



# EX-SERVICEMEN CONTRIBUTORY HEALTH SCHEME



**STANDARD OPERATING PROCEDURE**

*TREATMENT MANAGEMENT*

*IN*

*ECHS*



**28 SEP 2018**

# SOP: TREATMENT MANAGEMENT IN ECHS

## INTRODUCTION

1. Exservicemen Contributory Health Scheme (ECHS) was launched wef 01 Apr 03 as a mandatory scheme whereas it is optional for those retired on or before 31 Mar 03. The beneficiaries include retired pensioners of Army, Navy, Air Force, Coast Guard, SFF and Nepal Domiciled Gorkhas (NDGs). Assam Rifles may be added as and when approved by the Govt. At present, being ESM and defence pensioner is the mandatory criteria for ECHS membership.

2. The treatment is provided through a chain of Polyclinic (PCs), Service Hospitals, Govt Hospitals and Empanelled Hospitals. Since ECHS primarily serves middle & old age veterans and their dependants, it is therefore essential that the procedures are user friendly while optimizing the allocated budget and preventing unfair practices. It has been experienced that majority of problems being faced by ECHS beneficiaries are primarily due to lack of clarity on rules and regulations at all ends, be it the beneficiary, ECHS Staff at different echelons, service and empanelled hospitals. The problem is further compounded due to subjective interpretation of rules and regulations.

3. Since number of proposals are in advanced stage with the Govt and therefore some of them have also been covered in this document to give complete picture but their operationalisation will take place after approval. A careful reading of this document is therefore essential. Issues needing approval have been given in bold. Some imp aspects have been also given in bold. **Since Service Hosps and Empanelled Hosps for all ailments are not available in large No of districts, the thrust has been given to utilize local treatment facilities. Some aspects have been deliberately repeated for sake of clarity.**

## AIM

4. This SOP is aimed to bring out clarity on ECHS patient's treatment issues in a singular document so that ECHS not only remains an unparalleled scheme in conception but also achieves the same reputation in execution domain as well.

## Preview

5. The document has been divided in the following parts:-

- (a) **Part 1.** Activities at Home.
- (b) **Part 2.** Activities at Polyclinics.
- (c) **Part 3.** Activities at Govt Hosps.
- (d) **Part 4.** Activities at Emp Hosps.
- (e) **Part 5.** Activities Post Visiting PCs/Hosps.

## **PART 1 : ACTIVITIES AT HOME**

6. Before any treatment process is initiated, certain preparatory actions are essential to avoid difficulties in treatment. These will also result in selection of suitable option for treatment which are covered in succeeding paras. Even if a person is eligible, the treatment benefits through ECHS will commence only after issue of ECHS Card (Permanent/ Temp).

### **Documentation**

7. The following documents must be kept ready with all ECHS beneficiaries:-

(a) **Primary Beneficiary and Spouse.** ECHS Card/ White Card (as applicable), Aadhar Card and treatment book having record of treatment & medicines drawl details must be carried. ESM veteran card/ PPO/ PAN Card/ Ration Card/ Voter Identity Card/ Driving License/ Bank Pass book/ Passport and Aadhar card may be required to be shown as a proof in case any dispute arises regarding verification of identity of ECHS beneficiary including dependants. Docu(s) to be accepted as proof of identity should have certified photo.

(b) **Dependants (Other than Spouse).** ECHS Card/ White Card (if applicable), Aadhar Card, Affidavit for income for the current year and treatment book having record of treatment & medicines drawl details must be carried. Dependants should also have the details of primary beneficiary on whom they are dependant. ESM dependant card/ PPO/ PAN Card/ Ration Card/ Voter Identity Card/ Driving License/ Bank Pass book/ Passport and Aadhar card may be required to be shown as a proof of identity. Dependants must ensure their eligibility from income criteria as amended from time to time which is Rs 9000/- PM excluding DA from all sources at this stage. **Income criteria is mandatory condition and overrules eligibility under PWD Act 1995/2016 as well. Any change/ clarification on this issue will be notified after approval of competent authority specially in the case of children who have been given pension and in the process, they don't meet income criteria.**

(c) Based on Govt notification, other docu(s) can also be accepted as proof of identity.

8. **Eligibility due to PWD Act 2016.**

(a) PWD Act 1995 was earlier applicable which gives lifelong treatment to sons (Auth: Min of Health & Family Welfare OM No 4-24/96-C&P/CGHS(P) dt 29 Aug 2007) and brothers (Auth: Gol (MoD) letter No 18(17)/2011/US(WE) dt 31 Oct 2012) if the person is suffering from one or more of the seven disabilities viz Blindness, Low vision, Leprosy Cured, Hearing Impairment, Locomotor Disability, Mental Retardation & Mental Illness. This has been superseded by Gol (MoD) letter No 18(77)/2017/WE/ D(Res-I) dt 18 Sep 18 which has adopted PWD Act 2016.

(b) Govt has now approved PWD Act 2016 which has 21 disabilities/ailments to include Blindness, Low-vision, Laprosy cured persons, Hearing impairment (deaf and hard of hearing), Locomotor disability, Dwarfism, Intellectual disability,

Mental Illness, Autism Spectrum Disorder, Carebral Palsy, Muscular Dystrophy, chronic Neurological conditions, specific learning disabilities, Multiple sclerosis, Speech & language disability, Thalassemia, Sickle cell disease, Acid Attack Victim, Parkinson's disease, Multiple disabilities including deaf and blindness,. (Pages S No 33 to 35 of PWD Act 2016 are attached as Encl 1) wherein unmarried sons will be eligible for life time treatment if they are suffering from one or more disabilities/ ailments out of 21. **Case for eligibility of minor brothers as well as married sons who are now not eligible has been taken up with MoD(ESW).**

(c) All affected eligible persons under PWD Act 2016 will be eligible for priority of treatment in ECHS PCs. The priority will be applicable from reception onwards and will be maintained till medicine distribution. These persons will be given **white card**. (Auth: CO ECHS letter No B/49711-NewSmartCard/AG/ECHS dt 10 Aug 2018)

(d) Disability certificate as per PWD Act must be made by Service Hosp/District Disability Board/ Govt. Medical College/ Hospital Disability Board as per format at Encl 2. Eligibility is only subject to minimum 40% disability and not being able to earn.

9. **Other Categories for Priority Treatment at PCs.** In addition to white card holders based on PWD Act, the following category of persons are also given priority in their treatment at all stages of treatment at PCs:-

(a) Battle casualty & War Wounded/ Disabled Veterans. (**War Disabled** is being endorsed on the new smart card of war disabled persons & their spouses. White card is not being given) (Auth : CO ECHS letter No B/49770/AG/ECHS/ Policy dt 23 Jun 2017 read in conjunction with CO ECHS letter No B/49711-NewSmartCard/AG/ECHS dt 10 Aug 2018)

(b) Spouses of Battle casualty & war disabled veterans.  
(Auth: CO ECHS letter No B/49701-PR/AG/ECHS dt 12 Dec 2013)

(c) Males over 75 years of age.

(d) Females over 70 years of age.  
(Auth : CO ECHS letter No B/49701-PR/AG/ECHS/2015 dt 31 Oct 2016)

**Note.** Patients needing urgent medical attention will override all categories to reach MO irrespective of rank & age. **Special care should be taken in case of battle cas & war wounded/ disabled veterans at all stages of treatment.**

10. **Method to Keep Documents.** It has been observed that ECHS beneficiaries don't carry all documents with them which results in problems related to identification and also inputs related to treatment. While these issues will get addressed to large extent once new smart card is fully populated combined with full automation but in interim, documents as per Para 7 should be carried. It is therefore essential that these documents be kept in a convenient and easy to retrieve places.

ECHS beneficiary is free to adopt any of the suggested methods below or any other method as one feels appropriate as per his/her discretion :-

(a) **Digital Locker.** Documents can be kept in digilocker. Docu(s) produced with this mode will be acceptable. However, **ECHS Card will need to be presented at the time of reporting to PC/Empanelled Medical facility.** Guidelines to use Digilocker are available at [digilocker.gov.in](http://digilocker.gov.in).

(b) **Whatsapp/ Electronic Mode.** Subject to decision of ECHS beneficiary, copy of documents can be kept in this method as well. If the copies of documents are legible, these will be also acceptable.

(c) **Emergency Recovery of Documents.** Photocopy of one set of documents is recommended to be prepared and retained at a place as decided by ECHS beneficiary for use should main docu get lost/misplaced.

(d) **SOS Friend.** Beneficiary should select a friend staying in neighbourhood who can respond in his/her emergency. **New 'Medical app' with 64 KB smart card will have a 'SOS' button which when pressed will send the location of ECHS beneficiary to his selected friend so that assistance can be provided. Once 'medical app' with new smart card is launched, Mob Number of SOS friend will need to be registered. SOS friend need not be an ECHS beneficiary.**

(e) **Loss of ECHS Smart Card.**

(i) New ECHS 64 Kb Smart Card when lost can be obtained on the similar lines as applicable to bank credit/debit cards. ECHS beneficiary should select 'loss' option in online application mode and make the payment for card. ECHS beneficiary will have the option of card delivery at his selected address if courier charges are paid by the ECHS beneficiary.

(ii) The following actions should be taken :-

(aa) Login to Online Smart Card Portal with credentials and select option LOSS OF CARD.

(ab) An option will be provided to select the member for which new card is to be printed. The new card printed will be a duplicate of the existing card and same will be printed as per data available.

(ac) After selecting the members, an option will be provided for delivery of card at selected address as per records through courier. The home delivery service of card is optional. Applicant can also collect his/her card from the Stn HQ without any delivery charges. One has to proceed for Payment option which will be made available after 'Loss of card' option is selected. The payment will be only for the number of duplicate cards applied and for courier charges (as applicable), if opted.

(ad) Those who have selected collection of card from Stn HQ will receive a SMS on delivery of their card at Stn HQ and same can be collected from concerned Station HQ as hithertofore.

(iii) **Loss of Non 64 KB Smart Card.** The procedure required to be initiated in case of loss of non 64 KB Smart card is as under :-

(aa) The applicant has to fill full online application with details of every member for 64 KB smart card. The attachments as asked needs to be uploaded for each member. However, there is no requirement for uploading of copy of lost Smart Card.

(ab) An option to select the member for which new card is to be printed will be provided. On selecting member/ members for whom Smart Card is to be issued, a self declaration for loss of Smart Card will be presented to the applicant for accepting.

(ac) After selecting the members and accepting self declaration, Proceed for payment option will be made available. The payment required will be only for the number of cards applied.

(ad) The flow of application will be same as other applications i.e. verification by Record Office and then printing of Smart Card. Verification of application by Record Office will be for full application.

(ae) Smart Cards needs to be collected from Stn HQ by each beneficiary. Temporary slip issued for lost card is required to be submitted at Stn HQ at the time of collection of new Smart Card.

(af) Since the data of all the members has already been captured and verified by the Record Offices, individual can apply for printing of new 64 Kb Smart Card in future by just paying the Smart Card fee. However, a re-check of eligibility in terms of age, marriage & income for dependent son, daughter, brother and sister will be carried out at the time of initial applying for upgradation of 64 Kb Card as applicable. This will save time of the verification by the Record Offices. **It is the responsibility of primary card holder to ensure that eligibility is valid at all stages. Obtaining card on wrong criteria will result in cancellation of ECHS membership.**

### **Decision on Treatment Option While at Home**

11. **Special Category of ECHS Beneficiaries.** The following category of persons will form 'Special Category' of persons and will include the following wherever mentioned in this document hereinafter:-

- (a) ECHS beneficiaries over 80 years of age.
- (b) Cancer patients.
- (c) Parkinson patients.
- (d) Dementia patients.
- (e) Battle cas and war disabled persons (**amputees**).
- (f) PWD Act 1995/2016 covered persons.

- (g) Bedridden/chair bound patients.
- (h) Any other category as specified by CO ECHS from time to time.

12. **Domiciliary Visit to Seriously ill Patients.** Once Pan India proposal is approved by MoD alongwith projected manpower, it will be possible to have manageable footfall in most of the PCs. Once the same status is achieved, MO/ Specialist of PC may be allowed to visit seriously ill patient at his/her residence through OIC PC. The following norms are proposed to be followed subject to PC being able to meet the requirement without adversely affecting the treatment of other ECHS patients reporting to the PC (Auth : Para M of Chapter 5 of CGHS SOP (Medical Facilities Under CGHS)) :-

- (a) Due to load of patients at PC, it may not be possible for OIC PC to spare a MO for attending the request. It should be seen as 'add on' support and not as a 'right'.
- (b) Support may be extended if the patient resides within municipal limit as well as within eight km of the PC. ECHS beneficiary / attendant should speak to the MO so that required medical eqpt/ medicines can be taken along and issued.
- (c) Light vehicle/ Ambulance vehicle of PC/ Veh arranged by patient attendants could be used for movement of MO from PC to residence of patient and back. No fee will be paid to the MO by the ECHS patient.
- (d) OIC PC will keep a record of such requests including compliance wherever feasible.
- (e) 'SPARSH' volunteers could be utilized for the said purpose.

**Note.** All ECHS beneficiaries will be notified once the said provision as above is implemented.

- (f) Lal Path Lab in Delhi NCR has provided **free of cost sample collection service** for 'special category' of persons as covered in our letter No B/49770/AG/ECHS/Gen dt 05 Jun 2018. The beneficiary need to call their helpline No 011-39885050 for such a facility. Referral document should be signed by beneficiary and Mob No should be endorsed. Regular effort will be made for such service by others as well that too on Pan India basis. This will be notified from time to time.

13. **Nature of Treatment.** Earlier only allopathic treatment was allowed to ECHS Beneficiary, however wef 08 Aug 18, MoD (DOESW) has also approved the treatment option through AYUSH (Ayurvedic, Yoga, Unani, Sidha and Homeopathy). The following aspects are important to utilise treatment through AYUSH (Auth: Gol (MoD) letter No 22B(06)/2017/WE/D(Res-I) dt 08 Aug 2018 and CO ECHS letter No B/49769/AG/ECHS/ Med/Policy dt 04 Sep 2018):-

- (a) **Need of Permission.** ECHS beneficiary will need to take permission for treatment through AYUSH from one of the three places as per his/her convenience viz PC/RC/CO ECHS as per attached format (Encl 3). These need

not be his/her parent PC. Permission to change from AYUSH to Allopathic will also be required in the similar manner. Format is attached (Encl 4).

(b) **Use of Govt/ Nominated Hospitals.** All Govt AYUSH Hospitals and those included in Gol (MoD) letter No 22B(06)/2017/WE/D (Res-I) dt 08 Aug 2018 circulated vide CO ECHS letter No B/49769/AG/ECHS/Med/Policy dt 04 Sep 2018 can be utilized for treatment.

(c) **Only One Type of Treatment.** ECHS beneficiary is allowed to utilize only one type of treatment at any time. If allopathic medication is continuing, the same has to cease before application for AYUSH is moved as per Encl 3. It will be the responsibility of ECHS beneficiary to ensure that only one type of treatment is taken at any point of time. ECHS beneficiary will have option to switch over from one type to another type of treatment with the proviso of 'only one type' of treatment at any chosen time. Permission for change from AYUSH to Allopathic will be taken on format as per Encl 4. **In emergency relating to life threatening conditions as defined as per Para 16, any mode of treatment can be used.**

(d) **Treatment on Reimbursement Basis.** All AYUSH treatments will be taken on reimbursement basis. 100% reimbursement will be allowed including the cost of medicines once prescribed by Govt hospitals (Central/ State/ Local self Govt). Expenditure on account of toiletry (Aloevera, soap, shampoo etc), food vitamins (Revital etc) is not allowed.

(e) **Processing of Bills.** Bills will be presented to parent PC for processing through UTI-ITSL (BPA). No processing charges will be paid by the beneficiaries and it will be borne by the Govt.

(f) **Processing Charges for all individual reimbursement bills are being borne by Govt wef 01 Mar 18 besides five free SMS being given at different stages to keep the ECHS beneficiary informed about progress of individual reimbursement bills (Auth: Gol (MoD) letter No 2D(31)/2017/WE/D(Res-I) dt 01 Mar 2018).**

14. **Treatment in Govt Hospitals.** (Auth: Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003 and 22D(09)/2013/US(WE)/D(Res) dt 26 Jul 2016)

(a) All ECHS beneficiaries can avail treatment in any Govt Hospital (Central/State/Municipal Corporations/ Cantonment Boards etc) **without the need of referral from Polyclinic except those in Para 14(b) covered in succeeding sub para. This treatment will be reimbursed at actual expenditure and CGHS rates don't apply.** This option is very advantageous where PCs are located far off as reimbursement process has been speeded up.

(b) Referral from polyclinic will be required for treatment in Govt hospitals only for the following ailments:-

- (i) Major cardiac surgery/ interventional cardiology.
- (ii) Oncology.
- (iii) Organ transplant cases.
- (iv) Joint Replacement cases.
- (v) Major Neurosurgical / Neurology cases.
- (vi) Bariatric Surgery.

(c) Medicine bills and prescription should be duly signed by treating doctor and counter signed by Medical Superintendent / Director of the hosp.

(d) Since all Govt Hospitals are deemed empanelled, the treatment can be cashless if they sign MOA with concerned RC for which deliberate effort is being made. (Auth: Gol (MoD) letter No 22D(09)/2013/US(WE)/D(Res) dt 26 Jul 2016)

15. **Treatment in Empanelled Hosps on Payment Basis at CGHS Rates on Voluntarily Basis.**

(a) ECHS PCs are limited in Nos and remain open only from 0800 hr to 1600 hr on weekdays. Not only this, some of the beneficiaries may be located close to an empanelled hosp.

(b) No of ECHS patients may need routine medical support wherein they may prefer to use empanelled hospital due to administrative reasons. No of requests have been received from ECHS beneficiaries wherein they are willing to make payment to empanelled hosps on CGHS rates without any claim for reimbursement to avail the treatment.

**(c) Any empanelled hospital can offer consultation/investigation/treatment in routine cases at CGHS rates if ECHS beneficiary discloses his/her identity and is willing to make payment voluntarily. Such expenditures cannot be claimed from ECHS on any ground as they are neither referral based nor emergency cases. Bills given by the hospital will have 'rubber stamped' as 'NOT FOR CLAIM'. Even if not stamped, these will not be admissible for reimbursement.**

(d) This arrangement is between ECHS patients and empanelled hospitals exclusively and based on willingness of both and is purely voluntarily. No ECHS beneficiary will insist for this if empanelled hosp is unwilling for the said support.

**(e) No medicines can be demanded from PCs based on this voluntarily treatment if they are subscribed by empanelled hosps. Any resultant prescription for any tests will also not be valid unless approved by PC.**

16. **Treatment in Emergency.**

(a) If in 'emergency', patients can go directly to any empanelled / non empanelled hosp. 'Emergency' in ECHS is defined as life threatening conditions to include the following :-

(i) Acute Cardiac Conditions/ Syndromes including Myocardial Infarction, Unstable Angina, Ventricular Arrhythmias, Paroxysmal Supraventricular Tachycardia, Cardiac Tamponade, Acute Left Ventricular Failure/ Severe Congestive Cardiac Failure, Accelerated Hypertension, Complete dissection.

(ii) Vascular Catastrophies including medical and surgical shock and peripheral circulatory failure, Acute limb ischaemia, Rupture of aneurysms.

(iii) Cerebro-Vascular Accidents including Strokes; Neurological Emergencies including coma, cerebro meningeal infections, convulsions, acute paralysis, acute visual loss.

(iv) Acute Respiratory Emergencies including respiratory failure and decompensated lung diseases.

(v) Acute abdomen including acute obstetrical and gynaecological emergencies.

(vi) Life threatening injuries including road traffic accidents, Head injuries, Multiple injuries, Crush injuries and thermal injuries.

(vii) Acute poisonings and snake bite.

(viii) Heat stroke and cold injuries of life threatening nature.

(ix) Acute endocrine emergencies like Diabetic Ketoacidosis.

(x) Acute Renal Failure.

(xi) Severe infections leading to life threatening sequelae including Septicaemia disseminated/ miliary tuberculosis.

(xii) Any other condition in which delay could result in loss of life or limb.

**(b) 'Emergency' provision should not be misused. It is related to medical condition of the patient and not with closing hour of PC/ holidays.**

**(c) This provision should not be used as a 'short cut' to avoid going through PC.**

**(d) In life threatening conditions, moving to one of the closest hospital is the natural response and therefore all emergency admissions will be viewed from this perspective as well. Hospital should also be careful while treating such cases. Intimation within 24 hr by empanelled hospital for ER and within 48 hr from non empanelled hosp by individual (EIR) is mandatory.**

(e) All empanelled hospitals must allow treatment/ admissions in case of genuine emergencies only. 'Benefit of doubt' should be given to the patient. After stabilisation, patient should be discharged viz a patient may come to empanelled hosp feeling chest pain but on examination, he/she may be suffering from gastric problem and all tests done don't indicate heart problem, such patients after stabilisation and basic medication, should be discharged and charges raised on day care basis to ECHS. Empanelled hospital will indicate date and time of reporting and discharge on discharge summary/ bills (Auth: Para 4(b)(iv) of Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003) to the nearest as well

as parent PC. The bills under emergency clause will be raised with specified documents as under:-

- (i) Copy of ECHS Card.
- (ii) Emergency room case sheet/ discharge summary indicating time of reporting / discharge.
- (iii) Copy of ER.
- (iv) The applicable charges will be as under :-
  - (aa) Consultation Charges (max two) as per CGHS rates. Second consultation is allowed if a specialist attends in addition to MO.
  - (ab) Emergency investigation charges.
  - (ac) Medicines & consumables used for stabilisation including POP charges etc.
  - (ad) No room rent will be paid.

(f) **Those misutilising the provision be it ECHS beneficiaries/empanelled hospitals will be strongly penalised.**

(g) **Emergency Treatment in Non Empanelled Hosp and Reimbursement.** All beneficiaries are allowed to get themselves treated in any hospital in case of emergency, though empanelled hospitals will submit their bills online, patients who have treated themselves in non empanelled hosp to process their reimbursement bills through parent PC. Mandatory documents are as under :-

- (i) Copy of ECHS Card.
- (ii) Emergency certificate issued by the hosp.
- (iii) Discharge summary (must include admission date & discharge date correctly with details of disease & treatment provided).
- (iv) Emergency room case sheet.
- (v) Copy of EIR.
- (vi) Bill in detail with summary.
- (vii) All images, pouches, barcode, invoices etc.

#### 17. **Treatment for Eye Related Issues.**

(a) No of eye hospitals have voluntarily opted for **free consultation** for eye related issues.

(b) List of these eye hosps will be available on ECHS website as well as at affected PCs.

(c) ECHS patient has to come to PC for further management of his eye treatment after free consultation. He/She can select same or any other eye hospital for his/her treatment. This has been done so that waiting time at PC be avoided since no eye specialists are available at ECHS PCs currently.

(d) **Lasik surgery** is considered cosmetic and is not allowed at this stage.  
(Auth: Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003)

(e) **When a patient is referred to an empanelled hosp for cataract operation, package cost includes treatment/procedure including admission charges, accommodation charges, ICU/ICCU charges, monitoring charges, operation theatre charges, operation charges, anesthetic charges, procedural charges/Surgeon fee, cost of disposables, surgical charges and cost of medicines used during hospitalization, related routine investigations, physiotherapy charges etc. and the package rate does not include diet, telephone charges, TV charges and cost of cosmetics, toiletry and tonics. (Auth : Para 4(b)(iv)(v) of MoD (Gol) letter No 24(8)/03/US(WE)/D(res) dt 19 Dec 2003). Tendency to send back patients for lab & other tests is an unfair practice and is not to be followed.** Issue of this kind must be brought to the notice of OIC PC who will inform Dir RC to initiate action against errant hosps.

18. **Prior Sanction for Treatment in Non Emp Hosp.**

(a) ECHS beneficiary may be needing treatment in a non emp hosp due to continuing treatment with a particular doctor, higher trust in a particular establishment, nonavailability of empanelled hospital in the city of his/her residence, administrative convenience or any other reason, **such permission will now be accorded by Dir RC (Due care to be exercised by Dir RC) once the application is recd at RC expect in the following cases which will be accorded by CO ECHS:-**

- (i) Major cardiac surgery/ interventional cardiology.
- (ii) Oncology.
- (iii) Organ transplant cases.
- (iv) Joint Replacement cases.
- (v) Major Neurosurgical / Neurology cases.
- (vi) Bariatric surgery cases.

(c) Format of prior sanction by Dir RC ECHS will be same as is being followed by CO ECHS.

(d) Bills will be reimbursed at CGHS Rates only. No representation will be accepted for full reimbursement in such cases.

(e) No TA is admissible in such cases.

(f) **An attempt is being made to automate the process to address the difficulties of ECHS beneficiaries to ensure that there is no delay in such sanctions.**

19. **Treatment in Hospitals of National Repute.** ECHS beneficiary may decide to utilise services of hospital of national repute details of which are covered below:-

(a) The following hospitals are currently part of hospitals of national repute (Auth : Para 5(b) of Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003):-

**Govt Hospital/Institute**

- (i) All India Institute of Medical Sciences, New Delhi.
- (ii) Post Graduate Institute, Chandigarh.
- (iii) National Institute of Mental Health and Neuroscience, Bangalore.
- (iv) Medical Colleges and Hospitals under the Central or State Govt.
- (v) JIPMER, Pondicherry.
- (vi) Sanjay Gandhi Post Graduate Institute, Lucknow.

**Non Govt Hospital/Institute**

- (vii) Tata Memorial Hospital, Mumbai (for Oncology).
- (viii) Christian Medical College, Vellore.
- (ix) Shankar Nethralaya, Chennai.

(b) Treatment norms/ process for Govt hosp / Institute at Para 19 (a)(i) to (vi) above will be as covered at Para 14 above.

(c) In case of Non-Govt National Repute hosp, the following procedure will be followed :-

(i) **Tata Memorial Hospital (TMH), Mumbai.** Referral from Parent PC will be taken once cancer diagnosis has been established/ confirmed for the ECHS beneficiary. The person under RC Mumbai will directly report to TMH Mumbai after referral from parent PC whereas those outside from RC Mumbai will report to nearest PC of TMH Mumbai for availing treatment. Effort is underway to sign MoA after which treatment will be cashless.

(ii) **Christian Medical College (CMC), Vellore.** Referral from Parent PC will be taken with opinion of concerned specialist of Service Hosp/ Empanelled Hosp/ Govt Hosp if the beneficiary opts for treatment at CMC Vellore. In case of patient outside RC Chennai, the patient after specialist opinion will report to PC Vellore and then go to CMC Vellore with fresh referral.

(iii) **Shankar Nethralaya, Chennai.** Referral from parent PC will be taken and patient will report to Mil PC Chennai. He/She will then take opinion of eye specialist from MH Chennai and thereafter will proceed to Shankar Nethralaya, Chennai. If the patient has already got endorsement of eye specialist from service hosp in his AOR, opinion of eye specialist from MH Chennai will not be needed. Only referral from PC Chennai will be adequate.

**Note. These referrals will not allow cashless treatment but will be required for preferring the reimbursement claims and are part of regulatory mechanism.**

(d) Reimbursement can be claimed in case of Govt Hosp at 100% whereas in balance cases, it will be as per CGHS rates only.

(e) Effort is being made to enlarge the list of hospitals of National Repute besides process of automation.

## **PART 2: ACTIVITIES AT POLYCLINIC**

20. **Primary Treatment Centre.** ECHS PCs are primary treatment centres for all ECHS beneficiaries. It has MOs, DO, Specialists (Medical Specialist, Gynecologist, Radiologist) in varying combinations based on type of PC, footfall and availability. PCs have dental chair, labs, X-Ray centre and physiotherapy facilities besides a treatment room for dressing and injections. Facilities in part/full may exist based on varying factors. PCs are classified into two categories for the purpose of treatment:-

(a) **Parent PC.**

(i) This is the PC which is selected by ECHS beneficiary at his place of residence/work/any other administrative requirement. Selection & documentation of parent PC is a 'Key factor' for efficient health services of ECHS beneficiaries.

(ii) All members of the family may have same PC as parent PC or may select different PC based on their requirement viz son/daughter eligible for ECHS treatment studying away from parents may select a different PC.

(iii) ECHS beneficiary can change his/her parent PC once in six months. In the current system, NOC from current parent PC will be needed for new parent PC to register the beneficiary. The broad procedures are as under:-

(aa) Beneficiary applies to his parent PC for change of PC indicating name of new PC.

(ab) With the approved application he/she will report to his new PC.

(ac) Old parent PC will delete his/her name and new parent PC will include the name.

(iv) **Once new smart card is populated with full automation, ECHS beneficiary will be able to change the same from his/her end and data base will be automatically updated at both ends.**

(v) All entitlements are allowed through parent PC and therefore when moving out, ECHS beneficiary must collect the medicines in case suffering from chronic ailments. Medicines are allowed for three months for chronic patients whereas those going to foreign trip, upto six months /duration of stay whichever is earlier. However, stock position of medical store will decide the actual duration for issue of medicines. 'Referral' should also be taken from parent PC if any planned treatment is needed in transitory location viz if an ECHS beneficiary is moving from Palampur(HP) to Delhi for one to two months and wants cataract operation done in Delhi, he/she should take a referral from parent PC Palampur(HP) which can be deposited to a PC in Delhi for fresh referral for operation.

(b) **PCs other than Parent PC.**

(i) All ECHS beneficiaries can take treatment from any PC in the country on production of ECHS card. However, in case of non parent PC, the treatment will be limited to the facilities available in the PC.

(ii) **Medicines can be issued only for seven days at a time from non parent PC. However, if medicine is available and issue does not affect patients dependant on PC, medicines can be issued upto 30 days at the discretion of OIC PC. Medicines from ALC will not be used for non parent PC beneficiaries.**

(iii) In case of planned treatment/ procedure/ investigation, referral from parent PC will be needed. Whenever any ECHS beneficiary is moving out of AOR of parent PC and is planning a planned treatment viz cataract operation etc, a referral from parent PC should be taken which should be deposited within 30 days to the PC near place of transitory stay.

(iv) **Exception.** When a patient reports to a non parent PC due to his/her transitory stay in non parent PC location, MO can issue OPD/IPD referral with approval of OIC Polyclinic **if such treatment is considered essential and cannot be delayed. This will not be valid for any elective treatment.** This discretion must be used as an exception rather than routine norm. Parent PC should be given email information by non parent PC. Strict audit will be carried out.

(v) No TA will be allowed in such cases.

(c) **Issue of Medicines.** Though salient aspects have been covered in SOP on medicine management issued on 05 Sep 2017, some of the imp aspects are highlighted as under :-

(i) For bedridden/chairbound or seriously ill beneficiaries, medicines may be issued to a representative with an Identity card & authorization letter (Auth : Min of Health & Family Welfare letter Circular dated 16 Feb 2016). It will be responsibility of ECHS beneficiary to ensure that same medicine is not taken from two sources for the same period else it will

result in cancellation of ECHS card. Issue of medicine must be recorded in the treatment book pending full automation.

(ii) In case of NA medicines in the first visit, person of 'special category' covered at Para 11 above can be given medicines through proxy having authority letter in subsequent visit for NA medicines. Tele/ video verification should be done where needed.

(iii) ECHS beneficiary should visit Pharmacy for NA medicines directly and there is no need to go through Regn process again in the PC.

(iv) **An ECHS beneficiary can be issued medicines from PC/ Service Hosp med store only when prescribed by PC/ Service Hosp/Empanelled Hosp (Referral based and emergency based when ER has been timely raised)/ Govt Hosp. Medicines prescribed by individual practitioner cannot be issued. Similarly medicines prescribed by non empanelled hosps cannot be issued.**

21. **Treatment in Local City/ Town When there is No Empanelled Facility.** This policy document recognises the difficulties associated with long distance travel & substantial waiting time for ECHS beneficiaries and hence new provision is being created. The following facilities can be utilised locally as illustrated (Though it is optional for ECHS beneficiary to exercise this choice. He/She can avail cashless treatment in empanelled hosps wherever available):-

(a) There are large number of areas in the country where there are no empanelled facility despite PC being located. In such a situation, ECHS beneficiary has to travel long distances wasting both time and money for minor tests/ consultation/ ailments. These treatment facilities may exist in civil set up in the same town.

(b) To quote when a patient is recommended Ultrasound/ Thyroid test in Banda(UP) by PC Banda, he /she has to travel to far off districts like Allahabad etc for minor tests as there are no empanelled facilities in Banda at the moment. Such a situation exists in fairly large number of the stations in the country.

(c) All out efforts are being made to empanel hosps in all districts, however till then, the following norms will be utilized for treatment of such patients for reimbursement of treatment/ investigation/ procedures etc.:-

(i) Once an investigation and/or consultation has been written by ECHS PC which is NA in empanelled hosp/ service hosp within the municipal limit of that city/town, individual can get the consultation and/or test done & prefer the claim on reimbursement basis on CGHS rates, if such a non empanelled facility exists in the municipal limit. This will be treated as standing prior sanction of MD ECHS for treatment in non empanelled hosp. For IPD treatment, service hosp/ empanelled hosp should not be available not only within the municipal limit of PC but also not within the district. OIC PC will endorse on the referral the following :-

“Investigation/ Consultation for \_\_\_\_\_ is NA within municipal limit of \_\_\_\_\_ city/ town in empanelled hosp/ service hosp and individual reimbursement is allowed at CGHS rates. This cert is issued in

compliance with Para 21(c)(i) of SOP on Treatment Management in ECHS for taking treatment in non empanelled hosp within the municipal limits". For example if USG is written by PC MO in Sitamarhi (Bihar), Civ facility on reimbursement basis on CGHS rates can be availed in Sitamarhi rather than travelling to Patna.

(ii) Once a particular treatment recommended by PC (consultation / investigation/ hospitalisation) is NA in any empanelled facility / Service hosp not having requisite test/ treatment facility in the district in which PC is located, incl reimbursement at CGHS rates will be allowed after sanction of SEMO where SEMO is located in the said station. This will be standing prior sanction of MD ECHS exercised by SEMO. Cert as under will be given for each claim :-

"Investigation/ Consultation for \_\_\_\_\_ is NA within district limit of \_\_\_\_\_ city/ town in empanelled hosp/ service hosp and individual reimbursement is allowed at CGHS rates. This cert is issued in compliance with Para 21(c)(ii) of SOP on Treatment Management in ECHS for taking treatment in non empanelled hosp within the district limits". For example if cataract operation is written by PC MO in Faizabad(UP), Civ facility on reimbursement basis on CGHS rates can be availed in Faizabad rather than travelling to Lucknow.

(iii) In non SEMO stations, standing prior sanction of MD ECHS will be issued by OIC PC if there is no empanelled hosp/ service hosp in the district. Cert given will be as under (This will be vetted by OIC PC before issuing referral as empanelment of hosp is a continuous process):-

"Investigation/ Consultation for \_\_\_\_\_ is NA within District limit of \_\_\_\_\_ District in empanelled hosp/ service hosp and individual reimbursement is allowed at CGHS rates. This cert is issued in compliance with Para 21(c)(iii) of SOP on Treatment Management in ECHS for taking treatment in non empanelled hosp within the District limits".

(iv) If limited facility is available in the empanelled hosp and/or service hosp within the district, Dir RC can issue standing sanction for treatment of all ailments whose treatment is NA in empanelled hosp/ service hosp in the district except those covered at Para 18(a)(i) to (vi) for which sanction will be accorded by CO ECHS on case to case basis.

(d) No TA is allowed for such cases.

(e) These provisions should be used with due caution. Anyone misutilising the provision will be ineligible for use of ECHS facility.

**Note.** 1. Prior sanction, when an empanelled facility/ service hosp exists, will be regulated as per Para 18 above.

2. These provisions are applicable in those districts where PCs are located. Once the decision on FMA entitlement is approved by Govt, simplified procedure for non PC/ non service hosp districts will be issued.

22. **Treatment at PC.** It will be endeavour to treat max ECHS patients with ECHS resources at PC itself. Patient will explain his/her medical difficulties to facilitate treatment. The following norms will be adhered at PC:-

(a) Priority will be accorded to the white card holders and those patients as covered at Para 9 above.

(b) Those requiring lifelong medication viz suffering from chronic ailments, such chronic patients should be seen at least once by doctor in three months to adjust medicine dosages. An attempt should be made to see them on their every visit to the PC. Excessive medication should be avoided. Prescription like 'CT x all for 30 days' should be avoided. The doctors of PC are advised to write name of all medicines prescribed when patient comes for review after three months. This will enable a deliberate opportunity being available to MO/Specialist for review.

(c) Subject to availability of medicines, medicine for such patients could be issued for three months in one go but record of the same should be maintained in treatment book till full automation is evolved.

(d) Those proceeding to foreign country can collect medicines for their stay in the foreign country after providing proof of move but not more than six months/ limited to say duration whichever is less. Travel tickets and visa should be produced as supporting document. Medicine issue should be recorded in the treatment book correctly. Patient proceeding to foreign counters should notify the PC as much in advance as possible to organize the medicine issue. Issue of medicines is dependent on availability.

(e) **'Referral' cannot and will not be demanded by ECHS patient. Similarly, no demand will be made for any test/process by the beneficiary.** The ECHS patient will explain the medical problems, produce the treatment details and it will be exclusive prerogative of MO/ specialist at PC to decide on the 'referral' as considered best for the health of the patient.

(f) It is the duty of the MO seeing the patient to write the diagnosis clearly whether case is being sent for referral to specialists in the PC or to the empanelled/ service hosp. BP and pulse should be invariably checked for all cases and mandatorily for Hypertension cases.

### **Generation of Referrals at PCs**

23. **Generic Norms.**

(a) As highlighted earlier, PCs are the primary treatment centres and will under no circumstances be converted into 'referral centres'.

(b) Patient must present his/her medical difficulties to the MO/DO/Specialists if available. Doctors attending will utilize all resources of PC to treat the patient including lab, X-ray and physiotherapy. Patient can not demand referral.

(c) Once the doctor decides that the treatment required is beyond the capacity of PC resources, referral will be issued. This criteria should be also applied for lab, diagnostic, physiotherapy & Dental referral as well.

(d) ECHS beneficiary can select any station under RC for his/her treatment after going through list of empanelled facilities having valid MoA which will be available at PC as well as RC & CO ECHS. The referral will have only name of the 'station/city' and ECHS beneficiary can go to any empanelled facility in the selected station/city. "TA" will not be admissible when opting for a station/city when Empanelled facility is available in the station/ city of parent PC (Auth : Gol (MoD) letter No 18(54)/2018/WE/ D(Res-I) dt 02 Aug 2018). Individual should be sure about empanelment facility having valid MoA and no 'stop referral' so that undue difficulties are avoided.

(e) In case ECHS beneficiary wants to utilize any empanelled hospital outside RC, he/she will have to take referral for the city/town where he/she wants treatment. Such referral should have signature of the patient to facilitate verification. However, patient has to physically report to the PC closest to the hosp selected. Once he/she reports to the PC so selected, priority referral will be generated. OIC PC will not endorse name of hosp on the referral form and the same will be treated an unfair practice.

(f) Diagnosis of referring doctor will be mentioned besides signature of patient being obtained so that the patient signature can be verified when reporting to nearest PC of selected hosp outside RC. This will avoid impersonation and collusion of hosps for unfair practices.

(g) **New Born Baby.** New born babies will be considered dependant on mother (beneficiary) upto 3 (three) months of age without separate card being made and bills will be reimbursed to empanelled hospital facility. (Primary beneficiary is required to make ECHS card of new born baby within 3 months of birth for continued treatment). All norms of treatment as applicable to mother will be applicable to new born baby and all billing/ processing will be done in the name of mother with details of new born baby mentioned. (Auth: CO EHCS letter No B/49770/AG/ECHS/Policy dt 25 Sep 2007)

(h) TA will be entitled strictly in terms of Gol (MoD) letter No 22D(18)/2017/WE/D(Res-I) dt 07 Aug 18 consequent to which detailed instrs have been issued vide our letter No B/49783/AG/ECHS dt 17 Sep 18. Salient aspects are as under :-

(i) City/town of parent PC will be first preference to utilize the empanelled facilities. No TA is authorised.

(ii) If desired treatment is **not available** in the city / town of the parent PC, patient can select any empanelled facility within the RC. TA will be allowed only if selected city is the closest to the city/ town of parent PC. Even if desired treatment is available in parent city / town, patient can select any emp facility within RC but no TA will be admissible.

(iii) Patient can also opt for city / town outside RC for his/her own reasons for treatment but TA will not be admissible if same treatment is available in any empanelled hosp in the RC.

(iv) There is no restriction on mode of transport but entitlement will be limited to actual/ entitled class of rail travel/ Govt bus.

24. **Process for Mil PCs/ Service Hosps.**

(a) In case of PC being mil PC i.e PCs located with service hospitals (excluding those which are located in Mil Station as per Encl 5), all patients beyond treatment of Mil PC will be referred to service hospitals for subsequent treatment. (Auth : CO ECHS letter No B/49774/AG/ECHS/Referral dt 01 Dec 2009)

(b) Since treatment through PC is primarily a planned treatment and therefore ECHS patient where they feel the need of specialist consultation of service hospital, they should utilize the nominated days for OPD Consultation.

(c) IHQ of MoD (Navy) has allowed ECHS beneficiaries over 75 years of age to report directly to OPD in all Naval hospitals and has also given direct access to Specialists of service specialist on OPD days and therefore the same should be utilized without going through PC. **Similar concession has been requested from Army & AF hospitals.** (Auth: IHQ of MoD, DGMS (Navy) letter No ECHS/034/Poly Funct dt 06 Jul 2018)

(d) Continuous effort will be made to open large No of service hosps for specialist consultation on OPD days without going through PC to save time and ensure early treatment. ECHS beneficiaries must keep a track on such updates.

(e) When an ECHS beneficiary reports directly to OPD/ IPD of the service hosp/ after referral by ECHS PC, medicines as prescribed should also be preferably given through ECHS medical store in the service hosp to reduce unnecessary running around of the ECHS beneficiaries. Record of medicine issue must be entered in the treatment book. **Any one drawing medicines through two sources for the same duration will be ineligible for ECHS membership.**

(f) When an ECHS beneficiary has been referred from Mil PC to the adjacent service hosp, he/she will be treated by service hosp in totality. In case of capacity constraint, the patient can be referred to ECHS empanelled hosp by ECHS Cell if the same has been established in the said service hospital. 'Log in' credentials of Mil PC can be taken. In case of non availability of ECHS cell/Direct OPD consultation/non availability of requisite capacity in the service hosp, patient needs to come back to mil PC for referral to empanelled facility.

(g) An attempt is being made to utilize our service hosps to the extent feasible. When a service hosp has made it available to other patients than its own mil PC, disposal should be done as per Para 24(e) above. It should accept patients based on direct referral from the PC rather than going through Mil PC. For example, if PC Faizabad (MH Faizabad being small and not having many specialist facilities) or PC Raebareli (non Mil PC) refer a patient for cataract operation to Comd Hosp, Lucknow or for Joint replacement to Base Hosp, Lucknow, such patients should be treated by Comd Hosp, Lucknow/ Base Hosp, Lucknow directly. No referral from Mil PC Lucknow is required for treatment. These patients will be sent to PC Lucknow for referral to empanelled facility if the treatment is beyond Comd Hosp, Lucknow/ Base Hosp, Lucknow or there is no

spare capacity. While it is mandatory for Mil PC to route patients though service hosp, service hosp can treat any ECHS patient directly irrespective of his/her dependence on any PC in the country if the capacity exists.

25. **Duration & Validity of Referral: Timeline.**

(a) Normal referrals are valid for 30 days from the date of issue, both days inclusive viz if a referral has been issued on 15 Jan, it will remain valid till 13 Feb (15 Jan to 13 Feb:30 days including 15 Jan & 13 Feb).

(b) In case of Dialysis, Cancer (Radiotherapy, Chemotherapy etc), Diabetes, Hypertension & other cardiac patients, the referral will remain valid for 180 days (both days inclusive, No of sessions will also be specified).

(Auth: Gol (MoD) letter No 22A(55)/2013/US(WE)/D(Res) dt 05 Jul 2013)

(c) There have been complaints from dental patients/dental clinics that in certain cases they are not able to complete the process within 30 days of the referral. Dental referrals will therefore be valid for 60 days (both days inclusive) from the date of issue.

26. **Validity of Referral: Content wise.** It is essential that minimum difficulty is faced by the ECHS patient to get the desired treatment and there is no unnecessary running up and down for additional referrals. Procedure outlined as under will be followed:-

(a) Referring MO/Specialist will assess clearly the need of treatment to include consultation, lab & diagnostic tests and admission for treatment. The same will be clearly indicated in the referral form.

(b) Vague and generic referrals like consultation/test/admission '**as required**' **will not be issued**. Referring doctor should utilize his professional ability and endorse clear cut referrals.

(c) If there is reasonable necessity of any treatment activity, the same should be clearly endorsed in the referral form to avoid unnecessary running around by the veterans.

(d) Empanelled hospitals can reduce the tests prescribed if something is not needed but cannot increase the same. Empanelled hospitals will complete all activities given in the referral form and generate a consolidated bill after all activities are over.

(e) If an ECHS patient does not utilise/turn up for all tests, Emp hospitals can generate the bills for conducted portion after validity of referral duration is over. No bill will be generated for the treatment/ test not carried out.

(f) Since all claims are required to be signed by the ECHS beneficiary and should have Mob Number, these must be signed on regular basis even if claim is required to be preferred at the end of referral.

(g) When a patient is referred to an empanelled hosp for any treatment, it must be done in totality, for example, if a patient has been referred to an empanelled hospital, consultation, all investigations and surgical procedures will be done by the empanelled hosp. **Package cost includes treatment/procedure including admission charges, accommodation charges, ICU/CCU charges, monitoring charges, operation theatre charges, operation charges, anesthetic charges, procedural charges/Surgeon fee, cost of disposables, surgical charges and cost of medicines used during hospitalization, related routine investigations, physiotherapy charges etc. and the package rate does not include diet, telephone charges, TV charges and cost of cosmetics, toiletry and tonics. (Auth : Para 4(b)(iv)(v) of MoD (Gol) letter No 24(8)/03/US(WE)/D(res) dt 19 Dec 2003).** It has been seen that some of the empanelled hosps send back ECHS patients for lab/ diagnostic test from PC/ service hosp/ other hosps which is strictly prohibited. In case of all IPD cases also, if a particular test is NA in the referred hosp, same will be organized by empanelled hosp and ECHS will be billed as per CGHS rates. If such a test happens to be 'unlisted', sanction will be obtained by the empanelled hospital.

(h) Empanelled hosps will not prolong hospitalization pending tests/ sanctions beyond reasonable time.

27. **Number of Referrals.** Normally only one referral is to be given to the patient, however, it may not be possible to get all the treatments in single hosp for example, a patient may need eye treatment as well as dialysis which may not be in a single empanelled hosp or the patient may need to space out his/her treatment. To address such issues, patient may be given two referrals at one time on a particular day based on his/her medical condition. It is the duty of both ie ECHS beneficiary and well as empanelled hospital/ PC/ Service hosp that only legitimate persons are treated.

28. **Proxy Referrals.** Normally proxy referrals will not be given. However, in case of bed ridden/chair bound or any such serious cases, proxy referral may be given at the discretion of MO/Specialist of PC with approval of OIC PC. He/She can satisfy himself/herself with the condition of patient by video call (if required). Proxy person should be having valid authority letter and proof of identity in such cases.

29. **Generation of Referral.** Generation and issue of referral form takes unduly long time. Due to current need of signing of MO and OIC PC, it takes too much time specially when OIC PC is away on leave/out on official duties. The revised and simplified procedure is being worked out but following will be ensured:-

(a) All computers of MOs will be mac binded and will have particulars of MOs referring the patient when the referral printout is taken out/electronically despatched.

(b) Referral will be electronically moved to referral sec which will cross check city selected and availability of at least some empanelled hosp and will get the document signed. No document will be delayed beyond 30 mins. It will be stamped. In case of OIC being away, the same will be signed by nominated doctor record of which will be maint as Offg OIC PC.

(c) **Once automation is done, patient will be given a reference code by the reference cell and there will be no need to carry referral docu. Person can go to any empanelled hosp of the city selected, give code & referral will be activated.**

30. **Local Restrictions for Treatment in Service Hosps.** Our service hosps are islands of professional excellence and veterans repose their faith due to selfless service. An effort is being made to utilise the spare capacity of service hosps to give quality health care in a familiar environment besides conserving the expenditure. ECHS beneficiaries and all other stake holders need to be updated on this. Sailable aspects are as under :-

(a) For cardio and TKR/THR cases, all patients from any PC in the country (mandatory for all 13 Polyclinics of NCR) can be referred to Army Hosp (R & R) directly. Referral should be made to ECHS Cell, Army Hosp (R & R) (ECHS Polyclinic Base Hosp, Delhi Cantt). Such patients can directly report to ECHS Cell at Army Hosp (R & R) and no need to go to ECHS PC Base Hosp Delhi Cantt. Telephonic coord should be done between OIC Polyclinic referring the patient & ECHS Cell, Army Hosp (R & R) before the patient is sent on tele No 011-23338199 (extension 38020, 38254 & 38387). This utilization of Army Hosp (R & R) will be available till the time spare capacity is available and change, if any will be notified.

(b) In this regard, referral to Army Hospital(R&R), Delhi from ECHS polyclinics of NCR for CTVS and JRC is mandatory as specified vide Para 3 of CO ECHS letter No B/49774/AG/ECHS/ Referral dated 22 Jun 2017 and even letter No dt 20 Jul 2017 which specifies that "all **planned** cases of Cardio, TKR & THR will be referred to Army Hosp (R & R) first. If for some reason, AH(R&R) cannot treat such patients and waiting time is more than 45 days then only referral can be made for empanelled hospital." Exceptions may be granted only to those cases where part treatment has already been taken prior to 20 Jul 17. In case of waiting period being more than 45 days for TKR/THR at Service Hospital, the patient can be referred to the empanelled facility but endorsement of this effect by JRC at Army Hosp (R&R) will be mandatory.

(c) Cardio Treatment Centre & JRC at AH (R&R) **will not endorse that the patient does not want treatment in AH (R&R).** They will endorse the date of operation as per roaster. If waiting period is more than 45 days (both days inclusive ie date of reporting initially and date of operation), patient can return to ECHS PC and get his referral for an empanelled facility.

(d) Waiver for above conditions can be given by only MD ECHS based on merit of the case.

(e) OIC PC referring cases of this category to empanelled hospital without above process will be responsible for payment. Empanelled hosps undertaking such treatment will not get paid.

(f) **Patients coming to Delhi-NCR from outside for these two conditions will be also subjected to similar norms. If a patient from Lucknow comes to Delhi for TKR, he will be put though AH (R&R) JRC Centre.**

(g) All patients from Base Hosp Mil PC will also utilise Cardio & Ortho facilities (for TKR/THR) from Base Hosp Delhi Cantt. These two facilities can also be utilised by all PCs in Delhi-NCR as well as by other PCs in the country with due telephonic coordination. Contact No of Ortho Dept in Base Hosp Delhi Cantt is 23337199 (extension 37033) whereas that of Cardio Dept is 23337199 (extension 37024). Patients can go out to empanelled facilities if waiting time is more than 45 days as explained.

(h) Max TKR/THR cases in the country will be done in service hosps and RCS concerned will notify to all PCs in their AOR. Norms for treatment for extra reach out, when implemented, will be notified to CO ECHS.

(j) It has been observed that emergency cases when report to a service hosp are being sent to an empanelled hosp even without administering basic treatment/ stabilization. All concerned should be sensitised for life threatening conditions to treat/ stabilise the patient and assist in shifting to another facility.

(k) No local restriction will be imposed for waiting period for more than 45 days for an elective treatment which are not time sensitive.

31. **Preventive Tests.** It has been observed that some of the patients keep demanding number of tests/referral for tests for preventive reasons. These are currently not allowed. Only ailment based treatment/tests will be conducted both at PC/referred facility. **Proposal for annual health checkup is being forwarded to MoD(DOESW) for consideration so that timely screening can assist our veterans in early detection of ailments which will assist in quality health care well in time besides being cost saving in long run. Update will be notified when approved.**

32. **Issue of Medicines.**

(a) Medicine supply is the resp of O/o DGAFMS. It was being supplied through AFMSD but now SEMOs have been made responsible with effect from Sep 16. Adequate funds are allocated to O/o DGAFMS to meet this requirement. It should be therefore possible to meet bulk requirement of medicines through SEMO. SEMO must forward their fund requirement well in time to O/o DGAFMS.

(b) ECHS is mandated to issue 'generic medicines'. Patients should not insist on branded medicines/ medicines written by empanelled hospitals. Focus should be on the 'content'. If salt content is the same, any alternate medicine should be accepted.

(c) All stake holders must focus on 'curative medicines' as against food supplements/ vitamins. MOs should educate ECHS patients on healthy life style and healthy food as well as on philosophy of 'prevention is better than cure'.

(d) Comprehensive SOP on medicine mgt has been issued on 05 Sep 17. It's provisions should be utilised to modify prescription of medicines as required by MOs of PCs/ service specialists.

(e) Govt (MoD) has accorded approval for empanelling of Auth local Chemists (ALCs) for all PCs as per their letter No 22D(01)/2016/WE/D(Res-I) dated 22 Aug 17 for which detailed instructions have been issued vide our letter No B/49762/AG/ECHS/Medicine Policy dt 29 Aug 17. Govt has further relaxed the criteria vide their letter No 22D(01)/2016/WE/D (Res-I) dated 25 Jun 18 which should now facilitate all Stn Cdrs to empanel ALCs for all PCs. These ALCs are mandated to provide medicines within 24 hr (if loc within the municipal limit in which PC is loc) or upto 72 hr if located outside. Power of expenditure/month is as under:-

- |       |               |   |                     |
|-------|---------------|---|---------------------|
| (i)   | Type A& B PCs | - | Rs 2.5 Lakhs/Month. |
| (ii)  | Type C        | - | Rs 1.5 Lakhs/Month. |
| (iii) | Type D        | - | Rs 1 Lakh/month.    |

**Note.** Based on requirement, powers can be enhanced by MD ECHS for which an email should be sent to Dir (P&FC) and MD ECHS on their email by Stn HQ concerned after formal approval of the requirement by Stn Cdr. Enhancement is need based and not anticipatory.

(f) In addition to ALC, Jan Aushadhi Stores can be also empanelled for each PC and can be used to provide medicines which are NA in PC. Jan Aushadhi stores are deemed to be empanelled and therefore MoA can be signed straightway. Overall power of expenditure will not be exceeded as approved for a particular PC as given in Para 32(e) above. All Stn Cdrs would make endeavour to ensure that all PCs are covered by ALC as well as Jan Aushadhi.

(g) It needs to be noted that order for medicines for patient though ALC should be placed when medicines is NA in PC dispensary. It has nothing to do with medicine availability in service hosp/ medicine awaiting supply.

(h) In case of mil PCs, medicines NA in PC should be issued by MH Dispensary as well so that the patient gets prompt disposal. All processes must ensure that patient gets medicines earliest, at least 100% in curative segment.

**(j) Case has been taken up with MoD (DoESW) for allowing purchase of medicine on reimbursement basis if medicines are NA from PC dispensary as well as ALC. Exact procedure will be outlined once Govt approval is accorded and approved norms are known.**

(k) **Returned Medicines.** All ECHS beneficiaries should return the medicines which they don't use for reasons not withstanding through 'drop box' kept in each PC. It needs to be remembered that these medicines have been purchased from our funds and must be made use of details of which have been covered in SOP on medicine management issued on 05 Sep 17. All these medicines having residual shelf life will be taken 'on charge' and will be merged into stock.

33. **Additional Facilities.** The MOs of PC function as AMA (Authorised Medical Attendant) for ECHS beneficiaries, hence, the following additional facilities may be availed by ECHS card holders free of charge provided these don't affect healthcare of patients adversely (preferably between 1500 hr – 1600 hr subject to discretion of OIC PC): -

- (a) Sickness certificate.
- (b) Fitness certificate.
- (c) Medical certificate for Driving License or any other Govt requirement.
- (d) Medical fitness cert for employment if permitted by employing agencies.  
(Auth: CO ECHS letter No B/49773/AGE/CCHS/Rates/Policy dt 07 Jul 2015 and CO ECHS letter No B/49701-PR/AG/ECHS/2018 dt 10 Sep 2018)

34. **Participative Approach.** ECHS beneficiaries should adopt 'ownership' approach towards ECHS facilities at Polyclinic and maintain service norms. In case of breakdown of internet/SW or any other problem, focus should be on resolution of the problem rather than escalating the problem. An effort should be made to join 'SPARSH' as a volunteer and be part of process to help other beneficiaries. Documents required to be produced should be produced. Salient aspects of project 'SPARSH' commenced wef 10 Oct 17 are as under:-

- (a) Integrating veterans community into day to day activities of ECHS and making it more beneficiary friendly.
- (b) Involving serving community by reaching out to the veterans in ECHS PCs, service hosps and empanelled hosps. Making serving fraternity more connected with veterans and enhance the concept of Armed Forces as 'one large family'.
- (c) Involving NCC/ NSS/ NGOs willing to serve those who have served the nation. This will motive young generation and best talent will be willing to joining Armed Forces.
- (d) The Volunteers can involve themselves in multitude of activities which are undertaken by the staff PC and much more. The involvement of the volunteers is defined by his/her skill set, aptitude, professional qualification as well as local requirement dictated by the load of patients on the PC as well as individual requirement of veterans visiting the PC. A small list of tasks (which in no way is restrictive/ exhaustive) is appended below, (these can be taken as an indicator) under the overall control of OIC PC:-
  - (i) Segregation of returned medicines at PCs.
  - (ii) Assist War Wounded/ Battle Casualty/ Wheel chair bound patients.
  - (iii) Assist in mgt of waiting patients/ queues.
  - (iv) Counselling/ Taking/ assisting patients in distress. Guiding wrt rules and regulations.

- (v) Noting/ receiving concerns/ grievances of patients.
- (vi) Voluntarily sharing their skills in terms of Adm, IT, Documentation as on reqd basis.
- (vii) Cood with Service Hosp/ Empanelled Hosp wrt availability of specialist/ beds.

35. **Responsibility of Treatment.** It must be ensured that only eligible beneficiaries should take treatment. Treatment by ineligible patient/impersonation/ drawing of medicines from two sources for the same duration/declaration of wrong income/treatment by more than one treatment discipline or any unfair practice will make such persons and their dependents 'ineligible' for ECHS benefits.

### **PART 3 – ACTIVITIES AT GOVT HOSPITALS**

36. All ECHS beneficiaries are entitled to avail all facilities of all Govt Hospitals on **100% reimbursement basis. CGHS rates don't apply.** Medicines issued during treatment can also be reimbursed. However, these must be purchased from the authorised medical stores of Govt Hospitals.

37. **No referrals from PC is required except in the following cases, however, the beneficiary must inform the parent PC within 48 Hrs of treatment having commenced :-**

- (a) Major cardiac surgery/ interventional cardiology.
- (b) Oncology.
- (c) Organ transplant cases.
- (d) Joint Replacement cases.
- (e) Major Neurosurgical / Neurology cases.
- (f) Bariatric Surgery.

38. The following hospitals are 'Hospitals of National Repute':-

#### **Govt Hospital/ Institute**

- (a) All India Institute of Medical Sciences, New Delhi.
- (b) Post Graduate Institute, Chandigarh.
- (c) National Institute of Mental Health and Neuroscience, Bangalore.
- (d) Medical Colleges and Hospitals under the Central or State Government.

- (e) JIPMER, Pondicherry.
- (f) Sanjay Gandhi Post Graduate Institute, Lucknow.

**Non Govt Hospital/Institute**

- (g) Tata Memorial Hospital, Mumbai (for Oncology).
- (h) Christian Medical College, Vellore.
- (j) Shankar Nethralaya, Chennai  
(Auth : GoI (MoD) letter No 24(8)/03/us(we)/d(Res) dt 19 Dec 2003)

39. Method of treatment for availing facilities of hospitals of national repute is as under:-

- (a) For all Govt Hosps/ Institutes – Applicable as per Para 19 above.
- (b) For Private Hosps/ Institutes – Referral & prior sanction must be taken. Exact procedure has been outlined at Para 19(c) above.  
(Auth : GoI (MoD) letter No 22D(09)/2013/US(WE)/D(Res) dt 26 Jul 2016)

40. While 100% reimbursement is allowed in Govt Hosp, the expenditure is required to be incurred by the individual first. Attempt is being made to sign MOA with leading Govt hosps after which the treatment will become 'cashless'.

41. **Advance for Treatment for Hosp of National Repute.** To address the concern of huge expenditure required to be incurred by the beneficiary while taking treatment in Govt Hosp/ Hosp of National Repute, advance upto 80% of likely expenditure can be provided to the individual for treatment. The amount will be paid to the treating hosp directly whereas balance amount can be claimed by the beneficiary after treatment is over. (Auth : CO ECHS letter No B/49773/AG/ECHS/Med Advance dt 16 Mar 2004). The salient aspect of the procedure is as under :-

- (a) Medical advances will be given through the cash assignment by the Dir RC/ Dy MD/ MD ECHS, through Regional Centre ECHS and will be provided as per limits laid below :-
  - (i) Indoor treatment in hosp for a General Condition – Rs 10,000/- or amount recommended by physician whichever is less.
  - (ii) Specialised procedure eg. Cardiology, Knee transplant etc. – 80% of package deal/ amount demanded by hosp.
- (b) ECHS beneficiary will obtain and submit a certificate/ estimate from the treating doctor of the recognised/ Govt Hosp (as mentioned in Para 38 above) to the OIC PC or, in the interim, to CO Service Hosp, alongwith his application for advance.

(c) The OIC PC or CO Service Hosp will thereafter submit the following to the SEMO/SMO/PMO :-

- (i) Application for advance from ECHS member, made on plain paper.
- (ii) Photocopy of ECHS card.
- (iii) Details of referral form and Regn No duly authenticated, ICD Code, Diagnosis and hospital referred to.
- (iv) Estimate of Hospital.
- (v) Certificate from ECHS member or dependant certifying that bills in original will be deposited with the OIC PC or CO Service Hosp within one month of discharge, failing which the ECHS membership will be terminated.
- (vi) The SEMO/SMO/PMO will scrutinize the documents and comment on the line of treatment proposed in the hosp and recommend if the advance may be given to the ECHS beneficiary.
- (vii) The documents will thereafter be forwarded to the CFA (RC ECHS/ CO ECHS) for scrutiny. CFA is the appropriate authority for sanctioning the medical advance. At the CO ECHS. the following action will be taken once advance is paid :-
  - (aa) Approval of competent financial authority based on estimates of treatment.
  - (ab) Inform Regional Centre, ECHS.
  - (ac) RC concerned to Inform OIC PC to subsequently track receipts of bills.
- (viii) A cheque will be issued by Dir RC in the name of the treating hospital after approval of CFA is obtained. In case the amount of advance is more than the authorized financial limit of MD ECHS, necessary approval of MoD (DoESW) will be obtained. **No Advance will be paid directly to ECHS members.**

#### **PART 4 - ACTIVITIES AT EMP HOSP/FACILITIES**

42. Empanelled facilities play a key role in providing quality healthcare to our veterans and their dependents. Having opted for empanelment and signed the MOA, it is the responsibility of empanelled facility to provide the prompt quality healthcare to our veterans without any bias. Respect as due to service veterans must be given. Similarly, ECHS patients must maintain the decorum for which they are known. This portion will illustrate functional aspects to bring clarity for effective implementation. No of Prosthetic centres have been empanelled for our disabled veterans.

43. **Voluntary Treatment at CGHS Rates.** Details have been covered at Para 15 above.

44. **Referral based Treatment.**

(a) All emp facilities will treat all ECHS patients based on valid 'referral' form from the PC within the RC with which they have signed MOA. No cross referral exists now after issue of our letter No B/49771/AG/ECHS/Emp/Gen dt 16 Feb 2018.

(b) ECHS patients coming from outside RC are mandated to report to nearest PC of the hosp where they want to take the treatment. In such cases, a fresh referral is required to be generated after which the patient becomes local to recipient PC. For example, when an ECHS patient dependent on PC Jammu decides to take treatment at Mumbai, he takes a referral from PC Jammu for Mumbai. On reaching Mumbai, if he/she decides to take treatment in Fortis Hospital Mulund, he needs to report to PC closest to the Fortis Hosp, Mulund which will generate a fresh referral based on which the patient will report to his selected hosp viz Fortis in the instant example. Hospital will treat this patient as a patient from PC of Mumbai, treat and prefer the bill on RC Mumbai. Harassment of any kind will draw penalties on erring entities.

(c) **Even if a patient comes with a referral form from a PC for a treatment for which the hospital is not empanelled, treatment will not be provided.** Hospital must provide the treatment only for the facilities they are empanelled. No claim will be permissible for honouring a wrong 'Referral' based treatment when not holding valid MoA or under 'Stop Referral' as hospitals must be clear with Govt order for which they are empanelled and signed MoA. In case of any variation, Gol (MoD) order will be the base document.

(d) No separate timings/days will be earmarked by any hospital resulting in unfair/delayed/discriminatory treatment. CGHS rates of payment being low will not be given as an excuse for such activities as hospitals have opted for empanelment willingly and voluntarily.

(e) In case of bed not being available, authentic inputs will be maintained. Wrong inputs will draw penalties. In case bed is NA, empanelled hosp should send the patient to other empanelled hosp under its own coordination.

(f) All specialists as available in the empanelled hospital for facilities empanelled will be made available to ECHS patients without any discrimination.

(g) Dedicated person will be earmarked with his Mob No/Contact No available to all ECHS beneficiaries including one stage up respondent so that ECHS beneficiaries can approach them for their treatment related difficulties.

(h) No Cheque/ Cash/ Payment will be taken from ECHS patients under any circumstances except when the patient opts for higher value implant than the ceiling limit for which written consent will be obtained. No payment for disposal etc is allowed to be charged. (Auth : Para 4(b)(x) of Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003)

(j) **Disposable Surgical Sundries.** No reimbursement is allowed for the items of common surgical materials like gauze bandages, leucoplast, cotton, crepe bandage etc. which are supplied from the hospital.

(k) Normal referral is valid for 30 days except incase of dental where it is valid for 60 days. Referral for Dialysis, Cancer (Radiotherapy, Chemotherapy etc), Diabetes, Hypertension & other cardiac disease is valid for 180 days. All treatment required in response with these referrals will be initiated within this period provided first day of admission falls within referral period. If it results in admission, treatment can continue as per specified period. Bills will be raised after completing all activities as per the referral form. A single bill will be raised at the end of 30 days (normal referral cases)/ 45 days (dental cases). In case a test result is received late, the timing of upload will commence from the last test result recd.

(l) In case of Dialysis, Cancer (Radiotherapy, Chemotherapy etc), Diabetes, Hypertension & other cardiac disease where referral is valid for six months with number of sessions specified as advised by PC/ Service/ Govt specialist, bills can be raised after each session.

(Auth : GoI (MoD) letter No 22A(55)/2013/US(WE)/D(Res) dt 05 Jul 2013)

(m) ECHS beneficiary must sign and put Mob No on the bill both in case of OPD as well as IPD treatment. In case of standalone diagnostic lab where reports are released online, signature & phone number of ECHS beneficiary is mandatory on referral form to avoid inconvenience to the patients and the lab itself. Hospital must ensure that the beneficiary is valid and no impersonation takes place. In case beneficiary not in fit mental/physical condition, sign and Mob No of NOK should be taken. This holds good for permission/consent wherever required.

(n) Patients must scrutinise the details of ward, medicines & other aspects which have been billed to them. It is our 'budget' and all ECHS patients should assist in arresting wrong and excessive billing.

(o) All empanelled facilities of the hosp must be provided. **Selective availability is Not allowed.**

(p) When a patient is referred to an empanelled hosp for any treatment, it must be done in totality, for example, if a patient has been referred to an empanelled hospital, consultation, all investigations and surgical procedures will be done by the empanelled hosp. Package cost includes treatment/procedure including admission charges, accommodation charges, ICU/ICCU charges, monitoring charges, operation theatre charges, operation charges, anesthetic charges, procedural charges/Surgion fee, cost of disposables, surgical charges and cost of medicines used during hospitalization, related routine investigations, physiotherapy charges etc. and the package rate does not include diet, telephone charges, TV charges and cost of cosmetics, toiletry and tonics. (Auth : Para 4(b)(iv)(v) of MoD (GoI) letter No 24(8)/03/US(WE)/D(res) dt 19 Dec 2003). It has been seen that some of the empanelled hosps send back ECHS patients for lab/ diagnostic test from PC/ service hosp/ other hosps which is strictly prohibited. In case of all IPD cases also, if a particular test is NA in the referred hosp, same will be organized by empanelled hosp and ECHS will be billed as per CGHS rates. If such a test happens to be 'unlisted', sanction will be obtained by the empanelled hospital.

(q) Empanelled hosps will not participate/ organise any medical camp outside their premises for ESM/ ECHS patients. Written permission of RC will be taken if free screening/ test is offered within the premises of the hosp.

45. **Emergency based Treatment.**

(a) Condition of emergency has been clarified at Para 16 above.

(b) **The basic principle of emergency for individual rushing to/ brought by others relates to nearby facilities.** There is no justification of patients from Sonipat running to hospital in Greater Noida as emergency case. These will be treated as misuse unless the person developing emergency happens to be in Greater Noida due to some reason cases of which kind will be few and will be specifically examined.

(c) Once an ECHS patient reports to any empanelled hospital on basis of emergency, doctor will decide the level of emergency. At times, patient feels that there is emergency and doctor needs to conduct tests to decide on the emergency. In such cases, when the emergency is confirmed, the treatment will commence on 'cashless' basis and ER will be raised within 24 hr. It needs to be known that empanelled hospital will make their non-empanelled facilities also available for treatment of emergency patients that too on cashless basis.

(d) Since emergency as defined in ECHS environment as life threatening condition, treatment will not be delayed for any sanction even if it is an unlisted procedure. 'Procedure' will be undertaken and will be justified in discharge summary by the empanelled hospital.

(e) **In case after evaluation, it is found that the emergency is 'not real', the patient will be discharged and bill will be preferred on day care basis as per Para 4(b)(iv) of Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003 (1 day for day care/ minor procedures (OPD)). The hosp can prefer bill including Consultation charges, investigation & medication (no room rent will be paid if detention not more than 6 hour) as per following details:-**

(i) **Online intimation of such cases will be raised on BPA website immediately on reporting of patient.**

(ii) **Date & time of reporting (admission) and date & time of discharge (No of hours detained / admitted in emergency room/ ICU) will be clearly mentioned in discharge summary.**

(iii) **Hosp can prefer bill including consultation, investigation and medication charges in such cases.**

(f) It will be responsibility of empanelled hospital to generate ER within 24 hr in such cases to facilitate verification by concerned PC. **Highest degree of professional acumen should be exercised by treating doctor so that this provision is not misutilised.**

(g) Cases of dog bite/snake bite/animal bite will be treated as an emergency & day care treatment can be provided & bills raised accordingly.

(h) Due to advancement of medical science, large number of procedures incl cataract operations are being done on day care basis. The bills can be raised on day care basis for all such cases. No unnecessary hospitalisation will be done for unnecessary billing.

46. **Hospitals should desist from generating wrong emergencies as the same will invite strict action.** In case of doubtful cases, the benefit of doubt must be passed on to the patients. **Tendency of wrong case sheet being written to project normal cases as emergency cases will be strictly monitored and the same will draw strict action. Attendants coming with emergency cases should not be admitted as emergency patient as the same is an unfair practice.**

47. **Duration of Hospitalisation.**

(a) Duration of hospitalisation for various ailments is broadly as under though it will depend on case to case basis:-

- (i) Specialised procedures - 12 days.
- (ii) Other major procedures - 07- 08 days.
- (iii) Laparoscopic surgery - 03 days.
- (iv) Day care/minor procedures - 01 day.

(b) The hospitals must focus on active treatment and admission duration should not be unduly extended only for generating unnecessary bills. Only minimum & essential duration should be used. The current duration for sanction is as under (no sanction required upto 12 days but it does not mean that patients have to be admitted for 12 days):-

- (i) OIC Polyclinic - 13 to 30 days.
- (ii) Dir Regional Centre - 31 to 60 days.
- (iii) MD ECHS - Above 60 days upto 120 days.

(c) **It is the resp of the emp hosp to get the hosp extn done that too well in time. Though an attempt is being made to automate the whole process when norms will also be changed, but empanelled hosps making attendants of patients run for this should not be done.** Timely sanction is essential.

(d) There have been cases wherein empanelled hosps tend to continue with patients for 12 days admission and discharge prior to that so that sanction is NOT required but the same patient is admitted in same hosp or in different hosp with break which is not permitted.

(e) There have been cases wherein patients take referral & get admitted in the empanelled hosps. An effort is made then to continue getting extns without any need of active treatment. Such cases will be strictly analysed.

(f) **Empanelled hosps will not forge signatures for extension/ consent/ bills under any circumstances. Any such act will result in initiation of disempanelment process.**

48. **Unlisted Procedure.** Appx 'A' for unlisted procedure should also be obtained by empanelled medical facility before undertaking the procedure but the obtaining of sanction should not be delayed to prolong the hospitalisation of the patient. Tendency to admit & bill and then commence actual process after No of days to be avoided. **An attempt is being made to automate this procedure as well.**

49. **Value of Implants.** In cases where ceiling rates of implants has been specified by CGHS/ECHS, any patient opting for higher value implants has to pay the difference of cost. Necessary written consent from patient/ NOK must be obtained by empanelled medical facilities (Auth: Para 4(b)(x) of Gol (MoD) letter No 24(8)/03/US(WE)/D(Res) dt 19 Dec 2003).

50. **Issue of Medicines.** Empanelled hosps will issue medicines upto seven days subject to value not being more than Rs 2000/- after patient is discharged in IPD cases (Normal as well as emergency cases). Medicines beyond this will be issued by PCs. Hosps will write generic medicines. **Once ECHS mgt sys in automated, it will endeavour to integrate with MIS of hosps to have better medicine satisfaction.** PCs should coordinate with empanelled hosps with their list of medicines for better satisfaction of patients.

51. **Issue of Treatment Documents.** One copy of entire treatment document will be given to patient incl DVD/X-Ray etc free of cost as after 01 Apr 2018 when the digital billing has commenced, hosp is generating only one copy of docu which is being kept with the hosp for records (original). Earlier this was being sent to RC for bill processing while one copy was being retained at empanelled hosp for records. In the changed sys, one copy of bills will be given to patients 'free of cost' so that they can use the same for future treatment besides checking the correctness of billing.

## **PART 5 - ACTIVITES POST VISITING PCs/HOSPITALS**

52. **Activities Post visiting PCs.**

(a) Patients must ensure that they are carrying back all their documents safely and endorsements have been made in their treatment book.

(b) Since the referral is now city/town based, they must check the details of empanelled facilities details of which will be made available at PCs. It is the responsibility of patient to go to the right hospital in the selected city.

(c) Patients requiring regular medication for chronic ailments may draw their medicines 10 days in advance of next due date (NDD) but medicine availability will be calculated from next due date (NDD).

(d) Though referral is valid for 30/60/180 days, an endeavour should be made to commence the treatment at the earliest so that the health problem does not aggravate.

(e) Patient must be clear about the manner in which medicine has to be consumed in terms of dosage, number of times in a day and empty stomach/after food as the case may be. Necessary guidance for the same should be given at the PC.

(f) Treatment details including medicines must be recorded in the treatment book till the time full automation takes place.

(g) **Domiciliary Medical Eqpt.** Procedure for procurement and issue of domiciliary medical eqpt has been issued vide our letter No B/49761/AGECHS/Policy dt 31 May 18 and letter No B/49762/AG/ECHS dt 31 Jul 18. SEMO is currently responsible for issue of domiciliary eqpt. Ceiling limits as applicable now are attached as Encl 6. **However, proposal for further easing out for procurement & issue of domiciliary eqpt for ECHS beneficiaries residing in Non-Mil stn and remote areas has been fwd to MoD for consideration.**

53. **Activities Post Hosp Visit.**

(a) Details of treatment has been checked and signed by beneficiary.

(b) Copy of treatment details & bills be obtained if required free of cost as covered at Para 51 above.

(c) Review date be noted. Some of the Hosps are providing free review after surgery which be availed without any referral. **Subject to their voluntarily decision, all empanelled hosps should provide first review free of cost after surgery.**

(d) For Patients who have come from outside their RC, one review referral can be generated by local PC without referral of parent PC if it happens to be within 30 days of discharge.

(e) **NA Medicines.**

(i) All out effort will be made by SEMO to provide medicines.

(ii) 'NA' medicines in PC store will be provisioned through ALC/ Jan Aushadhi Store.

(iii) Patient should be informed on tele/SMS about medicines availability to avoid inconvenience to the extent possible.

(iv) If some medicines are 'NA', patient should be able to draw the same from PC Pharmacy on a subsequent date without going through 'Regn process', however, acctg should be strictly done.

54. **Domiciliary Rehabilitation / Terminal Care.** Rehabilitation/terminal care will be provided in empanelled rehabilitative homes and hospices. Patients admitted to Service hospitals or empanelled hospitals/ nursing homes, however, when the finality of treatment has been reached and definitive medical treatment has run its course, will be referred to rehabilitative homes/ hospices for terminal care and rehabilitation. The conditions for which rehabilitative care will be admissible will be paraplegia, quadriplegia,

Alzheimer's disease, cerebro-vascular accidents, other neurological and degenerative disorders, amputations, cancer terminal care and other such medical conditions when duly referred by treating specialists. Approval of SEMO/SMO/PMO/CO ECHS will be obtained for these referrals. The payments for such cases will be regulated as under :-

(a) Rates of payment for rehabilitation/terminal care cases will be limited to maximum rates permissible under CGHS for Special Nursing/ Aya/ Attendant charges PLUS charges for medical treatment as per CGHS rules. Where the rates of CGHS are not laid down, AIIMS charges or **actual which ever is less** will be applicable. In case rates have not been defined by AIIMS, the actuals will be reimbursed. **Rehabilitative care/ terminal care does not include old age homes.**

(b) Reimbursement will be limited to maximum period of 6 months. Thereafter cost of such care has to be borne by the ECHS beneficiary.

(c) Conditions requiring **domiciliary rehabilitation intervention** as recommended by Service / Govt Specialist and recommended duration of domiciliary therapy are as under:-

(i) **Orthopedic Disorders.** Post joint replacement surgery in acute phase: Physiotherapy upto two weeks, post-discharge.

(ii) **Neurological Disorder** (for upto six weeks):

(aa) Post stroke: Occupation Therapy (OT) Physiotherapy (PT) and Speech Therapy (ST).

(ab) Traumatic brain injury : OT, PT and ST.

(ac) Gullian-Barre Syndrome : OT and PT.

(ad) Spinal cord injury with significant disability/ deformity : OT and PT.

(ae) Motor neuron disease : OT, PT and ST.

(iii) Locomotor disabilities, with a disability of over 80% or those who are totally dependent on care-giver, based on the opinion of two Government specialist, by certified care-giver. (Care-giver means Rehabilitation Council of India certified personnel + Physiotherapist and Occupational therapist (duly qualified diploma / degree holder). (Auth: Text of Min of Health & Family Welfare OM No S.11011/24/2011-CGHS(P) dt 01 Jun 2011).

(d) The care shall include specified therapies and reimbursement shall be allowed at following rates or as amended by Govt from time to time:-

(i) Physiotherapist/ Occupational therapist/ Speech therapist: Maximum Rs. 300/-.

(ii) Certified Care Giver : Maximum Rs. 150/-, or Rs. 3000/- per month for long-term requirements, whichever is less.

(iii) Purchase/ hiring of therapy equipment/ device shall not be reimbursed.

CONCLUSION

55. An attempt has been made in this document to consolidate most of the instructions besides addressing functional concerns of all stake holders with requisite clarity. These are broad guidelines and all stake holders need to respond positively to emerging challenges within framework of Govt Regulations and financial probity. A copy of this document should be maintained in physical form at each sec of CO ECHS, each RC and each PC. All appts at Comd HQs/ Area HQs/ Sub Area HQs/ Stn HQs dealing specifically with ECHS should have a physical copy for uniform application.

56. This has approval of MD ECHS.

File No : B/49770/AG/ECHS/Treatment

Central Organisation, ECHS  
Adjutant General's Branch  
IHQ of MoD(Army)  
Maude Lines, Delhi Cantt-110010  
Central Organisation ECHS



(IVS Gahlot)  
Col  
Dir (Medical)  
for MD ECHS

Date: 28 Sep 2018

Distr

AG Coord (a)  
DGDC & W Sectt  
O/o DGAFMS  
DGMS (Army)  
DGMS (Air)  
DGMS (Navy)  
IHQ of MoD (Navy)/Dir ECHS (N)  
DAV, Subroto Park  
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)  
AMA ECHS, Embassy of India, Nepal  
DIAV  
All Regional Centres  
UTI-ITSL - Please enable all automation as required on priority.

Internal

All Secs -

1. For info. Please maint a physical copy of this docu.
2. S & A Sec to upload on ECHS website.
3. **S & A Sec to forward copy to all empanelled hosps through email through UTI-ITSL.**
4. **S & A Sec to ensure software updation of smart card company & UTI-ITSL on priority.**

## THE SCHEDULE

[See clause (zc) of section 2]

## SPECIFIED DISABILITY

## 1. Physical disability.—

A. Locomotor disability (a person's inability to execute distinctive activities associated with movement of self and objects resulting from affliction of musculoskeletal or nervous system or both), including—

(a) "leprosy cured person" means a person who has been cured of leprosy but is suffering from—

(i) loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifest deformity;

(ii) manifest deformity and paresis but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity;

(iii) extreme physical deformity as well as advanced age which prevents him/her from undertaking any gainful occupation, and the expression "leprosy cured" shall construed accordingly;

(b) "cerebral palsy" means a Group of non-progressive neurological condition affecting body movements and muscle coordination, caused by damage to one or more specific areas of the brain, usually occurring before, during or shortly after birth;

(c) "dwarfism" means a medical or genetic condition resulting in an adult height of 4 feet 10 inches (147 centimeters) or less;

(d) "muscular dystrophy" means a group of hereditary genetic muscle disease that weakens the muscles that move the human body and persons with multiple dystrophy have incorrect and missing information in their genes, which prevents them from making the proteins they need for healthy muscles. It is characterised by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue;

(e) "acid attack victims" means a person disfigured due to violent assaults by throwing of acid or similar corrosive substance.

## B. Visual impairment—

(a) "blindness" means a condition where a person has any of the following conditions, after best correction—

(i) total absence of sight; or

(ii) visual acuity less than 3/60 or less than 10/200 (Snellen) in the better eye with best possible correction; or

(iii) limitation of the field of vision subtending an angle of less than 10 degree.

(b) "low-vision" means a condition where a person has any of the following conditions, namely:—

(i) visual acuity not exceeding 6/18 or less than 20/60 upto 3/60 or upto 10/200 (Snellen) in the better eye with best possible corrections; or

(ii) limitation of the field of vision subtending an angle of less than 40 degree up to 10 degree.

C. Hearing impairment—

(a) "deaf" means persons having 70 DB hearing loss in speech frequencies in both ears;

(b) "hard of hearing" means person having 60 DB to 70 DB hearing loss in speech frequencies in both ears;

D. "speech and language disability" means a permanent disability arising out of conditions such as laryngectomy or aphasia affecting one or more components of speech and language due to organic or neurological causes.

2. Intellectual disability, a condition characterised by significant limitation both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behaviour which covers a range of every day, social and practical skills, including—

(a) "specific learning disabilities" means a heterogeneous group of conditions wherein there is a deficit in processing language, spoken or written, that may manifest itself as a difficulty to comprehend, speak, read, write, spell, or to do mathematical calculations and includes such conditions as perceptual disabilities, dyslexia, dysgraphia, dyscalculia, dyspraxia and developmental aphasia;

(b) "autism spectrum disorder" means a neuro-developmental condition typically appearing in the first three years of life that significantly affects a person's ability to communicate, understand relationships and relate to others, and is frequently associated with unusual or stereotypical rituals or behaviours.

3. Mental behaviour.—

"mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, but does not include retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence.

4. Disability caused due to—

(a) chronic neurological conditions, such as—

(i) "multiple sclerosis" means an inflammatory, nervous system disease in which the myelin sheaths around the axons of nerve cells of the brain and spinal cord are damaged, leading to demyelination and affecting the ability of nerve cells in the brain and spinal cord to communicate with each other;

(ii) "parkinson's disease" means a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people associated with degeneration of the basal ganglia of the brain and a deficiency of the neurotransmitter dopamine.

(b) Blood disorder—

(i) "haemophilia" means an inheritable disease, usually affecting only male but transmitted by women to their male children, characterised by loss or impairment of the normal clotting ability of blood so that a minor wound may result in fatal bleeding;

(ii) "thalassemia" means a group of inherited disorders characterised by reduced or absent amounts of haemoglobin.

(iii) "sickle cell disease" means a hemolytic disorder characterised by chronic anemia, painful events, and various complications due to associated

tissue and organ damage; "hemolytic" refers to the destruction of the cell membrane of red blood cells resulting in the release of hemoglobin.

5. Multiple Disabilities (more than one of the above specified disabilities) including deaf blindness which means a condition in which a person may have combination of hearing and visual impairments causing severe communication, developmental, and educational problems.

6. Any other category as may be notified by the Central Government.

DR. G NARAYANARAJU,  
*Secretary to the Govt. of India.*

## FORMAT OF CERTIFICATE : PWD ACT 2016

[ भाग II - खण्ड 3(i) ]

भारत का राजपत्र : असाधारण

41

(b) Result of application \_\_\_\_\_

(13) Have you ever been issued a certificate of disability in the past? If yes, please enclose a true copy.

Declaration: I hereby declare that all particulars stated above are true to the best of my knowledge and belief, and no material information has been concealed or misstated. I further state that if any inaccuracy is detected in the application, I shall be liable to forfeiture of any benefits derived and other action as per law.

(signature or left thumb impression of person with disability, or of his/her legal guardian in case of persons with intellectual disability, autism, cerebral palsy and multiple disabilities, etc)

Date :

Place:

Enclosures:

1. Proof of residence (Please tick as applicable).

(a) ration card,

(b) voter identity card,

(c) driving license,

(d) bank passbook,

(e) PAN card,

(f) passport,

(g) telephone, electricity, water and any other utility bill indicating the address of the applicant,

(h) a certificate of residence issued by a Panchayat, municipality, cantonment board, any gazetted officer, or the concerned Patwari or Head Master of a Government school,

(i) in case of an inmate of a residential institution for persons with disabilities, destitute, mentally ill, and other disability, a certificate of residence from head of such institution.

2. Two recent passport size photographs

(For office use only)

Date:

Place:

Signature of issuing authority  
Stamp

Form-V

Certificate of Disability

(In cases of amputation or complete permanent paralysis of limbs or dwarfism and in case of blindness)

[See rule 18(1)]

(Name and Address of the Medical Authority issuing the Certificate)

Recent passport size  
attested photograph  
(Showing face only) of  
the person with  
disability.

Certificate No. \_\_\_\_\_

Date: \_\_\_\_\_

This is to certify that I have carefully examined Shri/Smt./Kum. \_\_\_\_\_ son/wife/daughter of Shri \_\_\_\_\_ Date of Birth (DD/MM/YY) \_\_\_\_\_ Age \_\_\_\_\_ years, male/female \_\_\_\_\_ registration No. \_\_\_\_\_ permanent resident of House No. \_\_\_\_\_ Ward/Village/Street \_\_\_\_\_ Post Office \_\_\_\_\_ District \_\_\_\_\_ State \_\_\_\_\_, whose photograph is affixed above, and am satisfied that:

(A) he/she is a case of:

- locomotor disability
- dwarfism
- blindness

(Please tick as applicable)

(B) the diagnosis in his/her case is \_\_\_\_\_

(A) he/she has \_\_\_\_\_ % (in figure) \_\_\_\_\_ percent (in words) permanent locomotor disability/dwarfism/blindness in relation to his/her \_\_\_\_\_ (part of body) as per guidelines ( .....number and date of issue of the guidelines to be specified).

2. The applicant has submitted the following document as proof of residence:-

Nature of Document	Date of Issue	Details of authority issuing certificate

(Signature and Seal of Authorised Signatory of notified Medical Authority)

Signature/thumb impression of the person in whose favour certificate of disability is issued

## Form - VI

## Certificate of Disability

(In cases of multiple disabilities)

[See rule 18(1)]

(Name and Address of the Medical Authority issuing the Certificate)

Recent passport size attested photograph (Showing face only) of the person with disability.

Certificate No. \_\_\_\_\_

Date: \_\_\_\_\_

This is to certify that we have carefully examined Shri/Smt./Kum. \_\_\_\_\_ son/wife/daughter of \_\_\_\_\_ Shri \_\_\_\_\_ Date of Birth (DD/MM/YY) \_\_\_\_\_ Age \_\_\_\_\_ years, male/female \_\_\_\_\_

Registration No. \_\_\_\_\_ permanent resident of House No. \_\_\_\_\_ Ward/Village/Street \_\_\_\_\_ Post Office \_\_\_\_\_ District \_\_\_\_\_ State \_\_\_\_\_ above, and am satisfied that:

(A) he/she is a case of Multiple Disability. His/her extent of permanent physical impairment/disability has been evaluated as per guidelines (.....number and date of issue of the guidelines to be specified) for the disabilities ticked below, and is shown against the relevant disability in the table below:

Sl. No.	Disability	Affected part of body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor disability	@		
2.	Muscular Dystrophy			
3.	Leprosy cured			
4.	Dwarfism			
5.	Cerebral Palsy			
6.	Acid attack Victim			
7.	Low vision	#		
8.	Blindness	#		
9.	Deaf	£		
10.	Hard of Hearing	£		
11.	Speech and Language disability			
12.	Intellectual Disability			
13.	Specific Learning Disability			
14.	Autism Spectrum Disorder			
15.	Mental illness			
16.	Chronic Neurological Conditions			
17.	Multiple sclerosis			
18.	Parkinson's disease			
19.	Haemophilia			
20.	Thalassemia			
21.	Sickle Cell disease			

(B) In the light of the above, his/her over all permanent physical impairment as per guidelines (.....number and date of issue of the guidelines to be specified), is as follows :-

In figures :- ..... percent

In words :- ..... percent

2. This condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is :

(i) not necessary,

or

(ii) is recommended/after ..... years ..... months, and therefore this certificate shall be valid till

(DD) (MM) (YY)

@ e.g. Left/right/both arms/legs

# e.g. Single eye

£ e.g. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of document	Date of issue	Details of authority issuing certificate

5. Signature and seal of the Medical Authority.

Name and Seal of Member	Name and Seal of Member	Name and Seal of the Chairperson

Signature/thumb impression of the person in whose favour certificate of disability is issued.

## Form - VII

## Certificate of Disability

(In cases other than those mentioned in Forms V and VI)

(Name and Address of the Medical Authority issuing the Certificate)

[See rule 18(1)]

Recent passport size attested photograph (Showing face only) of the person  
wit

Certificate No. \_\_\_\_\_

Date: \_\_\_\_\_

This is to certify that I have carefully examined

Shri/Smt/Kum \_\_\_\_\_ son/wife/daughter of Shri \_\_\_\_\_  
Date of Birth (DD/MM/YY) \_\_\_\_\_ Age \_\_\_\_\_ years,  
male/female \_\_\_\_\_ Registration No. \_\_\_\_\_ permanent resident of House No. \_\_\_\_\_  
Ward/Village/Street \_\_\_\_\_ Post Office \_\_\_\_\_ District \_\_\_\_\_ State \_\_\_\_\_,  
whose photograph is affixed above, and am satisfied that he/she is a case of \_\_\_\_\_  
disability. His/her extent of percentage physical impairment/disability has been  
evaluated as per guidelines (.....number and date of issue of the guidelines to be specified) and is shown against the  
relevant disability in the table below:-

Sl. No.	Disability	Affected part of body	Diagnosis	Permanent physical impairment/mental disability (in %)
1.	Locomotor disability	@		
2.	Muscular Dystrophy			
3.	Leprosy cured			
4.	Cerebral Palsy			
5.	Acid attack Victim			
6.	Low vision	#		
7.	Deaf	€		
8.	Hard of Hearing	€		
9.	Speech and Language disability			
10.	Intellectual Disability			
11.	Specific Learning Disability			
12.	Autism Spectrum Disorder			
13.	Mental illness			
14.	Chronic Neurological Conditions			
15.	Multiple sclerosis			
16.	Parkinson's disease			
17.	Haemophilia			
18.	Thalassemia			
19.	Sickle Cell disease			

(Please strike out the disabilities which are not applicable)

2. The above condition is progressive/non-progressive/likely to improve/not likely to improve.

3. Reassessment of disability is:

(i) not necessary, or

(ii) is recommended/after \_\_\_\_\_ years \_\_\_\_\_ months, and therefore this certificate shall be valid till (DD/MM/YY) \_\_\_\_\_

@ - eg. Left/Right/both arms/legs

# - eg. Single eye/both eyes

€ - eg. Left/Right/both ears

4. The applicant has submitted the following document as proof of residence:-

Nature of document	Date of issue	Details of authority issuing certificate

(Authorised Signatory of notified Medical Authority)  
(Name and Seal)

Countersigned  
{Countersignature and seal of the  
Chief Medical Officer/Medical Superintendent/  
Head of Government Hospital, in case the  
Certificate is issued by a medical authority who is  
not a Government servant (with seal)}

Signature/thumb  
impression of the  
person in whose  
favour certificate of  
disability is issued

Note.- In case this certificate is issued by a medical authority who is not a Government servant, it shall be valid only if countersigned by the Chief Medical Officer of the District

FORM - VIII

[Intimation of rejection of Application for Certificate of Disability]

[See rule 18 (4)]

No. \_\_\_\_\_

Dated :

To,

(Name and address of applicant  
for Certificate of Disability)

Sub: Rejection of Application for Certificate of Disability

Sir/ Madam,

Please refer to your application dated \_\_\_\_\_ for issue of a Certificate of Disability for the following disability:

2. Pursuant to the above application, you have been examined by the undersigned/Medical Authority on \_\_\_\_\_, and I regret to inform that, for the reasons mentioned below, it is not possible to issue a Certificate of Disability in your favour:

(i)

(ii)

(iii)

Encl 3  
(Refer to para 13(a))

**PRIOR PERMISSION LETTER : TREATMENT UNDER 'AYUSH'**  
**TO BE FILLED IN DUPLICATE**

1. I, No. ----- Rank ----- Name -----  
ECHS Card No., ----- request for prior permission for treatment under -----  
----- (specify which system of medicine) under AYUSH viz (Ayurveda, Yoga &  
Naturopathy, Unani, Siddha and Homeopathy) wef ----- from -----  
----- (Name of Govt Hospital) for -----  
----- (diagnosis/ disease).
2. From the date of prior approval, I shall not avail allopathic system of medicines and will not use concurrent Govt supplied medicines.
3. I am voluntarily opting for alternate system of medicines.

Sign of Applicant  
Name  
Date

Prior permission Granted/not Granted

Sign of OIC PC/ JD HS at RC/Dir (Med)

**PRIOR PERMISSION LETTER :****REVERSION OF TREATMENT UNDER 'ALLOPATHY SYSTEM OF MEDICINE**

1. I, No ..... Rank ..... Name.....  
ECHS Card No ..... was availing AYUSH treatment and now request for reversion of permission of treatment under Allopathy system of medicine wef ..... for all my treatments.
2. From the date of reversion approval, I shall not avail AYUSH system of medicine.
3. I am voluntarily reverting for allopathic system of medicines.

Sign of Applicant  
Name :  
Date :

**APPROVD / NOT APPROVED**

Sign of OIC PC/ JD(HS) at RC/ JD (Med) at CO ECHS

**LIST OF MILITARY POLYCLINICS WITHOUT SERVICE HOSPITAL**

<b><u>Ser No</u></b>	<b><u>Polyclinic</u></b>
1.	Janglot
2.	Moga
3.	Sangrur
4.	Sirsa
5.	Jaisalmer
6.	Ajmer
7.	Saharanpur (Sarsawa)
8.	Bharatpur
9.	Balasore
10.	Nagpur
11.	Yelahanka
12.	Dimapur
13.	Shajahanpur
14.	Kotdwara
15.	Haldwani
16.	Mumbai (Upnagar) Powai
17.	Solan
18.	Nahan
19.	Kapurthala
20.	Salt Lake
21.	Baramulla

**Encl-6**  
**(Refer to Para 52(g))**

**CEILING RATE OF DOMICILIARY MEDICAL EQUIPMENTS**

S No	Eqpt	Recommended by	Procurement by (as CFA)	Ceiling Rate/ Remarks
(a)	CPAP/ BIPAP machine	Respiratory Medicine Specialist	Comdt / CO Hosp where Respiratory Medicine Specialist is posted	(i) CPAP – Rs 50,000/- (ii) Bi-Level CPAP- Rs 80,000/- (iii) Bi-Level Ventilatory System – Rs 1,20,000/-
(b)	Hearing Aid	ENT Specialist	Comdt / CO Hosp where ENT Specialist is posted	(i) Body worn/Pocket type- Rs 3,000/- (ii) Analogue BTE – Rs 7,000/- (iii) Digital BTE – Rs 15,000/- (iv) Digital ITC/CIC – Rs 20,000/-
(c)	Artificial Appliances Related to Mobility Aids	Neuro Surgeon/ Neuro Physician/ Orthopaedician/ Surgeon	Comdt / CO Hosp where these Specialists are available	(i) The appliances will be allowed for re-issue on completion of 5 Yrs in case of adults and 2 Yrs in the case of children except motorized wheel chair and tricycle. (ii) Motorized wheel chair and tricycle may be re-issued after 5 Yrs irrespective of age. (iii) Approved rates as per Appx.
(d)	Nebuliser, Glucometer, Oxygen Concentrator	Medical Specialist	Comdt/ CO Hosp where Medical Specialist is posted	(i) Oxygen Concentrator- Rs 60,000/- (ii) CGHS rates will apply for Nebuliser and Glucometer.
(e)	Any other item recommended for domiciliary use authorized under CGHS Scheme	Concerned Specialist	Comdt / CO Hosp where the concerned Specialist is posted	CGHS rates will apply.

**Note :** All domiciliary medical eqpt will be allowed for re-issue on completion of 5 yrs. Policy for condemnation & disposal of eqpt will be applicable for domiciliary eqpt as well as issued by O/o DGAFMS. OIC PC will be responsible for documentation for the procedure.

**CEILING RATE OF MOBILITY AIDS**

<b><u>SI No</u></b>	<b><u>Name of Orthosis</u></b>	<b><u>Approved Rate / Price (Child above 12 Yrs)</u></b>	<b><u>Approved Rate / Price (Child 7-12 Yrs)</u></b>	<b><u>Approved Rate / Price (Child 0-6 Yrs)</u></b>
1.	Walking Stick (Adjustable) Aluminium	Rs. 350/-	Rs. 350/-	Not Applicable
2.	Tripod / Quadripod walking stick Aluminium	Rs. 750/-	Not Applicable	Not Applicable
3.	Auxillary Crutch/ Elbow crutch (Aluminium) Adjustable	Rs. 850/-	Rs. 650/-	Not Applicable
4.	Walker / Rollator (Aluminium)	Rs. 1,500/-	Rs. 1,200/-	Rs. 900/-
5.	CP Chair/ CP Stand	Not Applicable	Rs. 7,300/-	Rs. 7,000/-
6.	Commode Chair	Rs. 2,500/-	Rs. 2,500/-	Not Applicable
7.	Wheel Chair Folding (Chrome Plated)	Rs. 7,000/-	Rs. 4,000/-	Not Applicable
8.	Motorized Wheel Chair			
	(i) Quadriplegic wheel chair with chin and Head Control	Rs. 1,10,000/-	Not Applicable	Not Applicable
	(ii) Quadriplegic wheel chair with joy stick.	Rs. 60,000/-	Not Applicable	Not Applicable
	(iii) Motorized wheel chair (Handle driven)	Rs. 35,000/-	Not Applicable	Not Applicable
9	Tricycle Hand Propelled	Rs. 6000/-	Not Applicable	Not Applicable

# **CENTRAL ORGANISATION ECHS**

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