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UAE CLINICIAN RESOURCE

Top 20 reasons UAE insurance pre-authorizations get rejected

The denials that cost UAE clinics the most time and revenue — most common first, each with a plain-English cause and how to avoid it.

Grounded in: DOH Claims & Adjudication Rules V2025, Daman clinical guidelines & denial codes, and DHA / eClaimLink circulars.

1 No prior authorization for a service that needed it

AUTHORIZATION

WHY Advanced imaging (MRI/CT/PET), surgery, day-case procedures, high-cost drugs, biologics and inpatient admissions almost always need pre-approval. Treat first and bill later and there is usually no recovery — a missing pre-auth is denied outright (Daman AUTH-001) however justified the care was.

AVOID Keep a payer-specific pre-auth list and confirm whether the exact CPT needs approval on that plan before you render it. Get the approval reference in writing, including for downstream orders (telemedicine-prescribed meds/DME, add-on items, bundle components).

DOH Claims & Adjudication Rules V2025.1 §4.2–4.5; Daman AUTH-001.

2 Service not medically indicated / no supporting diagnosis

MEDICAL NECESSITY

WHY A service billed without a documented indication, or with a diagnosis that does not justify it under the coverage criteria, is denied (Daman MNEC-003/004). Classic triggers: imaging as screening with no signs or symptoms, obstetric ultrasound without a covered indication, pre-op labs on a low-risk case. "MRI brain please" with no duration, findings or red-flag screen fails automatically.

AVOID Document a specific indication — signs, symptoms, or an established diagnosis — that maps to the service's criteria, and code that diagnosis on the claim. For imaging, state symptom duration, focal findings, red-flag status and any failed conservative trial.

Daman MRI/CT Spine, Obstetric Ultrasounds, Pre/Post-Op Labs (MNEC-003/004); DOH V2025.1 §4.4.

3 Patient not eligible / policy lapsed or wrong payer ELIGIBILITY

WHY Cover that was expired, cancelled, suspended, not yet effective, or billed to the wrong plan or TPA is rejected before any clinical review. UAE eligibility is keyed to the Emirates ID against the payer's live system, so any mismatch — including cover lapsing between chronic-care visits — trips the eligibility denials.

AVOID Run a real-time eligibility check (eClaimLink, Shafafiya/Riayati) on the Emirates ID before registration and again before high-cost services — confirm plan name, network tier, effective and expiry dates, and the correct payer/TPA. Re-verify every repeat and chronic visit.

eClaimLink denial-code circular GC06/2018 (DHA / ISAHD); UAE RCM guidance.

4 Billed service doesn't match what was authorized AUTHORIZATION

WHY An approval exists, but the CPT, site/laterality, quantity or encounter level actually billed differs from what was pre-certified — so it is denied even though "we had an approval" (Daman AUTH-005). Common when the intra-operative situation changed, the case escalated to inpatient, or components were added.

AVOID Reconcile the final billed codes, quantity and site against the approval before you submit. If the clinical picture changed, obtain an amended or new authorization rather than assuming the original covers it.

Daman MRI/CT Spine & Pre/Post-Op Labs (AUTH-005); DOH V2025.1 §4.5.

5 ICD or CPT not coded to the highest specificity CODING

WHY Daman guidelines require ICD and CPT coded to the highest level of specificity. A truncated or "unspecified" code fails to establish site, severity and necessity and drives a coding or medical-necessity denial — vague codes read as insufficient justification.

AVOID Assign the most specific ICD-10 and CPT the note supports — laterality, site, degree or extent, gestational age, acuity — and avoid "unspecified" when a more specific code exists.

Daman MRI/CT Spine, OB Ultrasounds, PCSK9, Hep C, Wound Care (§3.2–3.4); DOH V2025.1.

6 Service or diagnosis not covered on the member's plan ELIGIBILITY

WHY A clinically valid request is still denied when the item is excluded from that plan tier — Basic plans exclude many devices and biologics, Visitor plans cover emergencies only, and maternity, IVF, obesity and refractive surgery are benefit-gated. A LASIK request that meets refraction criteria is still denied as a policy exclusion on a Basic plan.

AVOID Check the service against the member's exact Schedule of Benefits — plan type, drug list, riders, limits — before delivering. For non-covered items, advise self-pay rather than submitting.

DOH V2025.1 §4.4.1; Daman Renal Haemodialysis, PCSK9, Hep C, OB Ultrasounds (NCOV-001/003, BENX-002). Exact tier exclusions vary by policy year.

7 Test repeated too soon or too frequently MEDICAL NECESSITY

WHY Repeating a test before its minimum interval or above the allowed frequency is denied (Daman MNEC-005). Typical caps: no repeat MRI/CT spine for the same condition within 180 days, and a maximum of three obstetric ultrasounds per pregnancy. Several payers also cap chronic-disease lab frequency (e.g. HbA1c, vitamin-D testing) under their own policies.

AVOID Check when the same test was last done; if repeating inside the interval, attach the prior report plus documented new or progressive symptoms, and use the correct repeat indicator (R1/R2 radiology, L1/L2 lab) where required. Don't re-run to re-confirm a normal result.

Daman MRI/CT Spine (180 days), Obstetric Ultrasounds; eClaimLink MNEC-005; DOH Addendum 03 repeat indicators (effective 01 May 2026). Frequency caps are payer-policy specific.

8 Step-therapy or failed conservative trial not documented

MEDICAL NECESSITY

WHY Advanced imaging, surgery and biologics are denied when a required prior step was skipped, or the prior trial is mentioned without drug name, dose, duration and reason for failure. Examples: MRI spine with no physiotherapy trial, degenerative-meniscus surgery before an adequate conservative-care trial, a biologic before a conventional-DMARD failure.

AVOID Document every prior treatment with drug name, dose, duration and the specific reason for failure before requesting the next-line intervention. Confirm the exact required trial durations against your payer's current criteria.

Daman Meniscus AR 2019-MN-0034, HMB AR 2013-MN-0013; DOH MNEC-004.

9 Wrong clinician specialty for the service CODING

WHY Many services are restricted to named specialties; a claim from an ineligible clinician is denied for specialty mismatch (Daman CODE-010 / CLN-001). Gates include PCSK9 inhibitors (Cardiology, Endocrinology or Internal Medicine), Hepatitis C therapy (GI, hepatology or ID), and Thiqa elective MRI/CT spine (Specialist or Consultant only).

AVOID Confirm the ordering and performing clinician's licensed specialty is on the service's eligible list before billing, record both clinician IDs, and route specialty-gated drugs and imaging to an eligible specialist.

Daman PCSK9, Hep C, MRI/CT Spine, OB Ultrasounds (CODE-010 / CLN-001); DOH V2025.1 §4.2.

10 Insufficient or vague clinical documentation DOCUMENTATION

WHY Thin, generic notes — "patient stable, vitals normal" — leave the payer unable to verify the service was warranted, so it is denied. Vague onset ("a few months ago") and inconsistent dates compound it.

AVOID Write notes that state the diagnosis, the clinical reasoning and exactly what was done, so the documentation stands alone. Use clear, consistent dates and review completeness before coding.

DHA Claims Management Policy Directive PD-05-2025; UAE RCM guidance.

11 Required documentation or attachments not submitted

DOCUMENTATION

WHY Many services are covered only with specific attachments, and their absence is an outright rejection. Examples: haemodialysis needs clinical history and indication, Hepatitis C therapy needs baseline HCV RNA and genotyping, anti-VEGF injections need the intravitreal pre-requisite form, and high-cost items need an invoice with manufacturer, product and price.

AVOID Build a per-service attachment checklist keyed to the guideline and attach the mandated items at submission — clinical history, baseline labs, prior imaging reports, item invoices and required forms.

Daman Renal Haemodialysis, Hep C, Anti-VEGF AR 2018-PH-005; DOH V2025.1 §4.2–4.3.

12 Drug not on formulary / non-covered medication

FORMULARY

WHY A drug outside the plan's covered formulary — not on the Basic drug list, a brand where only generic is covered, or absent from the DHA/MOHAP or DOH drug list — is not payable (NCOV family). Generic substitution can also down-substitute a brand claim unless "brand necessary" is documented.

AVOID Verify the drug against the plan's formulary and the authority drug list before dispensing; substitute a covered or generic alternative where allowed, write "brand necessary" when substitution must be blocked, or use the formulary-exception process.

eClaimLink NCOV codes; Daman Drug Formulary; DOH approved-drugs list.

13 Drug needs prior approval or exceeds quantity/dose limits

FORMULARY

WHY A covered medication is still rejected when it is subject to prior authorization, step therapy, or quantity and supply limits — common for chronic and high-cost drugs and biologics. Dispensing without the approval, above the allowed quantity, or for an indication or age that does not meet the criteria (e.g. evolocumab below its paediatric age floor) is denied.

AVOID Before dispensing, check whether the drug needs prior approval or has quantity, step or age limits on that plan; obtain approval, match the exact covered indication and severity threshold, and stay within the allowed quantity and duration.

Daman PCSK9 (age floors) & Schedule of Benefits; UAE pharmacy-rejection guidance. Severity/age thresholds vary by drug.

14 Same-day evaluation with a procedure, without a valid Modifier 25

BILLING

WHY An evaluation (E&M) billed the same day as a procedure is only separately payable if it is a distinct, separately identifiable service beyond the routine pre- and post-procedure work — appended with Modifier 25 and documentation that says so. Modifier 25 without that supporting documentation is denied.

AVOID Only bill same-day E&M when it addresses a separate problem or separate decision-making; append Modifier 25 and document explicitly that the evaluation was separately identifiable, beyond routine pre/post-procedure care.

DOH Claims & Adjudication Rules V2025.1 §5.4.1.

15 Unbundling — billing services included in another code

CODING

WHY Billing a component already included in a parent code or bundle is denied (Daman PRCE-002/010). A surgical CPT already includes local anaesthesia, same-day pre-op evaluation and typical follow-up; wound cleansing and dressings bundle into the E&M; and a "without then with contrast" scan uses the single combined CPT.

AVOID Don't itemize services the code already includes; report bundled activities at zero charge where DOH requires; use combined or composite CPTs where they exist; keep the code library current with bundling rules.

DOH V2025.1 §4.2; Daman Wound Care, MRI/CT Spine (PRCE-002/010).

16 Duplicate claim or service

BILLING

WHY The same service submitted twice — a system re-send, a resubmission before the first adjudicated, or the same imaging repeated for the same condition within 180 days with no new indication — is rejected as a duplicate (Daman DUPL-002). DOH also requires all same-day, same-physician outpatient services on one claim.

AVOID Check submission and remittance history before resending; wait for the original remittance and mark resubmissions as corrected; consolidate same-day, same-physician outpatient services into one claim; document a new indication before repeating imaging.

DOH V2025.1 §4.1, §4.4; Daman Wound Care (DUPL-002).

17 Diagnosis–procedure mismatch or wrong/outdated code CODING

WHY The procedure is paired with an ICD-10 that does not clinically justify it, or the code contradicts the report ("MRI with contrast" billed when the report says without), or an outdated code is used. UAE payers require documentation to connect condition to treatment; a mismatch reads as not medically necessary and can flag you for coding audits.

AVOID Validate every procedure–diagnosis pairing and match codes exactly to the report using current ICD-10 and CPT sets; use certified coders and run pre-submission scrubbing to catch contradictory or default codes.

eClaimLink MNEC codes (GC06/2018); combined-CPT rule (Daman MRI/CT Spine); UAE RCM guidance.

18 Late submission or missed response to a payer query TIMELINESS

WHY Claims filed after the contractual window generally cannot be recovered — the payment right expires. Dubai's PD-05-2025 directive sets settlement and resubmission timelines and adds a delay fee (0.03% per day). The same applies when a TPA pends a claim for documents and you reply after the deadline.

AVOID Submit promptly rather than in batches; monitor days-since-service and prioritize claims nearing the deadline; track payer queries daily with clear ownership so documents go back within the stated window.

DHA Claims Management Policy Directive PD-05-2025 (settlement/resubmission timelines; 0.03%/day delay fee).

19 Incomplete or inaccurate patient / policy data DOCUMENTATION

WHY A misspelled name, invalid or mismatched Emirates ID, wrong member or policy number, or wrong date of birth is rejected before clinical review, because UAE payer systems are keyed to the Emirates ID. Even a minor front-desk keying error can auto-reject.

AVOID Capture demographics directly from the Emirates ID and the eligibility response rather than patient dictation; validate ID and member-number format at registration; confirm details before the claim is created.

UAE RCM sources (Emirates-ID linkage).

20 Screening test billed as diagnostic, or care level above justification

MEDICAL NECESSITY

WHY Indication-locked tests are denied when used as general screening in asymptomatic patients — tumour-marker panels, upper GI endoscopy without alarm features, or PET before conventional CT/MRI is inconclusive. Billing a day-case as inpatient without documented escalation criteria is re-leveled or denied.

AVOID Order indication-locked tests only for their named indication with supporting findings; complete and document inconclusive conventional imaging before PET; bill the setting the documentation supports.

Daman Tumour Markers AR 2013-MN-0008, Upper GI Endoscopy AR 2019-MN-0047, PET AR 2013-MN-0007, Day Care Guideline; DOH V2025.1 §4.1.

Compiled from published UAE payer rules — DOH Claims & Adjudication Rules V2025, Daman clinical guidelines, and DHA / eClaimLink denial-code circulars. General guidance for UAE clinicians, not legal, coding, or clinical advice — always verify against your insurer's current published criteria, as thresholds and excluded items vary by payer, plan and policy year.