consecutive minutes done while breathing the patient's usual FiO2; (c) for progressive neuromuscular disease (only) maximal inspiratory pressure is <60 cm H2O or forced vital capacity is < 50% predicted AND chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation.

(b) **Chronic Obstructive Pulmonary Disease (COPD)** (e.g. chronic bronchitis, emphysema, bronchiectasis) with symptoms (such as fatigue, dyspnea, morning headache etc.) and one of the following : (a) PaCO2 > 55 mmHg while awake and breathing patient's usual FiO2 of 50-54 mmHg and nocturnal desaturation of spO2 $\leq$ 88% for 5 continuous minutes while receiving oxygen therapy $\geq$ 2 LpM; (c) PaCO2 of 50-54 mmHg and hospitalization related to recurrent ($\geq$ 2 in a 12 month period) episodes of hypercapneic respiratory failure; optimal management with bronchodilators, oxygen when indicated must have been ensured; obstructive sleep apnea must have been excluded by polysomnography and there should preferably be an evidence of sustained hypoventilation as shown by prolonged episodes of desaturation during sleep.

(c) **Nocturnal hypoventilation** from additional disorders (alveolar hypoventilation: central alveolar hypoventilation: central alveolar hypoventilation, idiopathic central sleep apnea, obesity hypoventilation syndrome, Cheyne-Stokes respiration, obstructive sleep apnea combined with COPD and pulmonary hypertension or CHF i.e. overlap syndrome, radiation fibrosis or occupational exposure disease; NPSG criteria for OSA not responsive to CPAP include (i) PSG criteria for mixed sleep apnea; not responsive to CPAP therapy (ii) other forms of nocturnal hypoventilation.

4. **Indications for humidification**

(a) Positive Airway Pressure more than 12 cm water

(b) Recurrent and intractable nasal stuffiness and blockage

(c) Severe dryness of throat

(h) These indications are to be primarily thought of as palliative care. The patient should be willing to use for 16-18 hr per day. The decision to prescribe should be taken only after stabilization of medical treatment for 6-8 wks after acute exacerbation.

CONTRA-INDICATIONS TO OXYGEN PRESCRIPTION

(a) Dyspnoea in COPD with PaO2 > 60mmHg.
(b) Current tobacco smokers.
(c) Patients who have not received adequate therapy of other kinds.
(d) Patients who are not motivated to use oxygen therapy according to prescription.
(e) Patients who have cognitive impairment that prevent them from managing their own oxygen therapy appropriately and safely, or where a carer can not assist.

CERTIFICATE OF MEDICAL NECESSITY FOR PRESCRIPTION OF CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) / BILEVEL CONTINUOUS POSITIVE AIRWAY PRESSURE (BI-LEVEL CPAP) / BI-LEVEL VENTILATORY SUPPORT SYSTEM / OXYGEN CONCENTRATORS

(To be filled by the treating physician)

1. OPD Regn No ..... date .....

2. ECHS Card No .....

Name of patient ..... Age ..... Relationship with ESM .....

ESM Service No ..... Rank ..... Name .....

Tele No .....

3. (a) Brief history and physical findings

(b) Co-morbidity (if any)

(c) Whether accompanied by symptoms of

Excessive daytime sleepiness: Yes/No

Snoring: Yes/No

Impaired cognition: Yes/No

Documented cardiovascular disease like hypertension, ischemic heart disease or Stroke (specify if Yes) Yes/No:

4. Laboratory data (specify date against each parameter):

	1	2	3
Date			
Haematocrit			
ECG			
Blood Sugar			
Lipid Profile			
Arterial Blood gases pH paO2 paCO2			

HCO3 a			
HCO3 s			
BE			
O2 sat			
X-ray Chest			
Echocardiography			
Pulmonary function tests			
Thyroid function tests			
Ear, nose & throat examination			
Others (specify)			

5. Diagnostic nocturnal polysomnography (NPSG) data:

(a) Date of sleep study

(b) Address of sleep-laboratory /facility

(c) Duration of diagnostic NPSG study (in hours)

(d) Parameters studied during polysomnography

Electro encephalogram	Yes/No
Electrooculogram	Yes/No
Electromyogram	Yes/No
Oro nasal airflow	Yes/No
Chest & abdominal wall effort	Yes/No
Body position	Yes/No
Snore microphone	Yes/No
Electro-cardiogram	Yes/No
Oxyhaemoglobin saturation	Yes/No

(e) Average number of obstructive per hour of recorded sleep (in case of standard as well as split NPSG)

(i) Obstructive apnoea

(ii) Hypopnea

(iii) Flow limitation.

(iv) RERA

(v) Sustained hype ventilation

(f) Respiratory Distress index (RDI)

Only whole night polysomnography (Level-1) including channels for sleep, breathing, pulse oxymetry, leg EMG, ECG, snoring will be accepted for consideration of BI-LEVEL CPAP/BI-LEVEL ventilatory support system

6. Date of BIPAP/ CPAP titration study

7. (a) BIPAP settings:

Inspiratory pressure (IPAP)

Expiratory pressure (EPAP)

Backup Rate (if necessary)

Supplemental oxygen (flow rate or FiO2)

(b) CPAP pressure (in cm H2O) prescribed:

(c) Supplemental oxygen (flow rate or FiO2)

(d) Humidification required Yes/ No

8. Final Diagnosis

9. Recommended: Oxygen Concentrator/ CPAP/ BI-LEVEL CPAP / BI-LEVEL ventilatory support system with/ without Humidifier

I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I have carefully gone through the note for prescribers before filling up this Proforma.

Date: (Full Name, signature & address of physician)

RECOMMENDATIONS

Recommended/ Not recommended

Senior Adviser

Recommended/ Not recommended

Consultant

Tele: 25683476
ASCON: 36833

Central Organisation, ECHS
Adjutant General's Branch
Integrated Headquarters
Ministry of Defence (Army)
Maude Lines
Delhi Cantt-110010

B/49773/AG/ECHS/Rates/Policy

20 Jan 2015

IHQ of MoD (Navy)/Dir ECHS (N)
Air HQ (VB)/DPS
HQ Southern Command (A/ECHS)
HQ Eastern Command (A/ECHS)
HQ Western Command (A/ECHS)
HQ Central Command (A/ECHS)
HQ Northern Command (A/ECHS)
HQ South Western Command (A/ECHS)
HQ Andaman & Nicobar Command (A/ECHS)

UNLISTED CARDIAC IMPLANTS: MRI SAFE PACEMAKER AND ICDs

1. Cardiac implant rates were revised by ECHS vide their letter No B/49773/AG/ECHS/Rates/Policy dt 06 Aug 2014. Many empanelled hospitals have now resorted to filliing up appx 'A' for MRI safe pacemaker and ICDs as unlisted implants at rates many times higher than the listed cardiac implants.

2. Opinion of service cardiologist was sought in this regard which is as under:-

MRI safe cardiac implants specially pacemaker and ICDs have a place in modern cardiology practice, however two facts merit consideration:-

(a) Significant cost difference between conventional system and MRI safe devices.

(b) Globally overwhelming majority of patients are still getting conventional systems and only a small minority, the MRI safe devices. There are proven technical solutions to aquire MRI images in a patient with conventional pacemaker hence the decision to use MRI safe devises must be individualized, keeping in mind the real time requirements of MRI in a given patient, possibility of using other imaging modalities like CT scan and the expected life span of the patient.

3. It is requested that all the concerned authorities in the chain of command and empanelled hospitals be appraised of the judicious use of these unlisted devices.

RECEIVED 553 for info

(Vijay Anand)
Col
Dir (Med)
for MD ECHS

Copy to :-

DOESW -

DGAFMS-DG-3A
DGMS (Army)/DGMS-5(B)
DGMS (Navy)/Dir ECHS (Navy)
DGMS (Air Force) (Med-7) - for info please.

UTI-ITSL
1533/1, Above Farico Show Room - for info.
1st Floor, Old Madras Road Halasuru,
Bangalore, Karnataka-560008

Office of the CGDA - for info please.
Ulan Batar Road, Palam, Delhi Cantt-10

(_____)
All Regional Centres - Request confirm receipt and ensure action.

Internal

Ops & Coord, P &FC, Claim Sec
Stats & Automation Sec - for uploading on ECHS website of said letter.