the middle of that class (21% in our example). On the other hand, if the remaining adjustment factors are higher or lower than that used for the key factor rating, the resulting impairment grade will be modified, assuming the adjustment factor was reliable and not used to define the impairment. In our example, if Physical Findings and Objective Test Results (both non-key factors) each place a patient into class 3, the final rating will be class 2, (grade E) 27%. If the Physical Findings correspond to class 3 and the Objective Test Results to class 1, the final rating will be class 2, (grade C) 21%.

TABLE 1-5 Generic Template for Impairment Classification Grids

CLASS	CLASS 0	CLASS 1	CLASS 2	CLASS 3	CLASS 4
IMPAIRMENT RATING (%)	0	Minimal %	Moderate %	Severe %	Very Severe %
SEVERITY GRADE (%)		(ABCDE)	(ABCDE)	(ABCDE)	(ABCDE)
HISTORY OF CLINICAL PRESENTATION[a]	No current symptoms *and/or* intermittent symptoms that do not require treatment	Symptoms controlled with continuous treatment *or* intermittent, mild symptoms despite continuous treatment	Constant mild symptoms despite continuous treatment *or* intermittent, moderate symptoms despite continuous treatment	Constant moderate symptoms despite continuous treatment *or* intermittent, severe symptoms despite continuous treatment	Constant severe symptoms despite continuous treatment *or* intermittent extreme symptoms despite continuous treatment
PHYSICAL EXAMINATION OR PHYSICAL FINDINGS[b]	No current signs of disease	Physical findings not present with continuous treatment *or* intermittent, mild physical findings	Constant mild physical findings despite continuous treatment *or* intermittent moderate findings	Constant moderate physical findings despite continuous treatment *or* intermittent severe findings	Constant severe physical findings despite continuous treatment *or* intermittent extreme findings
CLINICAL STUDIES OR OBJECTIVE TEST RESULTS[c]	Testing currently normal	Consistently normal with continuous treatment *or* intermittent mild abnormalities	Persistent mild abnormalities despite continuous treatment *or* intermittent moderate abnormalities	Persistent moderate abnormalities despite continuous treatment *or* intermittent severe abnormalities	Persistent severe, abnormalities despite continuous treatment *or* intermittent extreme abnormalities

[a, b] Descriptors will be disease-specific; mild, moderate, severe, and extreme need to be defined.

[c] Descriptors will be disease-specific and based on the number of abnormalities found.

The following is used as a grade modifier in the musculoskeletal chapters:

FUNCTIONAL HISTORY[d]	Asymptomatic	Pain/symptoms with strenuous/ vigorous activity; Able to perform self-care activities independently	Pain/symptoms with normal activity; Able to perform self-care activities with modification but unassisted	Pain/symptoms with less than normal activity (minimal); Requires assistance to perform self-care activities	Pain/symptoms at rest; Unable to perform self-care activities
[d] Based on self-report or scores from the PDQ, *Quick*DASH, Lower Limb Outcomes Questionnaire, or other self-report tool.					

The following will be added in selected chapters when compliance with treatment minimizes objective evidence of organ dysfunction but results in a significant compromise in ADLs:

BURDEN OF TREATMENT COMPLIANCE[e]	None	Will be based on factors such as number and route of medications taken or the need to regularly undergo diagnostic tests or invasive procedures if ***not*** already considered in the preliminary rating
[e] Based on information in Appendix B; depending on the score, the examiner can opt to add 1 to 3 percentage points.		

5. If adjustment of the impairment rating otherwise moves the rating to a higher or lower impairment class, the examiner should stop at the highest or lowest grade in the impairment class initially determined by the key factor. For example, if the Functional History and Physical Examination both were rated as consistent with class 4, whereas the key factor (History of Clinical Presentation) somehow placed the patient in class 2, this would preclude going any higher than 27% (grade E), although the examiner might want to be certain that the non-key factors were, indeed, correct.
6. Use of the middle impairment grade in a given class as the default value under this new system would ordinarily leave one with no way to move a rating in the middle of class 4 (or the highest class in a given impairment table) to an even higher grade. In these situations, ratings for non-key factors may be used to move the rating to a higher grade in class 4 if the information regarding the other factors denotes extreme pathology. When relevant, instructions regarding how to make this determination will be provided in each table.
7. Some chapters will include an assessment of the Functional History that will be used as one of the non-key factors to adjust the final impairment rating within a class by using a self-report tool such as the PDQ, *QuickDASH*, Lower Limb Outcomes Questionnaire, or alternative. The examining physician is to score the self-report tool and to assess results for consistency and credibility before adjusting the impairment rating higher or lower than the default value. The rating physician must provide rationale for deciding that functional test results are clinically consistent and credible.
8. Some chapters will include an assessment of the BOTC in the impairment rating. These may shift the impairment grade in a class higher than it would otherwise be. Details are listed in the relevant chapters and differ among organ systems and diseases.
9. With the addition of the information from the BOTC and the functional history, there is no longer any justification for adding any additional impairment to the final