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RESEARCH ARTICLE

AN ANALYSIS OF CLAIMS ADJUSTMENT PROCESSES IN GEORGIA'S HEALTH INSURANCE SECTOR: QUALITATIVE STUDY

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ABSTRACT

OBJECTIVE:

Efficient management of insurance claims is essential for the financial stability of the healthcare system. This study aims to examine the challenges and systemic issues that affect health insurance claims management and to identify areas for operational improvement.

METHODOLOGY:

A qualitative research design was employed, supported by quantitative claims data to ensure methodological triangulation. Twelve in-depth semi-structured interviews were conducted with managers and administrative staff from a leading Georgian private insurance company and affiliated healthcare providers. Interview transcripts were thematically analyzed through an inductive–deductive coding process, informed by transaction cost and principal–agent theories. Quantitative data from the insurer's 2022–2024 internal claims database were analyzed using descriptive statistics to identify trends in submission, correction, and revision. Triangulation between qualitative themes and quantitative indicators served as a validation strategy.

RESULTS:

The qualitative analysis revealed recurring themes related to administrative inefficiency, communication barriers, and contractual non-compliance. Key themes included: (1) incomplete or inconsistent documentation leading to claim adjustments; (2) weak coordination and information sharing between insurers and providers; and (3) tolerance of deadline and pricing violations for high-demand clinics to maintain service continuity. Quantitative results showed that approximately 2% of all claims required correction or revision, primarily due to documentation and referral issues. Hospitals accounted for the majority of claims and adjustments.

CONCLUSION:

The study highlights significant operational inefficiencies and communication gaps in Georgia's health insurance claims process. The lack of standardized documentation protocols, reliance on manual systems, and frequent breaches of contract terms all contribute to delays, disputes, and financial strain for both insurers and providers. To improve claims management in Georgia, the process should be digitized and documentation standardized to reduce errors. Staff training must be strengthened, and regulatory oversight enhanced through performance-based contracts.

KEYWORDS

Health insurance, claims management, medical documentation, contract compliance, insurance providers

INTRODUCTION

Health insurance plays a critical role in protecting individuals and families from the financial risks associated with medical care. In both developed and developing countries, the effectiveness of insurance systems depends heavily on how efficiently claims are managed and processed. Efficient claims management not only ensures the financial sustainability of insurance providers but also directly affects the accessibility, quality, and timeliness of healthcare services received by insured individuals [1, 2].

Claims management typically involves the submission, verification, adjustment, and reimbursement of medical expenses incurred by policyholders. At the core of this process is the claim adjustment stage, during which insurance companies review and validate submitted claims to determine their eligibility for payment. While this process is vital for fraud prevention and financial control, it often leads to disputes and delays, particularly when documentation is incomplete, policies are unclear, or contractual terms are not adhered to [3, 4].

Global evidence shows that paper-based and poorly integrated claims systems are consistently associated with higher administrative costs, slower reimbursement, and larger volumes of corrected or rejected claims. Studies and policy reports from multiple settings demonstrate that digital claims platforms and standardized billing rules lower rejection rates and shorten payment cycles, improving provider liquidity and overall efficiency. Comparable experiences from Europe and Central Asia likewise document the administrative challenges that accompany transitions to social or mixed insurance models: countries that invested early in interoperable claims systems (for example, some Baltic states and selected European funds) observed measurable reductions in manual corrections and audit workloads [5].

There is also a growing literature from countries with transitional health systems -Armenia, Ukraine, Kazakhstan, and Moldova, that highlights how uneven implementation of purchasing rules and weak information flows increase transaction costs between payers and providers and can incentivize informal coping behaviors by clinics [6]. Country reports and analytic papers point to the same proximate drivers we observe in Georgia (documentation errors, referral irregularities, and contract compliance problems) while also showing how different policy choices (strategic purchasing, investment in digital infrastructure, stronger regulatory oversight) have produced divergent outcomes [7].

Bringing comparative evidence from post-Soviet and lower-middle-income countries into conversation with Georgian data has three advantages. First, it helps distinguish which problems are technical (fixable by digitization and training) versus structural (rooted in financing design, provider incentives, or regulatory gaps). Second, it provides practical pathways for reform: countries that paired standard billing formats with electronic submission portals and clear contracting rules saw rapid declines in simple documentation-based corrections [8]. Third, regional comparisons underscore governance lessons, how purchaser capacity, transparency in contracting, and credible enforcement mechanisms reduce adversarial disputes and litigation over claims [9].

In Georgia, where mixed public–private financing and a growing role for private insurers coexist with state-funded programs, efficient claims processing has direct implications for provider cash flow, insurer solvency, and patient access to care. These challenges are compounded by limited digital infrastructure, inconsistent standards across medical providers, and weak regulatory oversight. A study of insurance claims management in similar contexts has shown that delays in reimbursement and high rates of claim correction often stem from inadequate communication, disorganized medical records, and non-standardized billing systems [10, 11]. These inefficiencies undermine provider-insurer relationships, reduce patient trust, and contribute to systemic instability in healthcare financing.

In Georgia, the relationship between insurance companies and medical institutions is governed by contractual agreements that outline service costs, deadlines, and documentation protocols [12, 13, 14]. However, frequent breaches of these agreements, along with disputes over pricing and service coverage, have led to an increase in adjusted and

rejected claims. Insurance companies also face difficulties managing claims from a growing number of contracted medical providers, many of which operate with varying administrative capacities.

Given these challenges, it is essential to examine the mechanisms, behaviors, and systemic factors that affect the performance of the claims management process in Georgia. Understanding the root causes of inefficiencies can help identify strategies for improvement, reduce delays in payment, and strengthen the overall health financing system.
Although past research has described broad health-financing transitions in post-Soviet countries, there is limited empirical evidence focusing specifically on the micro-level administrative mechanics of claims adjustment in Georgia. Existing overviews of the region highlight persistent problems, fragmented information systems, uneven administrative capacity across providers, and unpredictable reimbursement timetables, but they rarely link these system-level features to concrete claims correction rates, revision drivers, or insurer–provider dispute processes. This paper fills that gap by (1) documenting the frequency and monetary value of adjusted and revised claims in a major Georgian insurer's portfolio; (2) identifying the operational causes of adjustments (documentation gaps, invalid referrals, coding inconsistencies, deadline breaches); and (3) situating these findings within broader regional experiences and policy options (digitalization, standardization, and governance reform).

The aim of this study is to analyze the claims adjustment process within Georgia's insurance sector, explore the reasons for claim revisions and delays, and identify institutional and systemic barriers that hinder efficient claims management. By combining qualitative insights with claims data from 2022 to 2024, this research seeks to generate practical recommendations for improving the accuracy, speed, and transparency of insurance reimbursement processes.

THEORETICAL FRAMEWORK

This study is grounded in the intersection of health systems theory, organizational transaction cost theory, and claims management principles from the field of insurance economics. These theoretical perspectives help explain the dynamics between insurers and healthcare providers, as well as the administrative and structural factors that influence claim processing outcomes.

HEALTH SYSTEMS THEORY

According to the World Health Organization (WHO), health systems are comprised of all organizations, institutions, and resources whose primary purpose is to improve health. Effective health systems must ensure access, quality, and efficiency of services while maintaining financial protection. Claims management is a core function of the financing sub-system, where proper documentation, timely reimbursements, and compliance with contractual agreements are essential for sustainability and trust. Weaknesses in administrative functions, such as delays, documentation errors, or inconsistencies in reimbursement, undermine overall system performance and user satisfaction [15].

TRANSACTION COST THEORY

Rooted in organizational economics, transaction cost theory (Williamson, 1981) posits that economic exchanges between organizations, such as between insurers and providers, are shaped by efforts to minimize the costs of coordination, negotiation, and enforcement of contracts. In the context of Georgia's health insurance sector, frequent adjustments and disputes over claims reflect high transaction costs, resulting from incomplete documentation, asymmetry of information, and unclear contractual terms. These costs are further amplified when standardized digital systems are lacking and when institutional capacity varies across providers.

CLAIMS MANAGEMENT AND RISK CONTROL THEORY

Within the insurance industry, claims management theory emphasizes the need for risk containment, fraud prevention, and efficiency in resource allocation. Claims adjustment serves not only to ensure that payments align with contractual terms and medical necessity, but also to prevent financial loss due to overuse, errors, or abuse. However, excessive scrutiny or inefficiencies in processing can result in delays and dissatisfaction. A balance must therefore be struck between control mechanisms and service quality.

PRINCIPAL-AGENT THEORY

This framework is also relevant in analyzing insurer-provider relationships. The insurance company (principal) relies on healthcare providers (agents) to deliver services to insured patients according to agreed terms. However, information asymmetry and divergent incentives often lead to agency problems, such as upcoding, provision of unnecessary services, or documentation manipulation, which in turn necessitate claim audits, adjustments, and at times legal review. Monitoring systems and incentive alignment are crucial to resolving such inefficiencies.

ANALYTICAL INTEGRATION

Together, these frameworks established the logic underpinning the study's methodological choices and interpretive approach. Transaction cost and principal–agent theories informed both the design of the semi-structured interview guide and the coding scheme used in thematic analysis, ensuring that observed operational challenges were interpreted in relation to coordination costs, incentive structures, and monitoring limitations. Health systems theory provided a broader policy and institutional context, while claims management theory grounded the analysis in measurable efficiency criteria. This combined framework enabled the study to move beyond description toward an explanatory understanding of why and how administrative inefficiencies persist in Georgia's insurance claims management process.

METHODS

RESEARCH DESIGN

Given the exploratory nature of this research, a qualitative design was employed to capture the perspectives, practices, and operational challenges of health insurance claims management in Georgia. To ensure data validation and depth, the study integrated quantitative claims data analysis within a qualitative framework (methodological triangulation). This combination enhanced credibility by aligning administrative data with respondent narratives.

DATA SOURCES AND SAMPLING

Qualitative data were collected through twelve semi-structured, in-depth interviews with insurance company managers, claims adjusters, and administrative staff from affiliated medical institutions. Participants were purposively selected based on their direct involvement in claims processing, auditing, and provider relations. Data collection continued until thematic saturation was reached, that is, when subsequent interviews produced no new insights or themes. Saturation was achieved after the tenth interview, with two additional interviews conducted to confirm stability of themes.

Quantitative data were obtained from the internal archives of a leading private insurance company in Georgia. These administrative records, used with company permission, covered all processed claims from January 2022 through December 2024. Inclusion criteria consisted of completed claims submitted within this period across hospital, outpatient, dental, and pharmacy services. Incomplete, duplicate, or pending claims were excluded from analysis. The dataset was de-identified prior to transfer to the research team, ensuring confidentiality and data security.

DATA COLLECTION INSTRUMENTS

The interview guide included questions on: (a) criteria for contracting providers, (b) causes of claim corrections and revisions, (c) documentation standards and communication protocols, (d) challenges in meeting reimbursement deadlines, and (e) perceptions of digitalization and administrative efficiency. Each interview lasted 50–60 minutes and was audio-recorded with participant consent. Transcripts were anonymized before analysis.

DATA ANALYSIS

Interview transcripts were analyzed using thematic content analysis, guided by a hybrid inductive–deductive approach. Initial deductive codes were derived from the theoretical frameworks (transaction cost and principal–agent theories), while additional inductive codes emerged during iterative reading of transcripts. Coding and theme development were performed by two independent researchers, who compared interpretations and discussed discrepancies until consensus was reached. Inter-coder reliability was reinforced through peer debriefing sessions and cross-checking of coded segments. Quantitative claims data were analyzed descriptively to identify the frequency and proportion of adjusted and revised claims, providing contextual validation for qualitative findings.

TRIANGULATION AND CREDIBILITY

Triangulation was applied across data sources (interviews and claims data) and analytical levels to enhance validity. Converging evidence between administrative trends and interview themes was treated as confirmatory, while inconsistencies guided further interpretive analysis. Peer debriefing and reflexive memoing were used to mitigate researcher bias and maintain analytic transparency.

ETHICAL CONSIDERATIONS

Ethical approval was granted by the Ethics Council of Caucasus University (CAU No. 018/24). Written informed consent was obtained from all participants after they were briefed on the study's objectives and confidentiality procedures. Audio recordings, transcripts, and administrative data were stored on a password-protected institutional drive accessible only to the core research team. All identifying information was removed from transcripts, and de-identified data were retained solely for analysis purposes.

RESULTS

The analysis drew on both interview data and a proprietary claims dataset obtained directly from the internal records of a leading private insurance company operating in Georgia. The dataset was used with permission from the company's management and de-identified before analysis to ensure confidentiality. It included all processed claims from January 2022 through December 2024 and covered hospital, outpatient, dental, and pharmacy services. These records represented administrative data routinely collected for internal auditing and financial reporting purposes, rather than a national or publicly accessible health database. Clarifying the origin of this dataset enhances transparency regarding data reliability and contextual scope—it reflects the operational realities of one major insurer within Georgia's mixed health-financing environment.

Between 2022 and 2024, over 1.28 million claims totaling approximately 58.2 million GEL were submitted by hospitals. Of these, around 1.8% were adjusted and 0.4% revised, resulting in 97.8% of the total being reimbursed. Hospitals accounted for the majority of both claims and adjustments. (Table 1; Table 2).

TABLE 1 - CLAIMS SUBMITTED AND ADJUSTED BY SERVICE TYPE, 2022–2024

	The total value (GEL)	Subject to correction	Subject to revision	Paid amount (GEL)
Hospital	*31,223,231*	*380,413*	*30,133*	*30,812,685*
Ambulatory	*6,141,813*	*35,654*	*11,804*	*6,094,355*
Dentistry	*3,945,734*	*25,589*	*0*	*3,920,145*
Pharmacy	*16,821,739*	*590,573*	*175,016*	*16,056,150*
Total	*58,132,517*	*1,032,229*	*216,953*	*56,883,335*

TABLE 2 - REASONS FOR ADJUSTMENT, (IN GEL) (2022-2024)

Reason Type	Adjustment Value	Percentage
Discount	97,123	9.3%
Late Submission	241,643	23.2%
Documentation Error	663,534	63.7%
Other	39,342	3.8%
Total	1,041,642	100%

IN-DEPTH INTERVIEW RESULTS

The qualitative data provide context to the quantitative findings and explain why certain claim types are more prone to correction or delay.

THE VALUE OF EXPANDING PROVIDER NETWORKS

Participants consistently emphasized the strategic role of maintaining a broad provider network to improve access and manage financial risk. A diverse network allows patients flexibility in choosing healthcare facilities, improves satisfaction, and gives insurers leverage in negotiating service prices and reimbursement schedules. Respondents noted that wide networks also facilitate deferred payments, which help insurers manage liquidity.

Key Advantages of Multiple Provider Networks:

- Improved Access and Flexibility: A diverse provider network enables insured individuals to access a broad spectrum of healthcare services, including specialized care. This ensures patients can choose facilities based on convenience, medical need, or geographic proximity.
- Enhanced Customer Satisfaction: Greater provider choice contributes to higher patient satisfaction by allowing policyholders to seek care from clinics that best meet their personal preferences and service expectations.
- Network Adequacy and Service Availability: Maintaining a sufficient number of contracted clinics ensures adequate coverage and helps prevent service delays due to long wait times or provider unavailability.
- Cost Control and Deferred Payments: By entering into contractual agreements with multiple providers, insurance companies can negotiate favorable service rates and defer reimbursements, thus improving cash flow and budgeting.

"There are several reasons why it is important for an insurance company to maintain a wide network of provider clinics. First, it ensures greater access to care, allowing policyholders to choose from various providers based on location, specialization, and availability. This variety enhances satisfaction and service quality. Moreover, a broader network helps maintain adequate coverage and reduces wait times. From a financial standpoint, it allows insurers to negotiate discounted rates and enter cost-sharing agreements, generating savings for both the insurer and the insured."

Respondent I

"As a financial entity, an insurance company is primarily focused on managing risks and costs. Having multiple contracted providers is advantageous in that it allows insurers to control the timing of payments. If a policyholder uses a provider clinic, reimbursements are processed according to contractual timelines—often delayed by one to two months—rather than requiring immediate reimbursement, as is the case with non-contracted clinics. Furthermore, a broad provider network enables insurers to better meet the diverse needs of their policyholders."

Respondent II

"A wide network of provider clinics gives policyholders valuable options in terms of medical specialization, service quality, and geographic accessibility. This variety not only improves patient experience but also strengthens the insurer's ability to deliver responsive and comprehensive healthcare coverage."

Respondent IV

CRITERIA FOR CONTRACTING MEDICAL INSTITUTIONS

Interviewees identified several key criteria for contracting medical institutions, including geographic accessibility, range of services, quality assurance mechanisms, and compliance with national healthcare standards. Providers demonstrating accreditation, strong patient satisfaction scores, and operational transparency were prioritized for contracting.

"Insurance companies typically assess several key factors before entering into contractual agreements with medical providers. While these may vary depending on the strategic goals of each insurer, certain core criteria are generally observed across the industry".

Respondent IX

"First and foremost, insurers evaluate whether a medical facility is capable of meeting the healthcare needs of their insured population. This includes assessing the institution's geographic reach, range of services, and its ability to provide timely and efficient care. A critical objective is to ensure that the provider network includes a diverse mix of clinics and hospitals that can offer comprehensive services across different regions.

Another major consideration is the quality of care delivered by the medical institution. This involves reviewing credentials such as accreditation status, clinical certifications, treatment outcomes, and performance in patient satisfaction surveys. Additionally, insurers assess the provider's compliance with national healthcare standards and regulatory requirements."

Respondent XII

"Overall, insurance companies prefer to collaborate with medical organizations that demonstrate a strong commitment to service quality, operational transparency, and the capacity to serve patients effectively. These criteria help maintain the credibility of the insurer's provider network and ensure that policyholders receive reliable and professional medical services."

Respondent IV

REASONS FOR CLAIM ADJUSTMENTS

The analysis of interview responses revealed several recurring causes behind claim adjustments initiated by insurance companies. These adjustments often stem from administrative inconsistencies, procedural errors, or documentation deficiencies on the part of healthcare providers.

Key Reasons for Claim Adjustments:

- Incomplete or disorganized documentation;
- Use of invalid or outdated referral forms;
- Missing patient identification materials;
- Diagnostic discrepancies;
- Rapid rehospitalization of the same patient across multiple facilities;
- Incorrect or missing notification to the insurer in urgent cases;
- Application of discounts not reflected in the claim

"The most common reasons for correcting the amounts submitted by medical institutions include failures in the notification process, especially in urgent cases where either no message is sent to the insurer or the message is incorrectly issued. Additionally, discrepancies may arise from billing corrections due to discounts that were not properly documented or communicated during the submission."

Respondent X

"Claim adjustments frequently occur due to a variety of administrative and procedural shortcomings. These include incomplete supporting documentation, the use of expired or invalid referral forms, and the absence of necessary identity verification documents. Other common issues involve mismatches between the diagnosis and the services provided, or cases where a patient is transferred or rehospitalized within a short time frame between different medical institutions, which often triggers a reassessment by the insurer."

Respondent III

REASONS FOR DELAYED PAYMENTS FOLLOWING CLAIM ADJUSTMENTS

Delays in reimbursement often occur after claims are flagged for adjustment. Based on the interviews, these delays are primarily attributed to extended clarification processes, internal audits, and, in more complex cases, legal proceedings.

Common Causes of Payment Delays Post-Adjustment:

- Extended back-and-forth communication regarding justifications from medical institutions;
- On-site audits to verify the accuracy of documentation and services provided;
- Escalation of unresolved cases to legal departments and courts.

"Medical institutions are generally motivated to respond promptly to any adjustments raised by insurers in order to receive compensation within the contractually agreed timeframe. However, if the insurer finds the facility's explanation insufficient or requires further verification, the reimbursement timeline may be extended. In some cases, these 'problem claims' may remain unresolved for two or three months—or even longer—depending on the complexity of the issue."

Respondent XI

"When clarification between the insurer and the medical institution proves unsuccessful, the matter is escalated to the audit department. Auditors may conduct on-site reviews of the medical history to verify the legitimacy of the claim. If consensus is still not achieved, the case is handed over to the legal department for further evaluation. In certain cases, disputes reach the court system, including the Supreme Court, which significantly prolongs the reimbursement process."

Respondent VIII

HANDLING OF PERFORMANCE SUBMISSIONS AND DEADLINE VIOLATIONS

Timely submission and processing of medical service documentation are critical components of the claims management process. Both insurance companies and medical institutions rely on strict adherence to contractually defined deadlines to ensure operational efficiency and financial predictability. Interview findings show that failure to comply with these terms can trigger significant administrative consequences and affect contractual relationships. Thus, insurers and providers reserve the right to reject claims or terminate contracts in response to missed deadlines. Delays in documentation submission or payment can lead to strained relations and administrative escalation.

"Insurance companies are entitled to reject documentation submitted by medical institutions if it falls outside the deadlines established in the contract. This enforcement mechanism ensures compliance and discourages operational delays. Conversely, if the insurer fails to process payments on time, the medical institution has the right to request clarification, demand a detailed report, and—if deemed necessary—initiate termination of the contract. Such clauses are typically included to protect the interests of both parties and maintain accountability within the reimbursement process."

Respondent IV

FREQUENCY OF CONTRACT VIOLATIONS

Contract breaches between insurance companies and medical institutions are not uncommon. While such violations can undermine trust and cooperation, they are sometimes tolerated, particularly when involving clinics that are highly preferred by insured clients. The interviews highlighted a nuanced reality in which contractual discipline is balanced against practical service delivery needs. Contract breaches occur regularly, especially regarding deadlines and pricing. Violations are often overlooked when dealing with high-demand or strategically important providers. Both parties generally aim to maintain transparency and mitigate the impact of such breaches.

"Any breach of contractual terms can significantly affect the relationship between the insurer and the healthcare provider. As a result, both sides make efforts to keep each other informed at every stage of the process. When violations do occur, they typically attempt to resolve the issue constructively, taking into account the mutual importance of the partnership."

Respondent I

"Deviations from agreed deadlines and pricing are quite common and usually identified during ongoing operations. Although formal terms exist, real-time pressures and case-specific considerations often lead to non-compliance, which is managed case by case."

Respondent III:

"Strict adherence to contract terms can be challenging, especially when the clinic in question is popular with insured clients. In such cases, violations are more likely to be tolerated in order to maintain continuity of care and avoid patient dissatisfaction."

Respondent VI

MAIN REASONS FOR CORRECTIONS IN SUBMITTED DOCUMENTATION

One of the most frequent triggers for claim adjustments is the submission of incomplete or incorrect documentation by medical institutions. These documentation issues disrupt the claims review process and often result in delays, corrections, or payment denials.

Common Documentation Issues:

- Missing or incomplete information
- Inaccurate or inappropriate diagnoses

- Duplicate submissions or conflicting records
- Late submissions beyond agreed deadlines

"Documentation corrections occur for a variety of reasons, but the most common include missing or incomplete information, mismatches between diagnoses and treatments, duplicate data entries, and failure to meet submission deadlines. These errors hinder the smooth processing of claims and often necessitate follow-up."

Respondent II

"Identifying the cause of documentation errors is generally straightforward. In many cases, the issue arises from simple confusion or oversight. When this happens, we allow the responsible party to submit corrected documentation so that the claim can proceed without further complications."

Respondent VI:

COMPLEXITY OF REVISION CASES

Claim revisions are typically initiated when submitted documentation lacks clarity or raises questions during the insurer's internal review. These cases are considered more complex due to the additional verification steps they require and their potential to delay reimbursement.

Key Characteristics of Complex Revisions:

- Triggered by ambiguous, inconsistent, or incomplete documentation
- Often necessitate on-site audits by the insurance company
- Involve extended investigation to validate the accuracy of the claim

"When any member of the insurance company's team identifies inconsistencies or has doubts about the submitted documentation, a revision process is initiated. In such cases, auditors are dispatched to the medical facility to conduct an in-depth, on-site review. This ensures that the claim is thoroughly examined before any final decision on reimbursement is made."

Respondent III

DISCUSSION

This study investigated the operational challenges associated with health insurance claims management in Georgia, with particular attention to the adjustment and reimbursement processes between insurers and healthcare providers. The findings highlight a complex system marked by administrative inefficiencies, delayed payments, contract violations, and recurring disputes, all of which compromise the effectiveness of the country's health insurance system.

Between 2022 and 2024, over 1,282,000 cases were submitted to a major insurance company, with a total claimed value exceeding 58 million GEL. Of this amount, approximately 1.78% (1,041,642 GEL) was subject to correction, and 0.37% (216,953 GEL) was marked for revision, indicating that nearly 2.2% of total claims required additional administrative processing before reimbursement. Hospitals accounted for the highest share of both claim submissions and adjustments, representing over 50% of all claims submitted annually during the period studied.

The most frequent reasons for adjustments included incomplete documentation, invalid or outdated referrals, diagnosis inconsistencies, and missed submission deadlines. A finding consistent with previous research on claims inefficiencies in similar healthcare settings [16, 17]. These administrative shortcomings not only delay payments but also undermine financial predictability for medical institutions, especially those heavily reliant on private insurance reimbursements alongside state funding [18].

Respondents also emphasized the strategic importance of maintaining broad provider networks. Such networks increase access to care, reduce wait times, and enhance customer satisfaction. As Respondent I noted, "a wide network ensures policyholders can choose the clinic that best suits their needs," while Respondent II pointed out that contractual

arrangements with providers allow insurers to defer reimbursements, improving their cash flow. This is in line with international findings on network adequacy and cost control strategies in insurance management [19].

However, the breadth of provider networks also contributes to inconsistency in contract compliance. According to the interviews, violations of submission deadlines and pricing agreements are common, especially among clinics that are popular with insured patients. While such breaches are often tolerated to preserve patient satisfaction and service continuity, they erode accountability and introduce financial risk. Respondent III acknowledged that "strict adherence to contract terms is difficult when the provider is in high demand," illustrating how patient preferences can influence operational discipline.

A particularly problematic area is the handling of revision cases. These cases are triggered when documentation is ambiguous or questionable, often requiring on-site audits and even legal review. Such cases can delay compensation by two to three months or longer, and in some instances, are escalated to the Supreme Court, further complicating the process. This finding reflects broader trends in insurance systems globally, where dispute resolution and fraud prevention are major challenges in claims processing [20, 21, 22].

The absence of an integrated digital infrastructure further exacerbates inefficiencies. Manual data entry, lack of real-time claim tracking, and disjointed communication between insurers and providers contribute to frequent errors and administrative backlogs. This aligns with previous studies calling for the adoption of mobile and automated claims management solutions in emerging markets [23, 24].

This study's findings should be read in light of the broader literature on post-Soviet health system transitions and the evolving purchaser–provider relationships in the region. Since independence Georgia moved away from the Semashko inheritance toward decentralized provision and a mixed public–private financing model. Country reviews and Health Systems in Transition (HiT) reports document rapid privatization, the introduction of purchaser–provider splits, and efforts to broaden coverage through strategic purchasing, while also noting persistent administrative and governance weaknesses [25]. These longer-run institutional legacies help explain operational patterns observed in our data, including fragmented documentation practices, variable contracting discipline, and heterogenous provider administrative capacity [26].

Comparative studies of former Soviet republics and similar transition settings reveal recurring problems that align closely with our findings. The shift from highly centralized administrative control to more diversified purchaser and provider arrangements frequently produced gaps in purchaser capacity, weak oversight, and limited interoperability of information systems. In many countries in the region this has translated into high transaction costs, predominantly manual claims workflows, and recurring payer–provider disputes that impede efficient reimbursement and weaken the prospects for strategic purchasing. Conversely, the literature also documents successful reform pathways, often combining interoperable claims systems, standardized billing rules, and strengthened purchaser governance, that reduced simple documentation errors and enabled more advanced purchasing instruments [27].

Trust between insurers and medical institutions also emerged as a key issue. Disputes over reimbursement rates, delayed responses, and opaque adjustment processes undermine the working relationship. As Bes et al. (2013) highlight, effective claims management depends not only on clear contractual frameworks but also on mutual trust, ongoing communication, and shared incentives [28].

Formal contractual provisions and auditing rules are necessary, but they are not sufficient. Where mutual trust is low, actors respond with defensive behaviors (excessive documentation, frequent appeals, or protracted audits), which increase administrative workloads and prolong payment cycles. Where trust and predictable communication channels exist, characterized by shared claim-tracking tools, routine case reviews, and clear escalation protocols, insurer–provider interactions become more cooperative and less adversarial. These relational features reduce information asymmetries, speed up dispute resolution, and lower transaction costs.

Situating the Georgian experience in this regional context suggests several interrelated policy levers. First, digitization of claims submission and common billing formats are critical enablers, but only when combined with purchaser capacity strengthening (contract design, monitoring, and transparent dispute resolution). Second, formalized communication channels, regular liaison meetings, joint audit protocols, provider help-desks, and shared dashboards, convert adversarial contractual relations into collaborative problem-solving. Third, rules that increase transparency (public or shared audit criteria, clear timelines, and predictable penalties) reduce the scope for arbitrary enforcement and enhance predictability of reimbursements.

When interpreted through the post-Soviet transition literature and the governance lens above, the proximate causes of adjustments identified in our data (documentation errors, invalid referrals, and deadline breaches) are partially symptoms of deeper institutional features: fragmented IT systems, legacy administrative cultures, and enforcement asymmetries. The practice of tolerating contract violations by popular, high-volume providers reflects a pragmatic policy trade-off between strict enforcement and continuity of patient access—a trade-off also documented in other transitional systems. Therefore, successful reform must combine operational investments (training, digital platforms) with governance reforms that make contracts more credible, transparent, and enforceable..

CONCLUSION

This study provides an in-depth exploration of the operational and systemic challenges shaping health insurance claims management in Georgia. Drawing on interviews with insurance and healthcare personnel, as well as analysis of claims data from 2022–2024, the findings reveal that incomplete documentation, invalid referrals, and inconsistencies in diagnosis coding remain the primary causes of claim adjustments and payment delays. The persistence of manual documentation systems, limited interoperability between insurers and providers, and frequent breaches of contractual obligations exacerbate inefficiencies and financial uncertainty for both parties.

The study highlights that while the existence of multiple provider networks enhances access and patient satisfaction, it also increases administrative complexity and disputes over reimbursement. Prolonged claim reviews and the lack of standardized protocols further extend payment timelines, undermining trust and predictability in insurer–provider relationships.

These findings underscore the need for systemic reforms that strengthen administrative capacity, standardize documentation, and foster transparency in contractual enforcement. Addressing these challenges requires coordinated action between insurers, providers, and policymakers to establish a more reliable, efficient, and equitable claims management process within Georgia's evolving healthcare financing system.
Based on the findings of this study, several measures are recommended to improve the efficiency and transparency of claims management in Georgia's health insurance system.

First, the adoption of standardized digital documentation systems is essential to minimize errors related to incomplete or inconsistent records. Integrating hospitals and insurers into a unified electronic claims platform would reduce manual processing time and improve data accuracy.

Second, capacity building and continuous training should be provided for both insurance and healthcare administrative staff. Strengthening procedural knowledge and communication skills would help ensure compliance with contractual obligations and promote smoother coordination between institutions.

Third, clearer contractual frameworks and enforcement mechanisms are needed to address recurring breaches of deadlines and pricing agreements. Transparent auditing and dispute-resolution procedures would foster greater mutual accountability and trust between insurers and providers.

Finally, further research and monitoring are required to evaluate the impact of digitalization and administrative reforms on claims efficiency over time. Future research should expand the scope through comparative cross-country analysis across post-Soviet and lower-middle-income health systems to identify reform trajectories and contextual determinants of efficiency. Additionally, quantitative efficiency evaluations, using time-series or econometric methods, could measure the financial and administrative impact of digital reforms and governance interventions.

By strengthening these systemic components, Georgia can enhance the reliability, timeliness, and fairness of its health insurance reimbursement system.

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