

# Routine Antenatal Screening and Care Adjudication Guideline

**Rule Category:**  
Medical

**Ref: No:**  
2012-MN-0004

**Version Control:**  
Version No. 4.0

**Effective Date:**  
01/04/2017

**Revision Date:**  
31/01/2025

**Approved by:**  
Daman

**Responsible:**  
Medical Standards  
& Research

**Related Adjudication  
Guidelines:**  
N/A

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## **1. Abstract**

### **1.1 For Members**

Well-being of both the mother and the baby is monitored during pregnancy. Antenatal tests are designed to help make pregnancy safer by screening the mother for conditions and assessing the development of the baby. Pregnant women with complications, or have experienced complications in previous pregnancies, usually require additional care.

Aside from screening tests, antenatal care also includes education and counselling on many topics that affect pregnancy. These include ideal weight gain, proper nutrition, intake of supplements, vaccinations, breastfeeding, postpartum care, etc.

Coverage of routine antenatal care and screening by Daman is subjected to policy terms and conditions. Daman covers routine antenatal services for married women with maternity benefit.

### **1.2 For Medical Professionals**

This adjudication guideline provides coverage guidance on baseline clinical care for all pregnant women covered under Daman plans. Pregnant women with complications, or have experienced complications in previous pregnancies, usually require additional care, which must be determined by the treating physician.

## 2. Scope

This adjudication guideline highlights the coverage of routine antenatal screening tests and care for all health insurance plans administered by Daman. It also includes coverage of screening tests and care during the pre-conception period. Additionally, it provides guidance on baseline clinical care for all pregnant women covered under Daman plans. Pregnant women with current complications or have experienced complications in previous pregnancies usually require additional care, which must be determined by the treating physician.

This guideline was based on the local UAE standards (Department of Health- Abu Dhabi Standard for Routine Antenatal Screening and Care) together with the incorporation of the international best practice.

## 3. Adjudication Policy

### 3.1 Eligibility / Coverage Criteria

#### Coverage of Antenatal care and screening tests

Daman covers routine antenatal screening tests and care for married pregnant ladies with Maternity benefit. For coverage details, please refer to Tables 1, 2 and 7. Routine antenatal immunization & chemoprophylaxis coverage for pregnant ladies with maternity benefits is subject to policy terms and conditions. Please refer to Table 3.

#### Coverage of Pre-conception care and screening tests

Pre-conception screening should be limited to a maximum of one per year. Any subsequent care shall follow the clinical pathway appropriate for the screening findings. Daman covers pre-conception care for Thiqa members under Thiqa scheme Preventative Care. For Basic and Enhanced plans, coverage is subject to policy terms and conditions. For coverage details, please refer to Tables 4, 5 and 6.

### 3.2 Requirements for Coverage

ICD and CPT codes must be coded to the highest level of specificity.

### 3.3 Non-Coverage

Pre-Conception services are not covered, except for Thiqa members and Enhanced members with Medical Check-up benefit.

Antenatal services are not covered for unmarried females and for plans without maternity benefit.

#### Payment and Coding Rules

Please apply regulator's payment rules and regulations. Relevant coding manuals (ICD, CPT, etc.) should also be used.

#### Adjudication Examples

##### Example 1

**Question:** A 26-year-old female under Basic plan (Maternity benefit) with diagnosis of Supervision of normal first pregnancy, is advised CBC, Serological screening for Hepatitis B and Urine testing. Will these tests be covered?

**Answer:** Yes, as the tests are considered routine antenatal screening tests.

##### Example 2

**Question:** A 34-year-old female under Enhanced plan (Maternity benefit) with diagnosis of Supervision of other normal pregnancy is advised Cytomegalovirus test and Chorionic villus sampling (CVS). Will these services be covered?

**Answer:** No. CMV testing and CVS are not considered medically necessary as routine tests in a normal pregnancy. There should be other medical indications documented in the medical record and submitted on the claim for the services to be covered.

## 4. Denial Codes

| Denial Code | Code description                                                                                                        |
|-------------|-------------------------------------------------------------------------------------------------------------------------|
| CLAI-012    | Submission not compliant with contractual agreement between provider and payer                                          |
| CLAI-016    | Incorrect billing regime                                                                                                |
| MNEC-003    | Service is not clinically indicated based on good clinical practice                                                     |
| MNEC-004    | Service is not clinically indicated based on good clinical practice, without additional supporting diagnoses/activities |
| MNEC-005    | Service/supply may be appropriate but too frequent                                                                      |
| NCOV-001    | Diagnosis(es) is (are) not covered                                                                                      |
| NCOV-003    | Service(s) is (are) not covered                                                                                         |
| PRCE-010    | Use bundled code                                                                                                        |
| PRCE-002    | Payment is included in the allowance for another service                                                                |

## 5. Appendices

### 5.1 References

- <https://www.doh.gov.ae/-/media/53DDEF165163450481481DE46FCA653C.ashx>
- <https://www.isahd.ae/content/docs/Health%20Insurance%20Law.pdf>
- <https://www.nice.org.uk/guidance/ng201>
- <http://bestpractice.bmj.com/best-practicSRVConograph/493.html>
- <https://www.uptodate.com/contents/prenatal-care-initial-assessment>
- <https://www.uptodate.com/contents/prenatal-care-second-and-third-trimesters>
- <http://apps.who.int/iris/bitstream/10665/250800/1/WHO-RHR-16.12-eng.pdf?ua=1>

### Tables

#### Abu Dhabi Providers

**Table 1:** DOH-recommended Antenatal Counselling & Education

| Visit                                       | Counselling & Education (15 min)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Basic                                    | Enhanced                 | Thiqa            |
|---------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|--------------------------|------------------|
| First Antenatal Visit (ideally by 10 weeks) | <ul style="list-style-type: none"> <li>Medical and family history including risk profiles.</li> <li>Physical examination including height, weight, BMI, blood pressure.</li> <li>Physical activity.</li> <li>Nutrition &amp; diet including Vitamin D supplements.</li> <li>Nausea and vomiting.</li> <li>Importance of continuity of care.</li> <li>Physiology of pregnancy.</li> <li>Discuss antenatal screening including fetal aneuploidy screening.</li> <li>Genetic Counselling.</li> <li>Book first trimester combined Down Syndrome Screening.</li> </ul> |                                          |                          |                  |
| 16 weeks                                    | <ul style="list-style-type: none"> <li>Accurate recording of menstrual dates.</li> <li>Weight/ BMI, blood pressure.</li> <li>Fundal height.</li> <li>Pre-term labor screening*</li> <li>Nutrition and weight.</li> <li>List of herbal medications, supplements, vitamins.</li> <li>Fetal growth.</li> <li>Nutrition and weight.</li> </ul>                                                                                                                                                                                                                        |                                          |                          |                  |
|                                             | <ul style="list-style-type: none"> <li>Breastfeeding</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Included in E/M. Not covered separately. | Included in E/M. Covered | Included in E/M. |

|          |                                                                                                                                                                                                                                                                                                                                    |                                          |                                                                                  |                                         |
|----------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------|
|          |                                                                                                                                                                                                                                                                                                                                    |                                          | separately as 98960 as per policy terms and conditions.                          | Covered also as 98960.                  |
|          | <ul style="list-style-type: none"> <li>○ Nausea and vomiting.</li> <li>○ Physiology of pregnancy.</li> <li>○ Follow-up of modifiable risk factors.</li> <li>○ Continuity of care.</li> <li>○ Review labs from visit 1.</li> <li>○ Schedule Anomaly scan to be done at 18-20 weeks.</li> </ul>                                      | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 25 weeks | <ul style="list-style-type: none"> <li>○ Weight/ BMI, blood pressure.</li> <li>○ Fundal height.</li> <li>○ Follow-up of modifiable risk factors.</li> <li>○ Classes.</li> <li>○ Family issues.</li> <li>○ Length of stay.</li> <li>○ Gestational diabetes mellitus (GDM).</li> <li>○ Continuity of care.</li> </ul>                | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 28 weeks | <ul style="list-style-type: none"> <li>○ Weight/ BMI, blood pressure.</li> <li>○ Fundal height.</li> <li>○ Follow-up modifiable risk factors.</li> <li>○ Discussing plans for work.</li> <li>○ Physiology of pregnancy.</li> <li>○ Fetal growth.</li> <li>○ Awareness of fetal movement.</li> <li>○ Continuity of care.</li> </ul> | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 31 weeks | <ul style="list-style-type: none"> <li>○ Weight/ BMI, blood pressure.</li> <li>○ Fundal height.</li> <li>○ Continuity of care.</li> </ul>                                                                                                                                                                                          | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 34 weeks | <ul style="list-style-type: none"> <li>○ Weight/ BMI, blood pressure.</li> <li>○ Fundal height.</li> <li>○ Follow-up of modifiable risk factors.</li> <li>○ Travel.</li> </ul>                                                                                                                                                     | Covered.<br>Included in E/M.             |                                                                                  |                                         |
|          | <ul style="list-style-type: none"> <li>○ Breastfeeding.</li> </ul>                                                                                                                                                                                                                                                                 | Included in E/M. Not covered separately. | Included in E/M. Covered separately as 98960 as per policy terms and conditions. | Included in E/M. Covered also as 98960. |
|          | <ul style="list-style-type: none"> <li>○ Episiotomy.</li> <li>○ Labor &amp; delivery issues.</li> <li>○ Warning signs/pregnancy induced hypertension.</li> <li>○ Vaginal birth after caesarean (VBAC)*</li> <li>○ External cephalic version (ECV)*</li> </ul>                                                                      | Covered.<br>Included in E/M.             |                                                                                  |                                         |



|          |                                                                                                                                                                                                                                                                                                                                                                                                 |                                          |                                                                                  |                                         |
|----------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------|-----------------------------------------|
| 36 weeks | <ul style="list-style-type: none"> <li>Weight/ BMI, blood pressure.</li> <li>Fundal height.</li> <li>Follow-up of modifiable risk factors.</li> <li>Postpartum care.</li> </ul>                                                                                                                                                                                                                 | Covered.<br>Included in E/M.             |                                                                                  |                                         |
|          | <ul style="list-style-type: none"> <li>Breastfeeding.</li> </ul>                                                                                                                                                                                                                                                                                                                                | Included in E/M. Not covered separately. | Included in E/M. Covered separately as 98960 as per policy terms and conditions. | Included in E/M. Covered also as 98960. |
|          | <ul style="list-style-type: none"> <li>Pediatric care (care of new baby, vit K).</li> <li>Contraception.</li> <li>When to call provider.</li> <li>Discussion of postpartum depression.</li> <li>Vaginal birth after caesarean (VBAC)*</li> <li>Caesarean Section (C-S) consents and discussion if indicated*</li> <li>Pain management.</li> <li>Consider weekly visits.</li> </ul>              | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 38 weeks | <ul style="list-style-type: none"> <li>Weight/ BMI, blood pressure.</li> <li>Fundal height.</li> <li>Cervix exam.</li> <li>Follow-up of modifiable risk factors.</li> <li>Postpartum vaccinations.</li> <li>Infant CPR.</li> <li>Options for post-term pregnancy.</li> <li>Labor &amp; delivery update.</li> <li>C-S consents and discussion if indicated*</li> <li>Pain management.</li> </ul> | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 40 weeks | <ul style="list-style-type: none"> <li>Weight/ BMI, blood pressure.</li> <li>Fundal height.</li> <li>Follow-up of modifiable risk factors.</li> <li>Postpartum vaccinations.</li> <li>Infant CPR.</li> <li>Options for post-term pregnancy.</li> <li>Labor &amp; delivery update.</li> </ul>                                                                                                    | Covered.<br>Included in E/M.             |                                                                                  |                                         |
| 41 weeks | <ul style="list-style-type: none"> <li>Weight/ BMI, blood pressure.</li> <li>Fundal height.</li> <li>Follow-up of modifiable risk factors.</li> <li>Postpartum vaccinations.</li> <li>Infant CPR.</li> <li>Options for post-term pregnancy.</li> <li>Labor &amp; delivery update.</li> <li>Offer a membrane sweep.</li> <li>Offer induction of labor.</li> </ul>                                | Covered.<br>Included in E/M.             |                                                                                  |                                         |

**Table 2: DOH-recommended Antenatal Screening Tests**

| Visits                                          | Screening Tests                                                                                                                                                                                                                                                                                                                                                      | Basic                     | Enhanced                                             | Thiqa         |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------|---------------|
| First Antenatal visit (ideally before 10 weeks) | Confirming pregnancy; Pregnancy test                                                                                                                                                                                                                                                                                                                                 | Covered.                  |                                                      |               |
|                                                 | Rubella susceptibility                                                                                                                                                                                                                                                                                                                                               |                           |                                                      |               |
|                                                 | HIV                                                                                                                                                                                                                                                                                                                                                                  |                           |                                                      |               |
|                                                 | Varicella                                                                                                                                                                                                                                                                                                                                                            |                           |                                                      |               |
|                                                 | Syphilis (RPR, VDRL)                                                                                                                                                                                                                                                                                                                                                 |                           |                                                      |               |
|                                                 | Hepatitis B virus                                                                                                                                                                                                                                                                                                                                                    |                           |                                                      |               |
|                                                 | Complete Blood Count                                                                                                                                                                                                                                                                                                                                                 |                           |                                                      |               |
|                                                 | Vitamin D                                                                                                                                                                                                                                                                                                                                                            | Not covered. <sup>4</sup> | Subject to policy terms and conditions. <sup>4</sup> | Covered       |
|                                                 | Hemoglobinopathy screening*                                                                                                                                                                                                                                                                                                                                          | Covered. ***              |                                                      | Covered . *** |
|                                                 | ABO/Rh/Ab screen                                                                                                                                                                                                                                                                                                                                                     | Covered.                  |                                                      |               |
|                                                 | Urine – dipstick & CNS                                                                                                                                                                                                                                                                                                                                               |                           |                                                      |               |
|                                                 | Cervical cancer screening***                                                                                                                                                                                                                                                                                                                                         | Not covered. <sup>4</sup> | Subject to policy terms and conditions.              | Covered .     |
|                                                 | Book first trimester combined Down Syndrome Screening if clinically indicated or high risk: <ul style="list-style-type: none"> <li>Parental history of down syndrome</li> <li>Maternal age over 35 years</li> <li>Any abnormal ultrasound</li> <li>History of Down syndrome in previous pregnancies</li> </ul>                                                       | Covered.                  |                                                      |               |
|                                                 | Chorionic Villus Sampling (CVS)* should be done between 11-14 weeks, if medically indicated: <ul style="list-style-type: none"> <li>Parental history of chromosomal abnormalities or genetic disorders</li> <li>Any abnormal ultrasound or investigation findings which necessitate CVS</li> <li>History of genetic abnormalities in previous pregnancies</li> </ul> | Covered.                  |                                                      |               |
|                                                 |                                                                                                                                                                                                                                                                                                                                                                      |                           |                                                      |               |
| 16 weeks                                        | Urine - dipstick                                                                                                                                                                                                                                                                                                                                                     | Covered.                  |                                                      |               |
|                                                 | Preterm labour screening*                                                                                                                                                                                                                                                                                                                                            | Covered.                  |                                                      |               |
|                                                 | Amniocentesis* should be done after 16 weeks, if medically indicated: <ul style="list-style-type: none"> <li>Parental history of chromosomal abnormalities or genetic disorders</li> <li>Any abnormal ultrasound or investigation findings which necessitate amniocentesis</li> <li>History of genetic abnormalities in previous pregnancies</li> </ul>              | Covered.                  |                                                      |               |

|                                 |                                                                                                                                                                                                                                                                                                                                                                                                      |          |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| 25 weeks<br>(nulliparous women) | Urine dipstick - proteinuria                                                                                                                                                                                                                                                                                                                                                                         | Covered. |
| 28 weeks                        | Gestational Diabetes Mellitus screening if clinically indicated or high risk: <ul style="list-style-type: none"> <li>body mass index &gt;30 kg/m<sup>2</sup></li> <li>previous macrosomic baby ≥ 4.5 kg</li> <li>previous gestational diabetes</li> <li>family history of diabetes (first-degree relative with diabetes)</li> <li>ethnic family origin with a high prevalence of diabetes</li> </ul> | Covered. |
|                                 | Repeat Rh antibody screen*                                                                                                                                                                                                                                                                                                                                                                           | Covered. |
|                                 | CBC                                                                                                                                                                                                                                                                                                                                                                                                  | Covered. |
|                                 | Urine dipstick- proteinuria                                                                                                                                                                                                                                                                                                                                                                          | Covered. |
|                                 | Hepatitis B Ag*                                                                                                                                                                                                                                                                                                                                                                                      | Covered. |
| 31 weeks<br>(nulliparous women) | Urine dipstick - proteinuria                                                                                                                                                                                                                                                                                                                                                                         | Covered. |
| 34 weeks                        | Urine dipstick - proteinuria                                                                                                                                                                                                                                                                                                                                                                         | Covered. |
|                                 | Ultrasound*                                                                                                                                                                                                                                                                                                                                                                                          |          |
| 36 weeks                        | Urine dipstick - proteinuria                                                                                                                                                                                                                                                                                                                                                                         | Covered. |
|                                 | Confirm fetal position (if breech, offer cephalic version)                                                                                                                                                                                                                                                                                                                                           |          |
|                                 | Culture for group B streptococcus                                                                                                                                                                                                                                                                                                                                                                    |          |
|                                 | CBC                                                                                                                                                                                                                                                                                                                                                                                                  |          |
| 38 weeks                        | Urine dipstick - proteinuria                                                                                                                                                                                                                                                                                                                                                                         | Covered. |
| 40 weeks<br>(nulliparous women) | Urine - proteinuria                                                                                                                                                                                                                                                                                                                                                                                  | Covered. |
| 41 weeks                        | Urine - proteinuria                                                                                                                                                                                                                                                                                                                                                                                  | Covered. |
|                                 | Offer a membrane sweep                                                                                                                                                                                                                                                                                                                                                                               |          |
|                                 | Offer induction of labour                                                                                                                                                                                                                                                                                                                                                                            |          |
|                                 | Ultrasound                                                                                                                                                                                                                                                                                                                                                                                           |          |
|                                 | Fetal assessment (ultrasound+ CTG)                                                                                                                                                                                                                                                                                                                                                                   |          |

**Table 3:** DOH-recommended Antenatal Immunization and Chemoprophylaxis

| Visits                                          | Immunization & Chemoprophylaxis       | Basic        | Enhanced (subject to policy limits, terms and conditions) <sup>1,2</sup> | Thiqa    |
|-------------------------------------------------|---------------------------------------|--------------|--------------------------------------------------------------------------|----------|
| First Antenatal visit (ideally before 10 weeks) | Hepatitis B*                          | Not Covered. | Covered under Vaccination benefit only.2                                 | Covered. |
|                                                 | Tetanus booster*                      |              |                                                                          |          |
|                                                 | Progesterone*                         |              |                                                                          |          |
|                                                 | Influenza (inactivated)* -recommended |              |                                                                          |          |

|                              |                                               |          |
|------------------------------|-----------------------------------------------|----------|
|                              | Nutritional supplements including folic acid  | Covered. |
| 16 weeks                     | Unsensitized Rh-negative women require RhoGAM | Covered. |
| 25 weeks (nulliparous women) | Rh(D) Immune Globulin (RhoGAM)*               | Covered. |
| 28 weeks                     | Rh(D) Immune Globulin (RhoGAM)*               | Covered. |
| 34 weeks                     | Rh(D) Immune Globulin (RhoGAM)*               | Covered. |

*\*If clinically indicated or high risk.*

#### Numbered clauses:

1. Covered on reimbursement only.
2. For Customized plans, covered as per SOBs.
3. All kind of educational programs and/or learning disabilities treatments (General exclusion clause).
4. Health Services and associated expenses for Experimental, Investigational or Unproven Services, treatments, devices and pharmacological regimens.

**Table 4:** DOH-recommended Pre-Conception Counselling and Education

| Counselling & Education                                              | Basic        | Enhanced                                | Thiqa                        |
|----------------------------------------------------------------------|--------------|-----------------------------------------|------------------------------|
| Nutrition and weight                                                 | Not Covered. | Subject to policy terms and conditions. | Covered.<br>Included in E/M. |
| Smoking cessation                                                    |              |                                         |                              |
| List of medications, vitamins                                        |              |                                         |                              |
| Accurate recording of menstrual dates                                |              |                                         |                              |
| Importance of early registration of pregnancy and continuity of care |              |                                         |                              |
| Physiology of pregnancy                                              |              |                                         |                              |
| Genetic counselling                                                  |              |                                         |                              |

**Table 5:** DOH-recommended Pre-Conception Screening Tests

| Screening                   | Basic        | Enhanced                               | Thiqa    |
|-----------------------------|--------------|----------------------------------------|----------|
| Cholesterol & HDL**         | Not Covered. | Subject to policy term and conditions. | Covered. |
| Rubella, Varicella          |              |                                        |          |
| Vitamin D screening         |              |                                        |          |
| HbA1C**                     |              |                                        |          |
| Cervical cancer screening** |              |                                        |          |

**Table 6:** DOH-recommended Pre-Conception Immunization and Chemoprophylaxis

| Immunization & Chemoprophylaxis | Basic        | Enhanced                               | Thiqa    |
|---------------------------------|--------------|----------------------------------------|----------|
| Tetanus booster*                | Not Covered. | Subject to policy term and conditions. | Covered. |
| Rubella*                        |              |                                        |          |
| Varicella*                      |              |                                        |          |
| Hepatitis B vaccine*            |              |                                        |          |
| Folic acid supplement           |              |                                        |          |

\*If clinically indicated or high risk; \*\*As per protocol.

## Dubai Providers:

**Table 7:** DHA-recommended Antenatal Services

| Weeks AOG | Service                                                                                                                                                                                                                                                                           | Basic | Enhanced | Thiqa |
|-----------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|----------|-------|
| 10-14     | History and full physical examination screening                                                                                                                                                                                                                                   |       | Covered. |       |
|           | Complete Booking Risk Assessment Tool                                                                                                                                                                                                                                             |       |          |       |
|           | Offer 1st trimester genetic screening at 11-13 weeks                                                                                                                                                                                                                              |       |          |       |
|           | Discussion of Low-Risk GP led care                                                                                                                                                                                                                                                |       |          |       |
|           | Make scan appointment for 18-20 weeks at clinics/hospital                                                                                                                                                                                                                         |       |          |       |
|           | Confirmation of pregnancy                                                                                                                                                                                                                                                         |       | Covered. |       |
|           | Dating scan                                                                                                                                                                                                                                                                       |       | Covered. |       |
|           | Full Blood Count                                                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Blood group, Rhesus status and antibodies                                                                                                                                                                                                                                         |       | Covered. |       |
|           | VDRL                                                                                                                                                                                                                                                                              |       | Covered. |       |
|           | Urinalysis                                                                                                                                                                                                                                                                        |       | Covered. |       |
|           | Rubella serology                                                                                                                                                                                                                                                                  |       | Covered. |       |
|           | HIV                                                                                                                                                                                                                                                                               |       | Covered. |       |
|           | Hep C offered to high-risk patients                                                                                                                                                                                                                                               |       | Covered. |       |
|           | Glucose Tolerance Test if high risk<br>body mass index >30 kg/m <sup>2</sup><br>previous macrosomic baby ≥ 4.5 kg<br>previous gestational diabetes<br>family history of diabetes (first-degree relative with diabetes)<br>ethnic family origin with a high prevalence of diabetes |       | Covered. |       |
|           | Fasting/random blood glucose or HbA1c for all due to high prevalence of diabetes in UAE                                                                                                                                                                                           |       | Covered. |       |
| 11-13     | Genetic screening (Down's screening)                                                                                                                                                                                                                                              |       | Covered. |       |
| 16        | Antenatal visit                                                                                                                                                                                                                                                                   |       | Covered. |       |
| 18-20     | Detailed anomaly scan                                                                                                                                                                                                                                                             |       | Covered. |       |
| 20        | Antenatal visit                                                                                                                                                                                                                                                                   |       | Covered. |       |
| 25        | Antenatal review and risk status, record results                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Review ultrasound result (change EDD only if USG scan is 10 days different to menstrual dates)                                                                                                                                                                                    |       |          |       |
|           | Fetal growth surveillance                                                                                                                                                                                                                                                         |       | Covered. |       |
|           | Repeat GTT for high-risk patient if normal at first visit                                                                                                                                                                                                                         |       | Covered. |       |
| 28        | Antenatal review and risk status, record results                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Review ultrasound result (change EDD only if USG scan is 10 days different to menstrual dates)                                                                                                                                                                                    |       |          |       |
|           | Fetal growth surveillance                                                                                                                                                                                                                                                         |       | Covered. |       |
|           | Full Blood Count                                                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Rhesus antibody screen                                                                                                                                                                                                                                                            |       | Covered. |       |
|           | If Rh-, give Anti D one dose (28-30 wks)                                                                                                                                                                                                                                          |       | Covered. |       |
| 31        | Antenatal review and risk status, record results                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Fetal growth surveillance                                                                                                                                                                                                                                                         |       | Covered. |       |
| 34        | Antenatal review and risk status, record results                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Fetal growth surveillance                                                                                                                                                                                                                                                         |       | Covered. |       |
|           | Rhesus antibody screen                                                                                                                                                                                                                                                            |       | Covered. |       |
| 36        | Antenatal review and risk status, record results                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Confirm presentation                                                                                                                                                                                                                                                              |       | Covered. |       |
|           | Fetal growth surveillance                                                                                                                                                                                                                                                         |       |          |       |
|           | Low vaginal swab for group B haemolytic strep (screening)                                                                                                                                                                                                                         |       | Covered. |       |
| 38        | Antenatal review and risk status, record results                                                                                                                                                                                                                                  |       | Covered. |       |
|           | Confirm presentation                                                                                                                                                                                                                                                              |       | Covered. |       |

|    |                                                  |          |
|----|--------------------------------------------------|----------|
| 40 | Fetal growth surveillance                        |          |
|    | Antenatal review and risk status, record results | Covered. |
|    | Confirm presentation                             | Covered. |
| 41 | Fetal growth surveillance                        |          |
|    | CTG                                              | Covered. |
|    | Bishops score                                    | Covered. |
|    | Membrane sweep                                   |          |
|    | Appointment for induction of labor at 40+10      |          |

## 5.2 Revision History

| Date       | Change(s)                                                                                                    |
|------------|--------------------------------------------------------------------------------------------------------------|
| 01/06/2012 | V 1.0 Release.                                                                                               |
| 01/07/2013 | V 2.0 New template                                                                                           |
| 15/07/2014 | V 3.0<br>- Disclaimer updated as per system requirements.<br>- Restored original effective date.             |
| 01/03/2017 | V 3.1<br>- Incorporation of Dubai Health Authority Routine Antenatal Standards.<br>- General content update. |
| 31/01/2025 | V 4.0 New template                                                                                           |

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