

NYS Office of Mental Health Mobile Crisis Program Guidance

This document provides guidance to New York State approved Mobile Crisis providers who are eligible to be reimbursed under the Medicaid Managed Care 1115 Crisis Intervention Benefit. Eligible providers were identified by local county mental hygiene directors and approved by the state.

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1. Vision

The New York State Office of Mental Health (OMH) through dialogue with county leadership have developed a shared vision of a coordinated behavioral health crisis response system available to all New Yorkers, regardless of ability to pay. This system integrates existing crisis infrastructure with Medicaid Managed Care, Delivery System Reform Incentive Payment Program (DSRIP) and Value Based Payment (VBP) resources. The crisis response system goals are to maintain people safely in the community, reduce unnecessary emergency room visits and inpatient hospitalizations, and reduce the risk of future crises. The goal includes the coordination of information sharing among recipients, providers and involved support systems to reflect the recipients' goals toward recovery. These services shall be delivered in trauma-informed, recovery-oriented, and culturally and linguistically competent ways.

2. Purpose of this Guidance

- Explains the components of the Medicaid Managed Care 1115 Crisis Intervention benefit and reimbursable services;
- describes standards and guiding principles for the operation of mobile crisis services; and

- describes guidelines for mobile crisis service providers and expectations for documentation, performance and service delivery.

Please refer to [Managed Care Crisis Intervention Benefit Guidance](#) for additional details.

3. Mobile Crisis Services

The mobile crisis component reimbursed under the 1115 Medicaid Managed Care Crisis Intervention benefit includes the following:

- Telephonic triage and response;
- Mobile crisis response;
- Telephonic crisis follow-up; and
- Mobile crisis follow-up.

The goals of these services are engagement, symptom reduction, and stabilization.

These services are provided to children and adults who are experiencing, or are at imminent risk of experiencing, a behavioral health (BH) crisis. A BH crisis includes instances in which a person cannot manage their primarily psychiatric and/or substance use related symptoms without de-escalation or intervention. These services are designed to interrupt and/or ameliorate crisis by:

- Assessing the immediate crisis and facilitating resolution and de-escalation;
- providing crisis services in the community where the individual is experiencing a crisis;
- assisting the recipient to utilize community and family support systems with the intent of preventing the re-occurrence of similar events in the future;
- engaging the recipient to identify and link to supports and follow-up services that are necessary to manage and/or prevent further BH crisis episodes; and
- engaging with the recipients' service provider(s) and/or identified supports, when appropriate, to coordinate care.

4. Overview of Mobile Crisis Services

The mission of Mobile Crisis providers is to deliver person-centered, trauma-informed, culturally and linguistically competent services. These are high-quality, effective and integrated community-based BH services that promote resiliency, rehabilitation, and

recovery.

These services are available telephonically and face-to-face in the community to children and adults who are experiencing or are at imminent risk of experiencing a BH crisis. These services aim to provide immediate support and offer alternatives to hospitalization when appropriate.

A. Standards

- Mobile and telephonic crisis response services will be available 24 hours per day, seven days per week, and 365 days per year;
- mobile crisis response will provide an in-person intervention within 3 hours of determination of need;
- all services provided, including follow-up activities and efforts to enroll the recipient and/or family/caregiver to support services will be documented;
- depending on local conditions, mobile and telephonic response services should be integrated with local emergency systems (e.g. 911, local crisis hotlines) and law enforcement, up to and including co-response, to provide safe and coordinated crisis response;
- crisis service providers must be approved by the state to be reimbursed under the 1115 Medicaid Managed Care Crisis Intervention benefit; and
- use of [Psychiatric Services and Clinical Knowledge Enhancement System \(PSYCKES\)](#) as a tool for data sharing and mobile access to individuals' medical history, treatment information, and crisis response plan, if available.

B. Guiding Principles

The following principles guide the delivery of crisis services:

Deliver person-centered, trauma informed, culturally and linguistically competent services;

- coordinate and promote cooperation between service providers and across the continuum of care;
- coordinate with the recipient's current treatment provider(s) and other identified supports to resolve the current crisis and to aid in preventing future crises;
- interrupt or ameliorate the crisis and facilitate crisis stabilization;
- provide flexible and person-centered intervention;
- deliver services in the least restrictive available setting;
- deliver services consistent with recipient's safety plan, if available;
- value and protect the rights, privacy, and confidentiality of recipients, with the understanding that whenever necessary, contact will be made with collaterals who may have information to inform the assessment;

- provide follow-up services and efforts to access and connect the recipient to support services; and
- assist recipients through the introduction and reinforcement of crisis management skills and identification of community resources and supports.

C. NYS approved Mobile Crisis Provider Staffing Standards

All staff providing crisis services at a provider agency must:

- Undergo and clear a NYS Staff Exclusion List, NYS Criminal Background Check and Statewide Central Register;
- adhere to all Medicaid enrollee exclusion requirements; and
- obtain training on the administration of Naloxone (Narcan).

All NYS approved Mobile Crisis Providers will contract with Medicaid Managed Care plans for the reimbursement of Crisis Intervention Services.

D. Staffing

Each Mobile Crisis provider shall continuously have an adequate number of staff and an appropriate staff composition to carry out its goals and objectives 24 hours a day, 7 days a week and 365 days a year. The provider shall have a staffing plan that documents staff qualifications; including training, clinical experience and education. The plan shall demonstrate sufficient coverage by qualified staff, as described below, to meet the needs of the individuals served.

Mobile and Telephonic Crisis Response Services must be provided by one of the following individuals licensed in New York State as follows:

- Physician (MD), including Psychiatrist and Addictionologist/Addiction Specialist;
- Nurse Practitioner in Psychiatry (NPP);
- Licensed Psychologist;
- Unlicensed Psychologist employed by State or County Government;
- Licensed Psychoanalyst;
- Licensed Master Social worker (LMSW);
- Licensed Clinical Social Worker (LCSW);
- Licensed Marriage & Family Therapist;
- Licensed Mental Health Counselor;
- Licensed Creative Arts Therapists;
- Registered Nurse/Licensed Practical Nurse; and
- Clinical Nurse Specialist.

Non-licensed staff are eligible to provide crisis intervention services within their scope of practice when under supervision of an LMSW, LCSW, LMHC, Licensed Psychologist (Doctor of Psychology, Psy.D., Doctor of Philosophy, Ph.D.), Psychiatric Nurse Practitioner and/or MD. Non-licensed staff may accompany a licensed practitioner providing a mobile crisis response and may also assist with developing safety plans, provide support during and after a crisis and assist with connecting an individual with identified supports and linkages to community services.

Non-licensed staff include:

- Limited Permit staff;
- Students within approved NYS Education Department programs;
- Qualified Non-Licensed staff;
- Certified Peer Specialists;
- Credentialed Alcoholism and Substance Abuse Counselor (CASAC),
- Certified Recovery Peer Advocate (CRPA);
- Certified Recovery and Peer Advocate (CRPA) with a Family Specialty; and
- Qualified Peer Advocates and Certified Peer Specialists.

E. Consultation

Mobile Crisis staff will have access to a clinical supervisor 24 hours a day.

F. Supervision

Mobile Crisis staff will have access to routine clinical supervision.

G. Training

Mobile Crisis staff will receive training based on required job responsibilities which may include, but not limited to:

- Assessment Tools and Resources for individuals diagnosed with a Serious Mental Illness, Substance Use Disorder, and/or Serious Emotional Disturbance;
- Crisis Intervention;
- Trauma Informed Care;
- Motivational Interviewing;
- Harm Reduction;
- Cultural and Linguistic Competency;
- De-escalation Technique;
- Suicide Prevention/Zero Suicide;
- First Aid;
- Cardiopulmonary Resuscitation (CPR);
- Mandated Reporter,
- Safety Plan Development; and
- Administration of Naloxone (Narcan)*

*Required

- Refresher trainings, to maintain training qualifications, must be provided at the frequency required by standards identified by the individual trainings.
- Training plans must address the skills needed by crisis providers and the needs of the population being served.
- Training plans must be shared with local county mental hygiene directors as stated in county/regional mobile crisis response plans.

5. Types of Crisis Services

A. Telephonic Crisis Triage

Telephonic Crisis Triage is a service available 24 hours a day, seven days a week, 365 days a year for individuals experiencing, or at risk of experiencing a BH crisis. Callers may include the individual experiencing a BH crisis, families, providers, crisis hotlines, 911 operators or other sources. Reimbursement for this benefit is available when talking to the recipient or collaterals.

Telephonic crisis triage includes a preliminary assessment to determine the need for further evaluation, and to make treatment recommendations and/or referrals to other health and/or behavioral health services as clinically indicated and includes:

- Name, address and telephone number of the caller;
- the location of the individual in crisis and whether they are alone;
- identification of individuals available for support;
- the presenting problem, behavioral health symptoms/mental status examination and review of immediate needs;
- risk of harm to self or others;
- medication compliance and/or abuse;
- current substance use and potential for serious withdrawal; and
- medical stability.

*Please note, if the caller refuses to provide the information described above, staff should document the efforts made to collect such data.

After the preliminary assessment, if it is determined an emergency department level of care **is not necessary**, further telephonic assessment to determine if in-person mobile response is necessary:

- history of psychiatric treatment, suicide attempts and/or gestures, psychiatric hospitalizations, etc.;
- history of substance use and treatment including detox and rehabilitation;

- history of prescribed medications, including: psychiatric, medical and medication assisted treatment for individuals diagnosed with a substance use disorder;
- medical history;
- identification of treatment providers and supports;

If it is determined a mobile crisis response is **not** warranted, further telephonic assessment may include all or a combination of the following:

- Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms;
- referral and linkage to appropriate behavioral health community services as an alternative to more restrictive levels of care;
- development or review of a safety plan;
- collection of insurance information, if available; and
- collection of verbal consent to follow-up with service providers and/or identified supports as it relates to the telephonic crisis contact as needed.

B. Mobile Crisis Response

Mobile crisis staff is dispatched to an individual's home or any community setting following the preliminary telephonic triage when it is determined a face-to-face comprehensive crisis assessment is warranted.

A mobile crisis team consists of a licensed staff and another licensed or non-licensed staff. After triage, in certain circumstances, mobile crisis response may be provided by one licensed staff. Certain circumstances may include assurance of staff safety, connection with law enforcement at the site of the crisis, etc. Mobile Crisis response may also include co-response with local law-enforcement.

Mobile crisis response should include the following elements:

- **Evaluation**
 - Immediate review of safety concerns; and
 - assessment of behavioral health symptoms and crisis related needs
- **Intervention**
 - Therapeutic communication and interaction to alleviate psychiatric or substance use symptoms;
 - involvement of identified service providers and supports to resolve the recipient's crisis;
 - linkage to urgent psychopharmacology intervention, as needed; and
 - determination of whether an individual is able to remain safely in the community.
 - If the individual is able to remain safely in the community, a [safety plan](#) should be developed, or
 - If the individual is in need of a higher level of care, direct linkages are made.

- **Disposition**

- Completion of safety plan allowing recipient to remain in the community with appropriate referral and linkage to behavioral health or community services;
- referral to a more restrictive level of care for crisis respite or substance use treatment;
- linkage to a higher level of care for evaluation to determine necessity of Psychiatric or Medical inpatient hospitalization.

Catchment Area Protocol

If mobile crisis services are provided to an individual who is temporarily located in the catchment area for mobile crisis service delivery and resides in another jurisdiction, Mobile Crisis staff will conduct all applicable assessments, provide interventions necessary to stabilize the immediate crisis, and engage in any required safety planning. Staff will then assist with making referrals to providers in the recipient's community, facilitate exchange of relevant assessment information and document any specific follow-up care.

C. Mobile and Telephonic Follow-up Services

Mobile and telephonic follow-up services are provided to recipients of mobile crisis services who meet the criteria for a qualifying BH crisis (refer to definition section). These services consist of a short-term re-assessment of symptoms via therapeutic communication and interactions with the recipient and collaterals, when available, to maintain stabilization in the community.

Follow-up services may be delivered telephonically or face-to-face with the individual receiving services.

Examples of services include but are not limited to:

- Therapeutic communication and interactions to maintain stabilization following a crisis episode and prevent escalation of BH symptoms;
- facilitation of engagement in outpatient BH services, care coordination, medical health or basic needs related to the original crisis service; and
- confirmation with service providers of connections to care and support to the recipient in the community while he or she is awaiting initiation or resumption of services.

Follow-up contact between the Mobile Crisis staff and the recipient, service providers and identified supports will be initiated within 24 hours of the initial BH crisis or by the next business day. Direct contact with providers, in addition to e-mail, voicemail or fax, ensures receipt of information and must be done in accordance with privacy and confidentiality rules.

Mobile Crisis providers may be reimbursed by a Medicaid Managed Care Organization (MMCO) for mobile and telephonic follow-up services provided to Medicaid Managed care enrollees within 14 days of the qualifying BH episode.

6. Administrative Requirements

A. Oversight

Mobile crisis providers must be identified in County Mobile Crisis Response Plans and approved by the state to be reimbursed under the 1115 Crisis Intervention benefit. County plans include the process for oversight of these providers. Oversight processes may differ by county.

B. Policies and Procedures

All Mobile Crisis providers must have written policies and procedures for each crisis service it provides, including but not limited to:

- Criteria for face-to-face response and follow-up services;
- assessment criteria and clinical intervention;
- coordination of services with existing providers and identified supports;
- coordination with law enforcement, Child Protective Services, Adult Protective Services, local schools, etc.;
- provision of services to individuals who are non-English speaking, deaf or hard of hearing;
- client's rights;
- coordination of referrals to other service providers (e.g. care coordinator, other treatment providers and/or programs for mental health, substance use and/or medical needs, etc.);
- staff conduct and safety measures;
- documentation of crisis services; and
- documentation of payor sources.

C. Documentation of Mobile and Telephonic Crisis Response Services

Crisis services must be documented in the recipient's chart within 24 hours to identify discrete billable crisis response services related to a qualifying episode and/or within a 14-day follow-up period; and the case record shall be confidential, and access shall be governed by the requirements of sections 33.13¹ and 33.16² of the Mental Hygiene Law.

1. Telephonic crisis service, documentation shall include:

- At minimum, the information obtained in the preliminary telephonic crisis triage as defined in Section 3 of this guidance; as well as
- the disposition of the call, to include safety plan, referrals, etc.

¹ <https://codes.findlaw.com/ny/mental-hygiene-law/mhy-sect-33-13.html>

² <https://codes.findlaw.com/ny/mental-hygiene-law/mhy-sect-33-16.html>

2. In addition to the minimum telephonic crisis requirements, documentation for **mobile crisis response** services should include a detailed summary of the BH crisis response as follows:
3.
 - Rationale for mobile crisis response;
 - source of referral and cause for concern;
 - presenting problem, precipitating factors;
 - alert history and psychosocial history, if available;
 - collaterals on scene participating in the BH crisis resolution;
 - mental status examination of the recipient;
 - history of psychiatric and/or substance use treatment;
 - history of medical, emotional and/or social needs;
 - review of prescribed medications and compliance;
 - identification of current treatment providers with contact information;
 - identification of supports/resources, individual and family strengths and coping skills;
 - suicide and safety assessment and safety planning;
 - consents to release information;
 - date and duration of service; and
 - copy of safety plan.
4. **Crisis Follow-up** documentation should include:
 - Content of follow-up between the Mobile Crisis staff and existing and/or anticipated service providers and identified supports. This information should be documented within 24 hours of the initial BH crisis or by the next business day in progress note and signed by assigned staff;
 - progress notes related to the service summary for every recipient and collateral contact, signed by the staff member who provided the service;
 - documentation of (re)linkage to identified services or supports;
 - identification of barriers to linkage, if applicable; and
 - additional information necessary to complete and/or update the case record and/or service summary. This information may be obtained from program staff, the referral source, and/or outside medical and psychiatric staff including the recipients most recent mental health and/or substance use service provider, upon consent.

D. Quality Assurance

Each Mobile Crisis provider shall develop a quality assurance plan that identifies how the provider will:

- Document the date and time a request for services is made and the date and time when services are delivered;
- document and follow-up on grievances;
- document all substantiated grievances and assess the seriousness of the violation and what actions will be taken to address the complaint;
- maintain documentation that Mobile Crisis staff have the qualifications and have received training required by the program; and
- document incident reports.

E. Utilization Management

Prior authorization and retrospective review for Mobile or Telephonic Crisis Response Services is not required and coverage may not be denied³. Mobile Crisis services must occur within the context of a potential or actual psychiatric crisis⁴.

7. Relationships with the Community

A. Community and Crisis Prevention Outreach

Mobile Crisis providers are encouraged to provide information to the community about available services and how these services are accessed. Mobile Crisis providers are encouraged to participate in community activities and offer educational programs about crisis intervention and access to services.

Through collaborative, ongoing, and strategic relationships with hospitals, treatment providers, schools, primary care clinicians, youth serving systems, and other community programs, mobile crisis providers will promote system-wide development of crisis prevention, early identification of crisis symptoms, and crisis intervention and hospital diversion strategies. These strategies empower other providers and identified supports to build their own comfort and competency in crisis prevention and planning and in offering a first-level early crisis response.

Mobile crisis staff are encouraged to offer education, 1:1 consultation, and brief in-community services to help promote system transformation, such as a decrease in emergency room admissions.

Mobile Crisis providers should establish tools or protocols with system partners to support the development and maintenance of strategic, collaborative relationships aimed at crisis prevention and planning.

³ *Medicaid Managed Care Model Contract*, Emergency Services- Section 10.13(e), and Mental Health Services- Section 10.21(i)

⁴ *Medicaid Managed Care Model Contract*, Appendix K- Section 48. Crisis Intervention Services.

B. Relationship with Hospital Emergency Departments (ED)

In the event a recipient must be evaluated at an Emergency Department, mobile crisis providers will work in collaboration with EDs depending on the needs of the recipients. For example, when Mobile Crisis staff refer an individual experiencing a BH episode to an ED, they will notify the ED of the individual's arrival and the nature of the crisis (e.g. security may be needed, serious overdose situation, etc.). Upon the arrival of Mobile Crisis staff at the ED, they will immediately consult with the attending physician and/or charge nurse. Staff will provide necessary information to facilitate continuity of care.

C. Collaboration with Law Enforcement

Cooperation and collaboration between the Mobile Crisis providers and law enforcement agencies is essential for ensuring the safety of individuals experiencing a BH crisis and the staff and/or identified supports who are working with them. This may occur:

- During the triage process, staff may be required to determine, together with the caller, when a medical or physical emergency exists or if excessive risk requires the involvement of emergency responders, in addition to a Mobile Crisis response; and
- if a caller describes a serious injury or other medical emergency, or there is reason to believe the individual or those around him or her are at imminent risk of harm, the Mobile Crisis provider may call 911 to coordinate with emergency responders to ensure safety. Mobile Crisis staff will dispatch and meet emergency responders at the location of the crisis, and work to de-escalate the situation and coordinate additional services and/or follow-up care as needed.

8. Definitions

A. Behavioral Health (BH) Crisis

A BH crisis is an unplanned event that requires a rapid response. This includes instances in which an individual cannot manage their primarily psychiatric and/or substance use related symptoms without de-escalation or intervention. A BH crisis may also be defined as a situation in which the experience of challenges in daily life have resulted in, or are at risk of, an escalation in psychiatric and/or substance use symptoms.

B. Behavioral Health Crisis Intervention

BH Crisis Intervention is defined as an activity which utilizes therapeutic communication, interactions and supporting resources to interrupt and/or ameliorate acute BH distress and associated behaviors. This includes medication and verbal therapy, designed to address acute distress and associated behaviors when the individuals' condition requires immediate attention.

C. Behavioral Health Crisis Intervention Service: Qualifying Episode

A qualifying episode of crisis intervention begins with the provider's initial contact with the individual. The end of the crisis episode will be defined by the amelioration of the individual's presenting symptoms or if clinically indicated when the person is transferred to the recommended level of care.

D. Collateral

A person who is a member of the recipient's family or household, or other individual who regularly interacts with the recipient and is directly affected by or has the capability of affecting their condition and is identified by the recipient as having a role in treatment and/or is necessary for participation in the evaluation and assessment of the recipient prior to admission.

E. County Mobile Crisis Response Plans

A plan developed by the NYS County Director(s) of Community Services that describes the county or regional plan for the delivery and oversight of behavioral health crisis services and is approved by the state.

F. Mobile Crisis Provider

Providers approved by NYS to be reimbursed under the 1115 Crisis Intervention Benefit to help individuals who are experiencing a BH episode. In order to become an approved mobile crisis provider, the County Directors of Community Services must identify the mobile crisis provider in a County/Regional Crisis Response Plan. The identified provider must apply to the state for approval.

G. Qualified Non-Licensed Staff

An individual 18 years of age or older with a high school diploma or equivalent and 1-3 years of relevant experience or a bachelor's degree employed or under contract with a provider of services.

H. Safety Plan

An individualized document designed collaboratively with the individual experiencing a BH episode, Mobile Crisis staff and other identified supports which states the direct interventions in the instance of a crisis and to help anticipate and prevent future crisis episodes and direct interventions in the instance of a crisis. The plan should include the need for follow-up phone calls or face-to-face visits by mobile crisis staff or identified provider, assistance with linking to treatment, review of benefit of mobile crisis staff collaborating with treatment providers and identified supports to review BH crisis and outcome, etc.

The plan should assist the recipient, their providers and support system with identifying the antecedents that led to the BH crisis, the supports and services the individual can access in the future, the individual’s strengths and coping skills, as well as the roles and responsibilities of each safety plan development participant.

I. Students within approved State Education Department (SED) programs

Students and trainees who are actively participating in a program leading to attainment of a recognized degree or certificate in a field related to mental health at an institution chartered or approved by the New York State Education Department.

9. Billing

Mobile Crisis service providers may bill for mobile and telephonic follow-up services provided to a recipient of a qualifying crisis service. Follow-up services are eligible for reimbursement if provided within 14 days of the qualifying crisis episode⁵.

There are multiple billable services, differentiated by duration and provider type.

All claims must be submitted with the appropriate rate code for the service provided (see below). Please see the [New York State Health and Recovery Plan \(HARP\) / Mainstream Behavioral Health Billing and Coding Manual](#) for details on MMCO claiming processes.

A. Telephonic Crisis Triage and Response

Provider Type	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/Day
Licensed Professional	4609	H2011	GT	15 Minutes	Up to 90 minutes (6 Units)
Unlicensed/Certified Peer	4610	H2011	GT, HO	15 Minutes	up to 90 minutes

⁵See definition section for definition of qualifying crisis episode.

					(6 Units)
Licensed Professional	4611	S9485	GT	Per Diem	90 minutes-3 hours (1 Unit)
Unlicensed/Certified Peer	4612	S9485	HO	Per Diem	90 minutes-3 hours (1 Unit)

B. Mobile Crisis Response

Provider Type	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/Day
One Person Response: Licensed	4615	H2011	HE	15 Minutes	Up to 90 minutes (6 Units)
Two-person Response: Licensed and Unlicensed /Certified Peer	4616	H2011	HK	15 Minutes	Up to 90 minutes (6 Units)
Two-person Response: Both Licensed	4617	H2011	HE, HK	15 Minutes	Up to 90 minutes (6 Units)
Two-person Response: Licensed and Unlicensed/Certified Peer	4618	S9485	HE, U5	Per Diem	90 – 180 minutes (1 Unit)
Two-person Response: Both Licensed	4619	S9485	HE, HK, U5	Per Diem	90 – 180 minutes (1 Unit)
Two-person Response: Licensed and Unlicensed/Certified Peer	4620	S9485	HE	Per Diem	At minimum 3 hours of face-to-face contact (1 Unit)

Two-person Response: Both Licensed	4621	S9485	HE, HK	Per Diem	At minimum 3 hours of face-to-face contact
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C. Telephonic Follow-Up Services

Provider Type	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/Day
Licensed professional	4613	H2011	TS, GT	15 Minutes	Up to 60 minutes (4 Units)
Unlicensed/Certified Peer	4614	H2011	TS, HM	15 Minutes	Up to 60 minutes (4 Units)

D. Mobile Follow-Up Service

Provider Type	Rate Code	CPT Code	Modifier	Unit Measure	Unit Limit/Day
One Person face-to-face Response: Licensed	4622	H2011	TS	15 Minutes	Up to 90 minutes (6 Units)
One Person face-to-face Response: Unlicensed /Certified Peer	4623	H2011	TS, HE	15 Minutes	Up to 90 minutes (6 Units)
Two-person face-to-face Response: Licensed and Unlicensed/Certified Peer	4624	H2011	TS, SC	15 Minutes	Up to 90 minutes (6 Units)