भारत सरकार/ Government of India
क़ार्यालय अपर निदेशक (मुख्य)/ O/O Additional Director (HQ)
के. स. स्वा. यो./ Central Government Health Scheme
Ministry/Department of Health and Family Welfare/Directorate General of CGHS
CGHS Bhawan, Sector-13, R. K. Puram, New Delhi-110066,
Email: adhq.dl@cghs.nic.in, Tel: 011-20863435

मिसिल संख्या/File No. 29-1/2025 CGHS EZ (efile number 8315535) **दिनांक : 22/01/2025**

OFFICE MEMORANDUM

Subject: Standard Operating Procedure for transition to online mode for processing of permission for respiratory devices such as CPAP, BiPAP and Oxygen Concentrator

The processing of permission for respiratory devices such as CPAP, BiPAP and Oxygen Concentrator in respect of CGHS pensioner beneficiaries is currently in offline mode, starting from submission of physical documents in Wellness Centre by the beneficiary to physical transport through dak to Office of Additional Director to submission of physical file to O/O Additional Director (Reimbursement and Hospitalization) CGHS (HQ), sending to Committee of Respiratory Medicine Specialists for opinion regarding admissibility of the respiratory device and finally the physical file travelling back to the concerned Additional Director for physical letter to be issued to the pensioner beneficiary. The entire process takes anywhere between 15 to 45 days or longer, during which time the pensioner beneficiary often has to rent these respiratory devices, the cost of which is not reimbursable.

In order to expedite the processing of these critical respiratory devices and provide relief to the beneficiaries, it has been decided to transition the processing of permission for such devices, to an end-to-end online mode as follows:

1. At the Wellness Centre, the application for permission to purchase the respiratory device complete in all respects, as per the **attached checklist at Annexure A** including the **duly filled and endorsed proforma for the respiratory devices annexed as Annexure B, C, D** along with affidavit (**Annexure E**) (all Annexures are also available on CGHS website) shall be scanned and emailed to the Office of the concerned Additional Director of Zone and city.

2. In case high speed scanners are not available in the Wellness Centre at present, physical documents for the said permission shall be sent through dak to the Office of Additional Director within a day or two of receiving the application. Additional Directors shall procure high speed scanners for every Wellness Centre so that maximum possible dak including requests for permissions can be emailed to Office of Additional Director. Besides expediting the processing of

permissions for beneficiaries, this would also be a step forward in enabling end-to-end ebill processing.

3. The concerned section in the Office of Additional Director shall, on priority, scrutinize the application for permission to purchase respiratory devices received through email/dak for any deficiency. Any deficiency shall be communicated the same day to the beneficiary telephonically and through email for fulfilment. **The application complete in all respects shall then be put up in efile with all relevant documents hyperlinked, by the concerned section in the Office of Additional Director of city/Zone.**

4. The **subject matter of efile shall include the name of the beneficiary and the Beneficiary ID. All respiratory devices henceforth issued to the particular beneficiary shall be put up in the same efile**. This shall enable maintenance of an electronic record of permissions issued to the beneficiary.

5. An excel sheet having the Computer Number of the efile, name and Beneficiary ID of the beneficiary, name of device and the details of permission issued may be maintained separately in the concerned section dealing with permissions in the Office of the Additional Director, **for ease of tracking the efile.**

6. The efile shall be sent to the Office of Additional Director (Reimbursement and Hospitalization), CGHS (HQ) (directly by Delhi Additional Directors and through ADDG by outside Delhi cities) for forwarding to the Committee of Respiratory Medicine Specialists. **The recommendation of the Committee shall be uploaded in efile** and sent back to CGHS HQ and subsequently to the concerned Additional Director of the city/Zone. (In cities where a similar Committee of Specialists exists locally, they may continue sending the requests for permission for respiratory devices to their local Committee).

7. **The letter addressed to the beneficiary, conveying the recommendation of the Committee (recommended/rejected) shall be issued through eOffice, duly digitally signed by the Additional Director.** The soft copy of the permission shall be emailed to the beneficiary through his email ID or collected as a physical copy by the beneficiary as per his convenience.

This issues with the approval of the Director CGHS.

Digitally signed by Honnamma
Date: 22-01-2025 10:37:56

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अपर निदेशक के. स. स्वा. यो. (मु)

Encl: **Annexure A, B, C, D, E**

Copy for information to:

1. All Additional Directors of CGHS cities and zones
2. MCTC for uploading on CGHS website
3. Guard file

ANNEXURE A

Dispatch Number of WC- **Date-**

CHECKLIST FOR PERMISSION FOR BiPAP,CPAP,O2 CONCENTRATOR

(The following format is for CGHS serving employees and pensioners and is based on OM no. S.11011/4/2014-CGHS(P), MOHFW dated 5/3/2014. Similar format for checklist may be used by Departments/ Ministries/Autonomous bodies for their employees)

S No	Documents to be enclosed duly indexed	Page number
1	Request letter of CGHS serving/pensioner beneficiary duly forwarded by CMO I/C with despatch number of WC.	
2	Copy of plastic card of CGHS serving/ pensioner beneficiary(ies) (card holder and dependent who need the machine)-duly verified by CMO I/C with stamp	
3	Proforma duly signed by treating specialist with stamp	
4	Complete basic investigation reports	
5	Arterial Blood Gas (ABG) report (in stable state, room air, after discharge from hospital)-NEEDED IN CASE OF O2 CONCENTRATOR & BiLEVEL VENTILATORY SUPPORT SYSTEM	
6	Polysomnography (Sleep study report) **including all graphs, tracings and tables-**NEEDED IN CASE OF BiPAP AND CPAP	
7	Undertaking from main card holder on a non judicial stamp paper that he has not claimed reimbursement of the cost of the machine in the last five years in respect of himself/ his dependent in need of the machine and that the machine will be returned to CGHS through CMO I/C, after utility is over.	
8	In those cases where permission for a new machine is being sought and cost of old machine has been reimbursed by CGHS more than 5 years back, a condemnation certificate from a technical expert duly countersigned by treating doctor, needs to be enclosed, regarding the irreparable condition of the old machine.	
9	If representative of pensioner beneficiary is being sent to the Office of Additional Director to collect the permission letter then, the following are needed: 1. authority letter from pensioner beneficiary in favour of the representative 2. Photocopy and original ID card of representative. 3. Original plastic card to be sent with representative	

CGHS card is valid till _____ (dd/mm/yy) as per CGHS database.

The pensioner beneficiary has retired from Department_____ and whether Autonomous body or no _____ (Yes/No).

Contact number of pensioner beneficiary is _____, e mail ID is _____

Forwarded to Additional Director CGHS _____ (city/zone) for necessary action.

Name of CMO I/C /officiating CMO I/C _____

Wellness Centre_____

Signature and stamp of CMO I/C_____

Please note-All information as required in the above checklist, needs to be filled **mandatorily.*

ANNEXURE B

OXYGEN CONCENTRATOR (1)

Certificate of medical necessity to be issued to CGHS beneficiaries being prescribed long term oxygen therapy/OXYGEN CONCENTRATOR (to be filed by the treating physician

Certification :- Initial/Revised

1. Patient Name
2. Age of Patient
3. Physician Name
4. Address of Physician
5. Telephone no. of Physician
6. (a) Brief history and physical finding

   (b) Co-morbidity (if any)

   (c)Whether accompanied by symptoms of

   - Excessive daytime sleepiness : Yes/No
   - Snoring : Yes/No
   - Impaired cognition : Yes/No
   - Documented cardiovascular disease like Hypertension, ischemic heart disease or Stroke (specify if yes) : Yes/No

7. Laboratory data (specify date against each parameter)

Hematocrit

X-Ray Chest

Echocardiography (wherever necessary)

O_2 conctration (2)

Pulmonary function tests

Arterial blood gases:	1	2	3
Date			
pH			
paO_2			
$paCO_2$			
HCO_3 a			
HCO_3 s			
BE			
O_2 sat			

(Note: the Arterial blood gas values should include those during chronic, stable state (atleast 3 months after an acute exacerbation) of the disease e.g. in a case of COPD, the ABG value during acute exacerbation generally demonstrates moderate to severe hypoxemia and hypercapnia which may normalise during stable state and therefore may not be an indication for long term oxygen therapy)

Others (specify)

11. Final Diagnosis

12. Recommended: Oxygen concentrator / portable oxygen cylinder / compressed oxygen cylinders

    a. Flowrate
    b. Nasal prongs/ Cannula
    c. Nasal mask
    d. Number of hours per day

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

Date: **(Full Name, signature & address of Physician)**

oxygen concentrator

O_2 concentrator (3)

Note for prescribers (For diagnostic as well as for titration):

Home oxygen therapy is the home administration of oxygen at concentrations greater than the ambient air with the intention of treating or preventing the symptoms and manifestations of hypoxic or non-hypoxic medical conditions that are known to clinically improve with oxygen.

Clinical Indications

Home oxygen therapy is considered medically necessary in the following circumstances:

1. Chronic Hypoxia (generally long-term use). The conditions with which this may be associated include, but are not limited to:
   - Chronic obstructive pulmonary disease
   - Diffuse interstitial lung disease
   - Bronchiectasis
   - Widespread pulmonary neoplasm
   - Pulmonary hypertension
   - Recurring congestive heart failure due to chronic cor pulmonale

The following laboratory values, obtained while breathing ambient air, will be presumptive evidence for hypoxia:

Adults:

- Arterial partial pressure of oxygen (PaO2) less than or equal to 55mmHg or arterial oxygen saturation (SaO2) less than or equal to 88%
- PaO2 levels between 56 and 59 or SaO2 89% in the presence of pulmonary hypertension, cor pulmonale, edema secondary to right heart failure, or erythrocytosis with hematocrit greater than 55%

Note:

1. Patients who desaturate to an SaO2 less than or equal to 88% **only during exercise *and*** who demonstrate improvement in both the hypoxia and dyspnea and/or exercise capacity when using O2 are candidates for supplemental O2 during exercise only.
2. Patients who desaturate **only during sleep** to an SaO2 of less than or equal to 88% for more than 30% of the night or with evidence of otherwise unexplained pulmonary hypertension, cor pulmonale, edema secondary to right heart failure, or erythrocytosis with

O2 concentrator (4)

hematocrit greater than 55%, and in whom obstructive sleep apnea (OSA) and other nocturnal apnea or hypoventilation syndromes have been ruled out or, if OSA present, have persistent desaturation despite correction of AHI (RDI) by CPAP, are candidates for nocturnal O2.

Infants and Children:

- Arterial partial pressure of oxygen (PaO2) less than or equal to 60mmHg or arterial oxygen saturation (SaO2) less than or equal to 92%

Note: Portable oxygen systems are considered medically necessary only when needed to complement the medical needs of an individual who requires a stationary system

ANNEXURE C

CERTIFICATE OF MEDICAL NECESSITY TO BE ISSUED TO CGHS BENEFICIAREIS BEING PRESCRIBED

Long term Continuous Positive Airway Pressure- CPAP

SUPPORT SYSTEM

(To be filled by the treating physician)

Certification Type - *Initial/Revised*

1. Patient Name:

2. Age of Patient:

3. Physician Name:

4. Address of Physician:

5. Telephone No. of Physician:

6. (a) Brief history and physical findings:

   (b) Co-morbidity (if any):

   (c) Whether accompanied by symptoms of

   - Excessive daytime sleepiness : Yes/No
   - Snoring : Yes/No
   - Impaired cognition : Yes/No
   - Documented cardiovascular disease like Hypertension, Ischemic heart disease or Stroke (specify if Yes) : Yes/No

7. Laboratory Data (Specify date against each parameter)

Hematocrit:

ECG:

Blood Sugar (wherever necessary):

Lipid Profile (wherever necessary):

Arterial blood gases	1	2	3
Date			
pH			
paO_2			
$PaCO_2$			
HCO_3a			
HCO_3s			
BE			
O_2 sat			

(Note: The Arterial blood gas values should include those during chronic, stable state (atleast 3 months after an acute exacerbation) of the disease e.g. in a case of COPD, the ABG value during acute exacerbation generally demonstrates moderate to severe hypercapnia which may normalize during stable state and therefore may not be an indication for long term NIPPV)

X-ray Chest:

Echocardiography (wherever necessary):

Pulmonary function tests:

Thyroid function tests:

Ear, nose & throat examination:

Others (specify):

8. Diagnostic nocturnal polysomnography (NPSG) data: Only whole night polysomnography (Level-1) including channels for sleep, breathing, pulse oximetry, leg EMG, ECG, snoring will be accepted for consideration of BI-LEVEL CPAP/BI-LEVEL ventilatory support system

(a) Date of sleep study:

(b) Address of sleep-laboratory/ facility:

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

(d) Parameters studied during polysomnography

- ☐ Electro-encephalogram Yes/No
- ☐ Electro-oculogram Yes/No
- ☐ Electro-myogram Yes/No
- ☐ Oro-nasal airflow Yes/No
- ☐ Chest & abdominal wall effort Yes/No
- ☐ Body position Yes/No
- ☐ Snore microphone Yes/No
- ☐ Electro-cardiogram Yes/No
- ☐ Oxyhemoglobin saturation Yes/No

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

(I) Obstructive apnoea*

(ii) Hypopnea**

(iii) Flow limitations***

(iv) RERA

(f) Respiratory Distress Index (RDI)****

9. Date of CPAP titration study:

10. CPAP pressure (in cm H_2O) prescribed (to abolish obstructive apnoeas,hypopneas, RERAs and snoring in all sleep positions and sleep stages):

11. Supplemental oxygen (flow rate of FiO2):

12. Final Diagnosis:

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

Date:

(Full Name, signature & address of Physician)

Note for prescribers (For diagnostic as well as for titration):

Only whole night manually validated Level-1 polysomnography including channels for sleep, breathing, pulse oximetry, leg EMG, ECG, snoring & CPAP titration will be accepted for consideration of CPAP/ BiPAP. Screening studies such as Level III, Level IV (Cardio pulmonary sleep studies) shall not be acceptable. Auto titrated CPAP studies shall also not be acceptable.

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

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

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

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

Upper airway resistance syndrome (UARS): is an abnormal breathing pattern during sleep that is associated with isolated daytime sleepiness not explained by any other cause, including the obstructive sleep apnoea/hypopnea syndrome. Essential features include (a) the clinical complaint of excessive daytime sleepiness; (b) an elevated EEG arousal index (more than ten per hour of sleep) with arousals related to increased respiratory efforts as measured by continuous nocturnal monitoring of esophageal pressures; (c) a normal RDI of less than 5 events per hour of sleep. Supportive features include (a) the clinical complaint of snoring (b) an increase in snoring intensity prior to EEG arousals and (c) clinical improvement with a short-term trial of nasal CPAP therapy.

Split-Night Study NPSG: Patients with an RDI of > 40 events per hour during the first 2 hours of a diagnostic NPSG receive a split-night study NPSG, of which the final portion of the NPSG is used to titrate CPAP; split-night study may be considered for patients with RDI of 20-40 events esophageal pressures; (c) a normal RDI of less than 5 events per hour of sleep. Supportive features Include (a) the clinical complaint of snoring (b) an increase in snoring intensity prior to EEG arousals and (c) clinical improvement with a short-term trial of nasal CPAP therapy.
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ANNEXURE D

CERTIFICATE OF MEDICAL NECESSITY TO BE ISSUED TO CGHS BENEFICIAREIS BEING PRESCRIBED BILEVEL CONTINUOUS POSITIVE AIRWAY PRESSURE (BI-LEVEL CPAP) / BI-LEVEL VENTILATORY SUPPORT SYSTEM

(To be filled by the treating physician)

Certification Type - *Initial/Revised*

1. Patient Name:

2. Age of Patient:

3. Physician Name:

4. Address of Physician:

5. Telephone No. of Physician:

6. (a) Brief history and physical findings:

   (b) Co-morbidity (if any):

   (c) Whether accompanied by symptoms of

   - Excessive daytime sleepiness : Yes/No
   - Snoring : Yes/No
   - Impaired cognition : Yes/No
   - Documented cardiovascular disease like Hypertension, Ischemic heart disease or Stroke (specify if Yes) : Yes/No

7. Laboratory Data (Specify date against each parameter)

Hematocrit:

ECG:

Blood Sugar (wherever necessary):

Lipid Profile (wherever necessary):

Arterial blood gases	1	2	3
Date			
pH			
paO_2			
$PaCO_2$			
HCO_3 a			
HCO_3 s			
BE			
O_2 sat			

(Note: The Arterial blood gas values should include those during chronic, stable state (atleast 3 months after an acute exacerbation) of the disease e.g. in a case of COPD, the ABG value during acute exacerbation generally demonstrates moderate to severe hypercapnia which may normalize during stable state and therefore may not be an indication for long term NIPPV)

X-ray Chest:

Echocardiography (wherever necessary):

Pulmonary function tests:

Thyroid function tests:

Ear, nose & throat examination:

Others (specify):

8. Diagnostic nocturnal polysomnography (NPSG) data: Only whole night polysomnography (Level-1) including channels for sleep, breathing, pulse oximetry, leg EMG, ECG, snoring will be accepted for consideration of BI-LEVEL CPAP/BI-LEVEL ventilatory support system

(a) Date of sleep study:

(b) Address of sleep-laboratory/ facility:

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

(d) Parameters studied during polysomnography

- Electro-encephalogram Yes/No
- Electro-oculogram Yes/No
- Electro-myogram Yes/No
- Oro-nasal airflow Yes/No
- Chest & abdominal wall effort Yes/No
- Body position Yes/No
- Snore microphone Yes/No
- Electro-cardiogram Yes/No
- Oxyhemoglobin saturation Yes/No

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

(I) Obstructive apnoea*

(ii) Hypopnea**

(iii) Flow limitations***

(iv) RERA

(f) Respiratory Distress Index (RDI)****

9. Date of CPAP titration study:

10. CPAP pressure (in cm H_2O) prescribed (to abolish obstructive apnoeas,hypopneas, RERAs and snoring in all sleep positions and sleep stages):

11. Supplemental oxygen (flow rate of FiO2):

12. Final Diagnosis:

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

Date:

(Full Name, signature & address of Physician)

Note for prescribers (For diagnostic as well as for titration):

Only whole night manually validated Level-1 polysomnography including channels for sleep, breathing, pulse oximetry, leg EMG, ECG, snoring & CPAP titration will be accepted for consideration of CPAP/ BiPAP. Screening studies such as Level III, Level IV (Cardio pulmonary sleep studies) shall not be acceptable. Auto titrated CPAP studies shall also not be acceptable.

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

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

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

Upper airway resistance syndrome (UARS): is an abnormal breathing pattern during sleep that is associated with isolated daytime sleepiness not explained by any other cause, including the obstructive sleep apnoea/hypopnea syndrome. Essential features include (a) the clinical complaint of excessive daytime sleepiness; (b) an elevated EEG arousal index (more than ten per hour of sleep) with arousals related to increased respiratory efforts as measured by continuous nocturnal monitoring of esophageal pressures; (c) a normal RDI of less than 5 events per hour of sleep. Supportive features include (a) the clinical complaint of snoring (b) an increase in snoring intensity prior to EEG arousals and (c) clinical improvement with a short-term trial of nasal CPAP therapy.

Split-Night Study NPSG: Patients with an RDI of > 40 events per hour during the first 2 hours of a diagnostic NPSG receive a split-night study NPSG, of which the final portion of the NPSG is used to titrate CPAP; split-night study may be considered for patients with RDI of 20-40 events esophageal pressures; (c) a normal RDI of less than 5 events per hour of sleep. Supportive features Include (a) the clinical complaint of snoring (b) an increase in snoring intensity prior to EEG arousals and (c) clinical improvement with a short-term trial of nasal CPAP therapy.

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

BI-LEVEL CPAP is indicated in the following conditions:

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

BI LEVEL CPAP (with IPAP 4-22 cm water) and EPAP 4-22 cm water)

I. When CPAP pressure requirement is greater than 16cm

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

III. Pressure of central apneas due to too high pressures

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

V. Patients with persistent hypoxia and/or hypercapnia after treatment with CPAP

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

BI-LEVEL CPAP (with IPAP 4-30 cm water) and EPAP 4-30 cm water)

(I). Restrictive Thoracic Disease: (e.g. sequelae of polio, spinal cord injury, neuropathies, myopathies and dystrophies, amyotrophic lateral sclerosis, chest wall deformities and kyphoscoliosis, post thoracoplasty for TB) with symptoms (such as fatigue, dyspnoea, morning headaches etc.) and one of the following: (a) $PaCO_2 \geq 45$mmHg on room air or $PaCO_2 \geq 52$ mmHg, done while awake and breathing the patient's usual FiO_2, (b) sleep oximetry demonstrating oxygen saturation $\leq$ 88% for at least than 5 consecutive minutes done while breathing the patient's usual FiO_2; (c) for progressive neuromuscular disease (only) maximal inspiratory pressure is < 60 cm H_2O or forced vital capacity is < 50% predicted AND chronic obstructive pulmonary disease does not contribute significantly to the patient's pulmonary limitation.

(II) Chronic Obstructive Pulmonary Disease (COPD): (e.g. chronic bronchitis, emphysema, bronchiectasis) with symptoms (such as fatigue, dyspnoea, morning headache etc.) and one of the following: (a) $PaCO_2 > 55$ mmHg while awake and breathing patient's usual FiO_2 (b) $PaCO_2$ of 50-54 mmHg and nocturnal desaturation of $spO_2 \leq 88\%$ for 5 continuous minutes while receiving oxygen therapy $\geq$ 2 LPM; (c) $PaCO_2$ of 50-54 mmHg and hospitalization related to recurrent ($\geq$ 2 in a 12 month period) episodes of hypercapneic respiratory failure; optimal management with bronchodilators, oxygen when indicated must have been ensured; obstructive sleep apnoea must have been excluded by polysomnography and there should preferably be an evidence of sustained hypo-ventilation as shown by prolonged episodes of desaturation during sleep.

(III) Nocturnal hypo-ventilation from additional disorders (alveolar hypo-ventilation: central alveolar hypo-ventilation, idiopathic central sleep apnoea, obesity hypo-ventilation syndrome, Cheyne-Strokes respiration obstructive sleep apnoea combined with COPD and pulmonary hypertension of CHF i.e. overlap syndrome, radiation fibrosis or occupational exposure diseases; NPSG criteria for OSA not responsive to CPAP include (i) PSG criteria for mixed sleep apnoea not

responsive to CPAP therapy (ii) central sleep apnoea; (iii) other forms of nocturnal hypo-ventilation.

Indications for humidification

(iv) Positive Airway Pressure more than 12 cm water
(v) Recurrent and intractable nasal stuffiness and blockage
(vi) Severe dryness of throat

ANNEXURE E

AFFIDAVIT

Notarized Affidavit for CPAP/Bi-level CPAP/Bi-level Ventilatory system/Oxygen Concentrator Machine.

I Sh./Smt./Kum._____S/D/W/H/O_____

a serving/pensioner CGHS beneficiary, CGHS Ben ID No. _____

R/o _____ attached with CGHS dispensary _____
do solemnly affirm and declare that.

The CPAP/Bi-level CPAP/Bi-level Ventilatory system/Oxygen Concentrator machine has been advised by Dr._____ Hospital_____ on dated: _____ in respect of _____.

I undertake to return CPAP/Bi-level CPAP/Bi-level Ventilatory system/Oxygen Concentrator machine in good working condition to MSD, CGHS Gole Market, New Delhi, through concerned CGHS Wellness after its utility is over.

The responsibility for maintenance and upkeep of the machine will lie with me. I shall not claim Expenditure incurred, if any on upkeep and maintenance of the machine.

I will submit the claim at CGHS ceiling/approved rates and the remaining amount, if any, will be borne by me.

I have enclosed a complete sleep lab report/ABG report and proforma duly filled up by treating specialist.

I shall not use the aforesaid machine for any other purpose except treatment of _____.

I, the undersigned, do hereby declare that, I have not purchased any CPAP/BIPAP/Oxygen Concentrator machine, in the past five years at Govt. expenses.

1. Name :

2. CGHS I.D. No:

3. CGHS Wellness Centre which attached:

4. Validity of CGHS Card:

5. Address of Applicant/Mobile:

Dated:

Signature of the Applicant.