

Welcome to the Centers for Medicare & Medicaid Services OASIS-C Online Training. This module provides foundational education on the Neuro/Emotional/Behavioral domain of the OASIS data set. It covers M1700 Cognitive Functioning through M1750 Psychiatric Nursing Services.

Introduction

- Includes relevant guidance found in Chapter 3 of the December 2011 OASIS-C Guidance Manual.
- Specific OASIS conventions that apply to the domain
- Item intent for each specific item
- Time points for item completion
- Response-specific item instructions
- Data sources/resources



This module includes relevant guidance found in the December 2011 version of the OASIS-C Guidance Manual, specifically from Chapter 3, which contains OASIS item-specific guidance. Specific topics covered in this module include:

- Specific OASIS conventions that apply to the Neuro/Emotional/Behavioral domain
- Item intent or clarification about what each specific item is intended to report
- Time points when each item should be completed
- Response-specific item instructions, clarifying the differences between the various responses which could be selected for each item
- Data sources and resources related to the Neuro/Emotional/Behavioral domain items

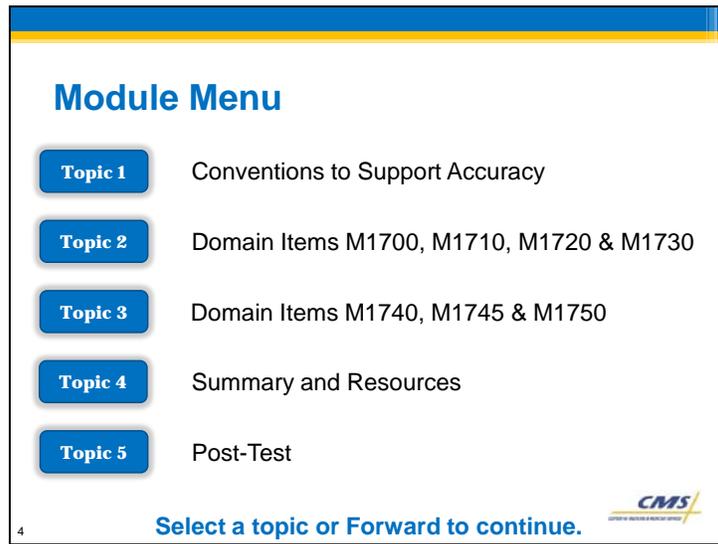
Module Objectives

- Identify three conventions that support accuracy in completing the Neuro/Emotional/Behavioral domain.
- Identify the intent of each item in the Neuro/Emotional/Behavioral domain.
- Specify the data collection time points for each item in the Neuro/Emotional/Behavioral domain.
- Identify response-specific guidelines for completing each item in the Neuro/Emotional/Behavioral domain.
- Identify data sources for each item in the Neuro/Emotional/Behavioral domain.



The objectives for this module include:

- Identify three conventions that support accuracy in completing the Neuro/Emotional/Behavioral domain.
- Identify the intent of each item in the Neuro/Emotional/Behavioral domain.
- Specify the data collection time points for each item in the Neuro/Emotional/Behavioral domain.
- Identify response-specific guidelines for completing each item in the Neuro/Emotional/Behavioral domain.
- Identify data sources for each item in the Neuro/Emotional/Behavioral domain.



The screenshot shows a 'Module Menu' interface. At the top, there is a blue header bar with a yellow underline. Below the header, the title 'Module Menu' is displayed in blue. There are five blue buttons, each labeled 'Topic 1' through 'Topic 5', followed by their respective descriptions: 'Conventions to Support Accuracy', 'Domain Items M1700, M1710, M1720 & M1730', 'Domain Items M1740, M1745 & M1750', 'Summary and Resources', and 'Post-Test'. At the bottom left, there is a small number '4'. At the bottom right, there is a CMS logo and the text 'Select a topic or Forward to continue.'.

Select the Forward button to review the entire module, or you may select a topic from the Module Menu to review a specific topic of interest.



This topic addresses conventions to support OASIS-C accuracy.

OASIS Conventions to Support Accuracy

- Understand the time period under consideration.
- Use multiple strategies as needed to complete OASIS data items.
- Score each item based only on what is included in that item.



There are specific conventions or general rules that should be followed when completing OASIS-C items. Although all the conventions are important to observe and apply when appropriate, three conventions are especially important to remember when reporting OASIS-C items in the Neuro/Emotional/Behavioral domain. These conventions are understanding the time period under consideration for each item, using multiple strategies as needed and as possible to complete OASIS data items, and scoring each OASIS item based only on the data that is to be included in that item.

Time Period Under Consideration

- Refers to how far back into the past you should consider when assessing the patient’s confusion or anxiety or disruptive behavior symptoms.



The convention for “understanding the time period under consideration” refers to how far back into the past you should consider when assessing the patient’s confusion or anxiety or disruptive behavior symptoms. Each item in this OASIS domain sets a time period to consider when collecting data and selecting a response. Pay careful attention to the specific time period for each item to ensure the accuracy of data collection.

Time Period Under Consideration, cont'd

- Report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance.
- The day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent for the home visit.



The image shows a calendar grid with a red arrow pointing to the date 17. Handwritten in red on the date 17 is 'Home Visit 10:30am'. The CMS logo is visible in the bottom right corner of the graphic.

This convention guides the clinician to report what is true on the day of assessment unless a different time period has been indicated in the item or related guidance. The day of assessment is defined as the 24 hours immediately preceding the home visit and the time spent by the clinician in the home for the home visit. Some of the items in this domain use a time period of the “last 14 days,” and another looks at behaviors that occur at least once a week. Become familiar with the specific time periods to consider for each of these OASIS items to ensure you select the appropriate response.

Use Multiple Strategies

- Combine relevant strategies as needed:
 - Patient observation
 - Interviews with caregivers or physicians
 - Physical assessment
- Recognize opportunities to gather data from multiple sources.



The second convention that is important to remember for the Neuro/Emotional/Behavioral domain is the ability to combine observation, interview, and other relevant strategies as needed to complete the OASIS data items. For accuracy of data collection in this domain, it will be important to recognize the opportunity to gather data from multiple sources such as patient observation, physical assessment, and interview with caregivers or physicians.

Consider Only Included Tasks, Behaviors, and Symptoms

- Understand what tasks are included and excluded in each item.
- Ensure accurate responses based only on what is expected to be included.
- Pay attention to behaviors and symptoms specifically included in each item.

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes verbal actions**)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

[Module Menu](#) 

The third convention to utilize when collecting data for this domain is to understand what tasks, behaviors, or symptoms are included and excluded in each item. This will help ensure you select an accurate response based only on what is expected to be included for that item. In other words, pay careful attention to the behaviors and symptoms that are specifically included in domain items such as confusion, depression, and impaired decision-making.



This topic addresses OASIS-C domain items M1700, M1710, M1720, and M1730.

Summary of M- Items

- M1700 Cognitive Functioning
- M1710 When Confused
- M1720 When Anxious
- M1730 Depression Screening
- M1740 Cognitive, Behavioral, and Psychiatric Symptoms
- M1745 Frequency of Disruptive Behavior Symptoms
- M1750 Psychiatric Nursing Services



The Neuro/Emotional/Behavioral domain consists of seven items:

- M1700 Cognitive Functioning
- M1710 When Confused
- M1720 When Anxious
- M1730 Depression Screening
- M1740 Cognitive, Behavioral, and Psychiatric Symptoms
- M1745 Frequency of Disruptive Behavior Symptoms
- M1750 Psychiatric Nursing Services

This topic covers items M1700, M1710, M1720, and M1730 in more detail.

M1700 Cognitive Functioning Item Intent & Time Points

(M1700) Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Collected at SOC, ROC & DC

Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources

The first item we'll discuss is M1700 Cognitive Functioning. The intent of this item is for the assessing clinician to identify the patient's current level of cognitive functioning. This includes the patient's alertness, orientation, comprehension, and immediate memory for simple commands.

Notice how current status is defined in parenthesis as the "day of assessment"? When we apply the OASIS convention discussed earlier, "day of assessment" means the time you are in the patient's home to complete the assessment, as well as the preceding 24-hour period of time. Also note how this item specifically directs the assessment of cognition to include: alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

The OASIS data collection rules specify the time points at which each OASIS item should be collected. M1700 Cognitive Functioning is collected at the Start of Care, the Resumption of Care, and Discharge from the agency when the Discharge is not due to an inpatient facility admission.

M1700 Cognitive Functioning Response-Specific Instructions

(M1700) **Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources

When selecting the correct response to M1700 Cognitive Functioning, read all the response options to identify which one best fits your patient’s status on the day of assessment. Consider the following guidelines when making a scoring decision. Notice how the response options progress from no impairment to severely impaired. When assessing your patient, consider signs and symptoms of cognitive dysfunction that have occurred over the past 24 hours. Also consider the amount of supervision and care the patient has required due to cognitive deficits.

Patients with diagnoses such as dementia, delirium, developmental delay disorders, and mental retardation will have various degrees of cognitive dysfunction; whereas patients with neurological deficits related to stroke, mood and anxiety disorders, or who receive opioid therapy may have cognitive deficits. Assess each patient individually and consider the degree of impairment when deciding which response to select.

M1700 Cognitive Functioning Data Sources / Resources

- Gather information from several sources:
 - Interview the patient and caregiver.
 - Observe the patient directly.
 - Conduct a physical assessment of the patient.
 - Rely on results of cognitive assessment tools you might include as part of your comprehensive assessment.
 - Review the patient’s past health history.
 - Review information obtained from the physician related to the patient’s status in the preceding 24-hour period of time.
- Links to resources for cognitive assessment tools are available in [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources 

When assessing your patient’s cognitive functioning, gather information from several sources to help you select an appropriate response:

- Interview the patient and caregiver.
- Observe the patient directly.
- Conduct a physical assessment of the patient.
- Rely on results of cognitive assessment tools you might include as part of your comprehensive assessment.
- Review the patient’s past health history.
- Review information obtained from the physician related to the patient’s status in the preceding 24-hour period of time.

Links to resources for cognitive assessment tools are available in Chapter 5 of the OASIS-C Guidance Manual.

M1710 When Confused
Item Intent & Time Points

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive

Collected at SOC, ROC & DC Not to Inpatient

Item Intent Time Points Response-Specific Instructions Data Sources/Resources



The next OASIS item in the Neuro/Emotional/Behavioral Domain is M1710 When Confused. The intent of M1710 is to identify the time of day or situations when the patient experienced confusion, if at all.

This item is collected at the Start of Care, Resumption of Care, and Discharge from the agency when the Discharge is not to an inpatient facility.

M1710 When Confused
Response-Specific Instructions

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive



Item Intent Time Points Response-Specific Instructions Data Sources/ Resources

Note that the “time period under consideration” for this item is stated as within the last 14 days. This means we are only reporting the time of day or situations when the patient experienced confusion, if those occurrences were within the last 14 days. Due to this time period, M1710 When Confused may not directly relate to M1700 Cognitive Functioning. M1700 only includes signs and symptoms of cognitive dysfunction that occur during the visit or in the preceding 24 hours. M1710 When Confused includes confusion that might have occurred within the last 14 days but not necessarily during the past 24 hours. Pay careful attention to the time periods under consideration as you select a response for each item.

While performing your assessment, if it is reported that the patient is “occasionally” confused, identify the situation(s) in which confusion has occurred within the last 14 days, if at all, to determine which response to select. The term “nonresponsive” means that the patient is unable to respond or the patient responds in a way that you can’t make a clinical judgment about the patient’s level of orientation.

M1710 When Confused Response-Specific Instructions, cont'd

S	M	T	W	TH	F	S
1	2	3	4	5	6 <i>DAY 14</i>	7
8	9	10	11	12	13	14
15	16	17	18	19 <i>DAY 1</i>	20 <i>SOC DAY 0</i>	21

Item Intent Time Points Response-Specific Instructions Data Sources/Resources

To accurately score M1710 When Confused, specifically assess for confusion in the past 14 days. The term “past fourteen days” is the two-week period immediately preceding the Start of Care date, the Resumption of Care date, or the Discharge date. For the purposes of counting the 14-day period, the date of admission is Day 0 and the day immediately prior to the date of admission is Day 1. For example, if the patient’s Start of Care date is August 20, any confusion occurring on or after August 6 would be considered.

M1710 When Confused
Data Sources / Resources

- Gather information from several sources:
 - Interview the patient and caregiver.
 - Observe the patient directly.
 - Conduct a physical assessment of the patient.
 - Review the patient’s past health history.
 - Obtain information from the physician.
- Links to a resource for patients with Alzheimer’s disease or dementia that you might find helpful are available in [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources 

When assessing confusion in your patient, gather information from various sources:

- Interview the patient or caregiver regarding any episodes of confusion that may have occurred.
- Observe the patient directly.
- Conduct a physical assessment of the patient.
- Review the patient’s past health history.
- Obtain information from the physician.

Links to a resource for patient’s with Alzheimer’s disease or dementia that you might find helpful are available in Chapter 5 of the OASIS-C Guidance Manual.

M1720 When Anxious
Item Intent & Time Points

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

Collected at SOC, ROC & DC Not to Inpatient

Item Intent Time Points Response-Specific Instructions Data Sources/Resources



The next item is M1720 When Anxious. The intent of this item is for the assessing clinician to identify the frequency with which the patient has felt anxious within the past 14 days.

The collection time points for this item include at the Start of Care, Resumption of Care, and Discharge from the agency when not to an inpatient facility.

**M1720 When Anxious
Response-Specific Instructions**

- Anxiety includes:
 - Worry that interferes with learning and normal activities
 - Feelings of being overwhelmed and having difficulty coping
 - Symptoms of anxiety disorders



Item Intent — Time Points — **Response-Specific Instructions** — Data Sources/
Resources



To accurately select the correct response for M1720, the assessing clinician must be aware of the response-specific instructions that describe anxiety that you should consider reporting. Specifically, anxiety includes:

- Worry that interferes with learning and normal activities
- Feelings of being overwhelmed and having difficulty coping
- Symptoms of anxiety disorders

M1720 When Anxious
Response-Specific Instructions, cont'd
(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

Item Intent Time Points **Response-Specific Instructions** Data Sources/
Resources



Notice how the item responses appear in order of increasing frequency of anxiety, from “none of the time” to “all of the time.” The option “nonresponsive” in this item means that the patient is unable to respond.

As with confusion, the assessing clinician will report any episodes of anxiety that have been reported or observed in the last 14 days. The phrase “last fourteen days” refers to the two-week period immediately preceding the Start of Care or Resumption of Care. This means for the purposes of counting the 14-day period, the date of admission, or Start of Care date, is Day 0, and the day immediately prior to the date of admission is Day 1.

M1720 When Anxious
Data Sources / Resources

- Gather information from several sources:
 - Interview the patient and caregiver.
 - Observe the patient directly.
 - Conduct a physical assessment of the patient.
 - Use information contained in the referral to home health.
 - Review the patient’s recent health history.
- Links to anxiety screening tools are available in [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources _____



When assessing anxiety in your patient, gather data from any of the following sources:

- Interview the patient and caregiver regarding any episodes of anxiety that may have occurred within the last 14 days.
- Observe the patient directly.
- Conduct a physical assessment.
- Use information contained in the referral to home health.
- Review the patient’s recent health history.

Links to anxiety screening tools are available in Chapter 5 of the OASIS-C Guidance Manual.

M1710 / M1720 Scenario

Your patient reports that he has a history of being confused upon awakening almost daily.

He has also experienced brief periods of anxiety that would occur weekly and last for several hours, rendering him unable to do anything but worry.

He states he has had this anxiety since a recent stroke but hasn't had any episodes since the day before the physician changed his medications 10 days ago.



Let's practice applying some of the data collection conventions and guidelines that we've discussed.

Your patient reports that he has a history of being confused upon awakening almost daily. He has also experienced brief periods of anxiety that would occur weekly and last for several hours, rendering him unable to do anything but worry. He states he has had this anxiety since a recent stroke but hasn't had any episodes since the day before the physician changed his medications 10 days ago.

M1710 Scenario Question

What response should you select for M1710 When Confused?

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive

[Review Scenario](#) **Select the correct response for this scenario.** 

What response should you select for M1710 When Confused?

M1710 Scenario Answer

What response should you select for M1710 When Confused?

(M1710) When Confused (Reported or Observed Within the Last 14 Days):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only**
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive

That is correct! You should select Response 2 – On awakening or at night only. Since the patient reported an episode of confusion within the time period under consideration (which is within the last 14 days), the clinician must identify when that confusion occurred.



That is correct! You should select Response 2 – On awakening or at night only. Since the patient reported an episode of confusion within the time period under consideration (which is within the last 14 days), the clinician must identify when that confusion occurred.

M1720 Scenario Question

What response should you select for M1720 When Anxious?

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

[Review Scenario](#) Select the correct response for this scenario. 

What response should you select for M1720 When Anxious which is within the last fourteen days but was not daily?

M1720 Scenario Answer

What response should you select for M1720 When Anxious?

(M1720) When Anxious (Reported or Observed Within the Last 14 Days):

- 0 - None of the time
- 1 - Less often than daily**
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

That is correct! You should select Response 1 – Less often than daily. The patient reported an episode of anxiety that met the descriptors of the definition for anxiety. This episode occurred during the time period under consideration, which is “within the last 14 days.”



That is correct! You should select Response 1 – Less often than daily. The patient reported an episode of anxiety that met the descriptors of the definition for anxiety. This episode occurred during the time period under consideration, which is “within the last 14 days.”

**M1730 Depression Screening
Item Intent & Time Points**

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2[®] scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

	Not at all 0 – 1 day	Several days 2 – 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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Collected at SOC & ROC

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____ 

The intent of M1730 Depression Screening is to identify if the home health agency screened the patient for depression using a standardized depression screening tool. CMS does not mandate that clinicians conduct depression screening for all patients, nor is there a mandate for the use of the PHQ-2[®] or any other particular standardized tool. This item is used to calculate process measures to capture the agency’s use of best practices in completing a comprehensive patient assessment. The best practices stated in the item are not necessarily required in the Conditions of Participation.

The collection time points for this item include at the Start of Care and at the Resumption of Care.

**M1730 Depression Screening
Criteria for a Standardized Depression Tool**

- Determine if the patient was screened using a standardized depression tool.
- A “standardized” depression tool must meet the following criteria:
 - Be scientifically tested on a population with characteristics similar to that of the patient being assessed.
 - Shown to be effective in identifying people with depression.
 - Include a standard response scale.
- Must be appropriate for the patient based on their cognitive and communication deficits.
- Must be administered appropriately.



The best practice under focus here is if the clinician assessed the patient using a standardized depression tool. Since the item provides the option of using the PHQ-2[®] or using other standardized validated tests to conduct depression screening, it is important to understand what is meant by a standardized tool. To meet the definition of a “standardized” depression tool, it must meet the following criteria: Be scientifically tested on a population with characteristics similar to that of the patient being assessed; shown to be effective in identifying people with depression; and include a standard response scale. The standardized tool must be both appropriate for the patient based on their cognitive and communication deficits and appropriately administered as indicated in the screening tool’s protocols.

M1730 Depression Screening Response-Specific Instructions

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2[®] scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2 [®] Pfizer	Not at all 0 – 1 day	Several days 2 – 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A, Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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Item Intent
Time Points
Response-Specific Instructions
Data Sources/
Resources



If a standardized depression screening tool is used, use the scoring parameters specified for that tool to identify if a patient meets the criteria for further evaluation of depression. In order to select Responses 1, 2, or 3, the standardized depression screen must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment. For a Start of Care, that would mean the assessment needs to be completed on or within five days following the Start of Care. For a Resumption of Care, the assessment needs to be completed within two calendar days of inpatient discharge or within two calendar days of the agency’s becoming aware of the discharge.

M1730 Depression Screening Response-Specific Instructions, cont'd

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2[®] scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2 [®] Pfizer	Not at all 0 – 1 day	Several days 2 – 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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Item Intent _____ Time Points _____
**Response-Specific
Instructions**
Data Sources/
Resources

Select Response 0 if a standardized depression screening was not conducted. Select Response 0 – No in situations when the clinician chooses not to assess the patient such as when there is no appropriate depression screening tool available for the patient or any other reason when the screening is not completed.

M1730 Depression Screening Response-Specific Instructions, cont'd

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2[®] scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2 [®] Pfizer	Not at all 0 – 1 day	Several days 2 – 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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Item Intent _____ Time Points _____
Response-Specific Instructions
Data Sources/
Resources

Select Response 1 if the PHQ-2[®] is completed, and mark the appropriate responses in rows a) and b). If the patient scores three points or more on the PHQ-2[®], then further depression screening is indicated.

M1730 Depression Screening Response-Specific Instructions, cont'd

(M1730) Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2[®] scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2 [®] Pfizer	Not at all 0 – 1 day	Several days 2 – 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment and the patient does not meet criteria for further evaluation for depression.

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Item Intent _____ Time Points _____
Response-Specific Instructions
Data Sources/ Resources

If the PHQ-2[®] is not used to assess the patient, the assessing clinician may choose to administer a different standardized depression screening tool with instructions that may allow for information to be gathered by observation and caregiver interview as well as self-report. In this case, the assessing clinician would select Response 2 or 3 for M1730, depending upon whether or not the screening tool used identified the need for further evaluation for depression.

**M1730 Depression Screening
Data Sources / Resources**

- Gather information from various sources as required by the tool used:
 - Interview the patient.
 - Interview a caregiver.
- Links to information about depression screening tools available in [Chapter 5 of the OASIS-C Guidance Manual](#).



Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources



When performing depression screening, data may be gathered from various sources, depending on the administration protocols for the screening tool used. The screening tool may require patient self report, in which case information would be collected through patient interview. Or the screening tool may allow information to be collected from a caregiver. It will be critical to be familiar with the administration protocols for any standardized depression screening tools you wish to use as part of your patient assessments.

Links to more information regarding the PHQ-2[®] and other depression screening tools are available in Chapter 5 of the OASIS-C Guidance Manual.

M1730 Depression Screening Question

Can the assessing clinician ask a caregiver the questions in the PHQ-2[®] to determine if there is a need for further evaluation for depression?

Yes

No

Select the correct response.



Let's practice applying some of the data collection conventions and guidelines that we've discussed.

Can the assessing clinician ask a caregiver the questions in the PHQ-2[®] to determine if there is a need for further evaluation for depression?

M1730 Depression Screening Question, cont'd

Can the assessing clinician ask a caregiver the questions in the PHQ-2[®] to determine if there is a need for further evaluation for depression?

No. The instructions for the PHQ-2[®] state, “Ask the patient: Over the last two weeks, how often have you been bothered by any of the following problems.”

Note the patient is the source, not a caregiver.

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The correct answer is No, the assessing clinician cannot ask a caregiver the questions in the PHQ-2[®]. The instructions for the PHQ-2[®] state, “Ask the patient: Over the last two weeks, how often have you been bothered by any of the following problems.” Note the patient must be the source of the findings, not a caregiver.



This topic addresses OASIS-C domain items M1740, M1745, and M1750.

Summary of M- Items

- M1700 Cognitive Functioning
- M1710 When Confused
- M1720 When Anxious
- M1730 Depression Screening
- M1740 Cognitive, Behavioral, and Psychiatric Symptoms
- M1745 Frequency of Disruptive Behavior Symptoms
- M1750 Psychiatric Nursing Services



As we discussed earlier, the Neuro/Emotional/Behavioral domain consists of seven items:

- M1700 Cognitive Functioning
- M1710 When Confused
- M1720 When Anxious
- M1730 Depression Screening
- M1740 Cognitive, Behavioral, and Psychiatric Symptoms
- M1745 Frequency of Disruptive Behavior Symptoms
- M1750 Psychiatric Nursing Services

This topic covers items M1740, M1745, and M1750 in more detail.

**M1740 Cognitive, Behavioral, and Psychiatric Symptoms
Item Intent & Time Points**

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

Collected at SOC, ROC & DC Not to Inpatient

Item Intent
Time Points
Response-Specific Instructions
Data Sources/Resources

M1740 Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least one a week requires the assessing clinician to report identification of specific behaviors associated with significant neurological, developmental, behavioral, or psychiatric disorders. Note the time period under consideration for this item is underlined and states that symptoms considered are being demonstrated “at least once a week.”

The collection time points for this item include at the Start of Care, Resumption of Care, and Discharge from the agency not to an inpatient facility.

**M1740 Cognitive, Behavioral, and Psychiatric Symptoms
Response-Specific Instructions**

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, in-ability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/
Resources 

Remember that the behaviors you report may be observed by clinicians or reported by the patient, family, or others. If the patient has more than one of the listed behaviors, score all that are reported or observed at least once a week. If Response 7 – None of the above behaviors is demonstrated is scored for this item, then no other responses should be selected.

**M1740 Cognitive, Behavioral, and Psychiatric Symptoms
Response-Specific Instructions, cont'd**

- Consider behaviors that are severe enough to:
 - Make the patient unsafe to self or others.
 - Cause considerable stress to caregivers.
 - Require the patient to have supervision or intervention.



Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/
Resources



When determining which response to select, consider behaviors which are severe enough to:

- Make the patient unsafe to self or others.
- Cause considerable stress to caregivers.
- Require the patient to have supervision or intervention.

M1740 Cognitive, Behavioral, and Psychiatric Symptoms Data Sources / Resources

- Gather information from several sources:
 - Patient and caregiver interviews
 - Direct observation of the patient
 - Physical assessment findings
 - Referral information received from a referring facility
 - Physician
- Links to resources for cognitive assessment tools available in [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources 

When assessing for cognitive, behavioral, and psychiatric symptoms, gather data from various sources including:

- Patient and caregiver interviews
- Direct observation of the patient
- Physical assessment findings
- Referral information received from a referring facility
- Physician

Links to standardized cognitive screening tools are available in Chapter 5 of the OASIS-C Guidance Manual.

M1745 Frequency of Disruptive Behavior Symptoms
Item Intent & Time Points

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

Collected at SOC, ROC & DC Not to Inpatient

Item Intent Time Points Response-Specific Instructions Data Sources/Resources



M1745 reports the frequency of any behaviors that are disruptive or dangerous to the patient or caregivers.

The collection time points for this item include at the Start of Care, Resumption of Care, and Discharge from the agency not to an inpatient facility.

**M1745 Frequency of Disruptive Behavior Symptoms
Response-Specific Instructions**

- Do not consider just behaviors listed in M1740.
- Include any problematic behavior which jeopardizes or could jeopardize the safety and well-being of the patient or caregiver.
- Include behaviors symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders.
- Examples include:
 - Sleeplessness
 - “Sun-downing”
 - Agitation
 - Wandering
 - Aggression
 - Combativeness
 - Getting lost in familiar places

Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/
Resources 

In determining which response to select, consider if the patient has any problematic behaviors. Do not consider just those behaviors that were listed in M1740 but any problematic behavior which jeopardizes or could jeopardize the safety and well-being of the patient or caregiver. Include behaviors considered symptomatic of neurological, cognitive, behavioral, developmental, or psychiatric disorders. Examples of disruptive/dangerous behaviors include sleeplessness, “sun-downing,” agitation, wandering, aggression, combativeness, and getting lost in familiar places.

**M1745 Frequency of Disruptive Behavior Symptoms
Response-Specific Instructions, cont'd**

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

Item Intent _____ Time Points _____ **Response-Specific Instructions** _____ Data Sources/
Resources 

Use clinical judgment to determine if the degree of the behavior is disruptive or dangerous to the patient or caregiver and, therefore, if it should be considered when responding to this item. Then consider how frequently these behaviors occur.

M1745 Frequency of Disruptive Behavior Symptoms
Data Sources / Resources

- Gather information from several sources:
 - Interviews with the patient and caregiver
 - Direct observation of the patient
 - Review of the patient’s recent health history
 - Review of the referral information
- Links to additional information available in [Chapter 5 of the OASIS-C Guidance Manual](#).

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/ Resources _____



When assessing for frequency of disruptive behavior symptoms, the data related to the behavior and the frequency may be gathered from interviews with caregivers or the patient, from directly observing the patient, or from review of past medical history or referral information.

Links to additional information are available in Chapter 5 of the OASIS-C Guidance Manual.

M1740 / M1745 Scenario

You are performing an SOC comprehensive assessment, and the patient's daughter reports that her mother experiences brief episodes of memory loss where her short term memory becomes significantly impacted.

The last time it occurred, she wandered from her home and became lost. The police found her wandering the neighborhood, confused and combative. The episodes don't last long, and her memory returns after the episode.

The daughter states, "It only happens about once a month, and the last time was three weeks ago." She does not report any other symptoms, and you do not observe any cognitive, behavioral, or psychiatric symptoms during your assessment.



Let's practice applying some of the data collection conventions and guidelines that we've discussed.

You are performing an SOC comprehensive assessment, and the patient's daughter reports that her mother experiences brief episodes of memory loss where her short term memory becomes significantly impacted. The last time it occurred, she wandered from her home and became lost. The police found her wandering the neighborhood, confused and combative. The episodes don't last long, and her memory returns after the episode. The daughter states, "It only happens about once a month, and the last time was three weeks ago." She does not report any other symptoms, and you do not observe any cognitive, behavioral, or psychiatric symptoms during your assessment.

M1740 Scenario Question

What response should you select for M1740 Cognitive, behavioral, and psychiatric symptoms?

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, in-ability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

[Review Scenario](#) **Select the correct response for this scenario.** 

What response should you select for M1740 Cognitive, behavioral, and psychiatric symptoms?

M1740 Scenario Answer

What response should you select for M1740 Cognitive, behavioral, and psychiatric symptoms?

(M1740) Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply.)

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, in-ability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - **None of the above behaviors demonstrated**

Correct. You should select Response 7 – None of the above since the patient did not experience any symptoms in the last week.



That is correct! You should select Response 7 – None of the above since the patient did not experience any symptoms in the last week.

M1745 Scenario Question

What response should you select for M1745 Frequency of Disruptive Behavior Symptoms?

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

[Review Scenario](#) **Select the correct response for this scenario.** 

What response should you select for M1745 Frequency of Disruptive Behavior Symptoms?

M1745 Scenario Answer

What response should you select for M1745 Frequency of Disruptive Behavior Symptoms?

(M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed)
Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month**
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

Correct. The daughter reports that the patient experiences episodes of memory loss about once a month. The seriousness of the episodes meets the descriptors of being dangerous and injurious to self or others. Because the memory loss is dangerous to the patient and occurs within the time period under consideration, it would be reported here. Therefore, the correct response is 2 – Once a month.



That is correct! The daughter reports the patient experiences episodes of memory loss about once a month. The seriousness of the episodes meets the descriptors of being dangerous and injurious to self or others. Because the memory loss is dangerous to the patient and occurs within the time period under consideration, it would be reported here. Therefore, the correct response is 2 – Once a month.

M1750 Psychiatric Nursing Services
Item Intent & Time Points

(M1750) Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

0 - No
 1 - Yes

- Intended to report if patient is receiving psychiatric nursing services at home.
- As provided by a qualified psychiatric nurse.
- Qualification based on:
 - Education
 - Certification
 - Experience

Collected at SOC & ROC

Item Intent _____ Time Points _____ Response-Specific Instructions _____ Data Sources/Resources _____



M1750 Psychiatric Nursing Services is intended to report whether or not the patient is receiving psychiatric nursing services at home as provided by a qualified psychiatric nurse. “Psychiatric nursing services” addresses mental/emotional needs, and a “qualified psychiatric nurse” becomes qualified through educational preparation, certification, or experience.

The collection time points for this item include at the Start of Care and Resumption of Care.

**M1750 Psychiatric Nursing Services
Data Sources / Resources**

- Gather information from several sources:
 - Interviews with the patient and caregiver
 - Review of the referral information
 - Physician orders or the home health plan of care
 - Information contained in the clinical record
- Additional information is available in Section 40.1.2.15 of Chapter 7 in the Medicare Benefits Policy Manual.

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Item Intent Time Points Response-Specific Instructions **Data Sources/
Resources**



When assessing for psychiatric nursing services, gather data from a variety of sources. You may gain relevant information from your patient or caregiver interview, from referral information, from physician orders or the home health plan of care, or from other information contained in the clinical record.

Home health agencies may choose to reference Section 40.1.2.15 of Chapter 7 in the Medicare Benefits Policy Manual for additional information.



CMS provides a variety of resources to assist with completing the items for the Neuro/Emotional/Behavioral domain. Let's review some highlights for this domain and supporting resources.

M1700–M1745 Time Points Under Consideration

OASIS Item	Time Point Under Consideration
M1700 Cognitive Functioning	Day of Assessment
M1710 When Confused	Within last 14 days
M1720 When Anxious	Within last 14 days
M1730 Depression Screening	Over the last 2 weeks
M1740 Cognitive, behavioral, and psychiatric symptoms	At least once a week
M1745 Frequency of Disruptive Behavior Symptoms	Recent, relevant past (an item response of "less than once a month" is available)



This slide summarizes the varying time periods under consideration that are identified with each of the Neuro/Emotional/Behavioral items. Be sure to pay careful attention to the appropriate time periods when scoring these items.

Summary of Domain

- Understand each item and individual responses.
- Use Chapter 3 of the OASIS-C Guidance Manual as your reference for the following concepts:
 - Item intent
 - Time points for completion
 - Response-specific instructions
 - Data sources and resources
- Additional guidance can be found in the CMS Q & As and the CMS Quarterly Q & As.



In summary, in order to accurately collect the items in the Neuro/Emotional/Behavioral domain accurately, it will be important for the assessing clinician to understand each item and its individual responses. Use Chapter 3 of the OASIS-C Guidance Manual as your reference to apply concepts and details related to the intent of each OASIS item, when each item should be completed, what the various response options mean, and what data sources and resources you can use to facilitate an accurate assessment.

Additional guidance related to data collection of the Neuro/Emotional/Behavioral items can be found in the CMS Questions and Answers and the CMS Quarterly OASIS Questions and Answers.

Resources / References

- OASIS-C Guidance Manual
 - www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html
 - Chapter 3 provides guidance on OASIS-C questions.
 - Chapter 5 provides neuro/emotional/behavioral resources.
- CHAMP Program
 - www.champ-program.org
- Home Health Quality Improvement (HHQI) National Campaign
 - www.homehealthquality.org
- OASIS Answers, Inc.
 - www.oasisanswers.com



Additional resources and references can be accessed at the links listed here. Particularly important is the guidance in Chapter 3 of the OASIS-C Guidance Manual, which served as the foundational content for this educational module. Home care nurses and therapists responsible for collecting OASIS data should consider having a copy of the Chapter 3 guidance accessible while conducting comprehensive assessments to enhance data accuracy.

Questions

- Talk with your clinical managers.
- Email OASIS training feedback site.
 - oasisctrainingfeedback@cms.hhs.gov
- Check the CMS Q & As.
 - www.qtso.com/hhdownload.html
- Check the Quarterly Q & As.
 - www.oasisanswers.com
- Contact State OASIS Education Coordinators.
 - www.cms.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf
- Submit Q & As to CMS.
 - [Send email to CMSOASISquestions@oasisanswers.com](mailto:CMSOASISquestions@oasisanswers.com)

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If you have comments related to this web module, please consider providing feedback to the OASIS training feedback mailbox at oasisctrainingfeedback@cms.hhs.gov.

Also, download and review additional guidance included in the CMS Q & As and the Quarterly Q & A updates, available at the links provided here.

If you should still have an unanswered data collection question after consulting the guidance contained in Chapter 3 of the OASIS-C Guidance Manual and the OASIS Q & As, contact your State OASIS Education Coordinator, who can provide free assistance in answering your OASIS data collection questions.

If your question cannot be resolved with the help of your OEC, consider submitting your inquiry to the CMS OASIS mailbox at CMSOASISquestions@oasisanswers.com

Thank you for your commitment to OASIS accuracy.



This is the Neuro/Emotional/Behavioral Domain Module Post-Test. This test consists of five questions covering the material covered in this lesson.

Post-Test Question #1

Your patient reports that he is never confused. During the assessment you observed that he became confused when trying to learn about his new feeding pump. He required several reminders and frequent prompting. No other confusion was noted.

What is the correct response for M1710 When Confused (Reported or Observed Within the Last 14 Days)?

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive

The correct answer is Response 1 - In new or complex situations only. He does not report any confusion, and you are able to observe that he only becomes confused in new and complex situations.



The correct answer is Response 1 – In new or complex situations only. He does not report any confusion, and you are able to observe that he only becomes confused in new and complex situations.

Post-Test Question #2

Upon admission the assessing clinician defers the depression screening to the MSW who will make a visit the next day to administer the Geriatric Depression Screening tool. The MSW screens the patient and identifies that the patient meets the criteria for further evaluation for depression. She notifies the assessing clinician of the results. How would the assessing clinician score M1730 Depression Screening: Has the patient been screened for depression, using a standardized depression screening tool?

0 - No

1 - Yes, patient was screened using the PHQ-2[®] scale. (Instructions for this two-question tool: Ask patient: "Over the last two weeks, how often have you been bothered by any of the following problems")

PHQ-2 [®] Pfizer	Not at all 0 – 1 day	Several days 2 - 6 days	More than half of the days 7 – 11 days	Nearly every day 12 – 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> na

2 - Yes, with a different standardized assessment-and the patient meets criteria for further evaluation for depression.

3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

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The correct answer is Response 0 - No. Response-specific instructions state, "In order to select Responses 1, 2, or 3, the standardized depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment."

The correct answer is Response 0 – No. Response-specific instructions state, “In order to select Responses 1, 2, or 3, the standardized depression screening must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.”

Post-Test Question #3

You are admitting a patient with a primary diagnosis of Parkinson's disease with dementia. The caregiver reports that prior to the hospitalization two weeks ago, the patient was combative, aggressive, and constantly yelling, frightening the caregiver. While in the hospital his medications were changed, and he has not been combative or aggressive in the last 12 days. He continues to yell throughout the day and night, affecting the patient and caregiver's sleep. He also continues to be affected by a significant memory deficit that requires continuous supervision for safety and performance of ADLs and IADLs, and his decision-making capabilities are significantly limited, requiring intervention by the caregiver throughout the day.

How would you score M1740 Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week (Reported or Observed): (Mark all that apply)?

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, in-ability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

The correct answer is Response 1 - Memory deficit, Response 2 - Impaired decision-making, and Response 3 - Verbal disruption. These are the only symptoms that occur at least once a week.

The correct answer is Response 1 – Memory deficit, Response 2 – Impaired decision-making, and Response 3 – Verbal disruption. These are the only symptoms that occur at least once a week.

Post-Test Question #4

You are admitting a patient with a primary diagnosis of Parkinson's disease with dementia. The caregiver reports that prior to the hospitalization two weeks ago, the patient was combative, aggressive, and constantly yelling, frightening the caregiver. While in the hospital his medications were changed, and he has not been combative or aggressive in the last 12 days. He continues to yell throughout the day and night, affecting the patient and caregiver's sleep. He also continues to be affected by a significant memory deficit that requires continuous supervision for safety and performance of ADLs and IADLs, and his decision-making capabilities are significantly limited, requiring intervention by the caregiver throughout the day.

How would you score M1745 Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety?

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

The correct answer is Response 5 - At least daily. Behaviors that are disruptive are occurring every day.



The correct answer is Response 5 – At least daily. Behaviors that are disruptive are occurring every day.

Post-Test Question #5

On the day of assessment you notice that while interviewing your patient you must repeat your questions several times and keep refocusing her as she gets distracted easily by others in the room. For almost every task, you must remind her who you are, what you are doing in her home, and what you want her to do as part of your assessment. The caregiver confirms that “this is how she usually is.”

How would you score M1700 Cognitive Functioning: Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands?

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

The correct answer is Response 3 - Requires considerable assistance in routine situations. The patient is not alert and oriented or is unable to shift attention and recall directions more than half the time.

The correct answer is Response 3 – Requires considerable assistance in routine situations. The patient is not alert and oriented or is unable to shift attention and recall directions more than half the time.
