INDICATION MATRIX

The Scientific Core of Structured Comparability

The Indication Matrix forms the clinical backbone of the Buiten.ai governance infrastructure.

It does not standardize treatment.
It does not impose foreign protocols.

It structures comparability between systems.

The objective is to model clinical equivalence across borders while preserving national autonomy.

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1. Why an Indication Matrix Is Necessary

Cross-border healthcare systems differ in:

- Escalation thresholds
- Conservative pathway duration
- Diagnostic confirmation requirements
- Severity classification standards

Without structured modeling, these differences generate:

- Administrative ambiguity
- Insurance disputes
- Institutional mistrust

The Indication Matrix transforms qualitative guideline differences into structured comparability parameters.

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2. Decision Node Decomposition

Each clinical procedure cluster is decomposed into measurable decision nodes:

1. Diagnostic confirmation criteria
2. Conservative management prerequisites
3. Escalation timing
4. Exclusion parameters
5. Complication modifiers

These nodes are mapped between systems and compared.

This allows structural divergence to be quantified without judging clinical legitimacy.

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3. Threshold Alignment Logic

Clinical escalation decisions are evaluated against structured reference thresholds.

Example:

In lumbar disc herniation:

- Minimum conservative duration
- Neurological deficit documentation
- Imaging confirmation requirements
- Red-flag symptom criteria

Variance from reference threshold generates a structured divergence indicator.

The system measures difference.
It does not declare error.

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4. Conservative Pathway Transparency

The matrix evaluates whether:

- Conservative therapy was attempted
- Duration requirements were met
- Documentation completeness is adequate

Incomplete documentation does not imply misconduct.
It increases review transparency.

Transparency reduces conflict.

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5. Mapping Confidence

Coding equivalence between systems may be:

High – Directly comparable
Moderate – Partially equivalent
Low – Structured manual review required

Ambiguity triggers oversight — not presumption.

The matrix acknowledges its own limits.

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6. Clinical Intent Layer

Clinical care cannot be reduced to numeric thresholds.

The Indication Matrix incorporates structured contextual review of:

- Physician justification
- Escalation rationale
- Failed conservative therapy documentation
- Functional impairment reporting

Intent matters.

Governance must recognize complexity.

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7. Risk-Adjusted Fairness Integration

Indication alignment is interpreted alongside:

- Age profile
- Comorbidity burden
- Frailty markers
- Procedure complexity

This prevents structural bias against tertiary centers and complex patient populations.

Comparability must be fair to complexity.

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8. Continuous Academic Recalibration

The Indication Matrix is not static.

It undergoes periodic academic review to:

- Integrate new clinical evidence

- Update escalation benchmarks
- Refine risk adjustment variables
- Incorporate institutional feedback

It is a living governance instrument.

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9. Role Within the Governance Stack

The Indication Matrix feeds structured signals into:

- Institutional Compliance Dashboard (buitenscore.com)
- Claims Governance Engine (buitenclaims.com)

It does not interact directly with patients.
It structures interpretability at institutional level.

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10. What the Indication Matrix Is Not

It is not:

- A protocol enforcement tool
- A sanction mechanism
- A public ranking instrument
- A clinical decision override system

It is a comparability engine.

Its purpose is structured transparency.