VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Working with the Veterans Health Administration:

A Guide for Providers

The Department of Veterans Affairs (VA) provides a nationwide system of health care services and benefits programs for America's Veterans. VA operates the nation's largest integrated health care system with more than 1,400 sites of care, including hospitals, community clinics, nursing homes, domiciliary, readjustment counseling centers, and various other facilities. Through the Veterans Health Administration (VHA), VA provides a broad spectrum of medical, hospital, and rehabilitative care to approximately 5 million Veterans annually.

VA manages the largest medical education and health professions training program in the United States, maintaining affiliations with more than 107 medical schools, 55 dental schools and more than 1,200 other schools across the country. Each year, VA medical facilities train about 90,000 health professionals and more than half of the physicians practicing in the United States received some of their professional education in the VA health care system.

Primarily, Veterans seeking VA health care should be seen and treated at VA medical facilities. Non-VA medical care, also known as Purchased Care, is only authorized under specific circumstances such as geographic inaccessibility, when VA facilities/services are not feasibly available or cannot be economically provided to the Veteran. VA may purchase care outside of VA for many forms of care a Veteran may need, including inpatient, outpatient, emergent medication prescriptions and long-term care, as long as it is related to a service-connected condition.

Once non-VA medical care is authorized by a VA provider, Veterans may receive treatment from a registered non-VA medical care provider in their community. This guide details what non-VA medical care providers should expect in terms of authorizations and referrals, claims payment, and the return of medical documentation of provided non-VA medical care treatment/services back to the authorizing VA medical facility.

VA Referrals and Authorizations

Once a VA referral for care is submitted by the VA provider, it must be reviewed and approved both clinically and administratively. Clinical approval indicates the care is medically necessary for the Veteran's health and well-being. Administrative approval indicates the Veteran is eligible for care outside the VA.

After establishing clinical and administrative approval, the local Non-VA Medical Care Office will generate an authorization for care. The legal document outlining outpatient care is VA Form 10-7079, *Request for Outpatient Services*; inpatient care is authorized using VA Form 10-7078, *Authorization and Invoice for Medical and Hospital Services*. These documents are provided to both the Veteran and the community provider prior to receipt of care.

Veterans cannot self-refer for non-VA medical care or services at VA's expense.

An authorization for care is the cornerstone for delivering purchased care and the blueprint for paying a claim properly. An authorization gives the non-VA medical care provider the authority to provide health care to the Veteran patient, and provides assurance of payment for those services. The authorization document binds VA to the language included on the authorization.

Per Federal authority, VA is the primary and exclusive payer for medical care it authorizes. As such, non-VA medical care providers may not bill the Veteran or any other party for any portion of the care authorized by VA. Federal law also prohibits payment by more than one Federal agency for the same episode of care; subsequently any payments made by the Veteran, Medicare, or any other Federal agency must be refunded to the payer by your facility upon acceptance of VA payment.

Non-VA medical care services should always be preauthorized, with the exception of certain VA Medical Benefit Emergency Care programs.

Referrals for Specialty Care

When non-VA specialty care is needed, the Veteran must either be evaluated in an urgent/emergent setting or call for an appointment with the VA primary care team. The Veteran is then screened to determine the medical necessity of the referral. When a VA provider determines that a specialty consult is needed, a request is completed.

Authorizations and Notifications

All non-emergent, non-VA medical care must be pre-authorized by VA. Office visits, outpatient diagnosis and treatment, and elective inpatient admissions must be preauthorized. A VA representative will contact your office to coordinate the Veteran's appointment date, time, and additional pertinent information. Care is authorized on a VA Form 10-7079, *Request for Outpatient Services* or VA Form 10-7078, *Authorization and Invoice for Medical and Hospital Services,* for inpatient services. A sample of VA Form 10-7078 is shown on the next page.

Obtaining Additional Services

All additional, non-emergent, follow-up ancillary or treatment requests not contained or specified within the original authorization must be coordinated and pre-approved by VA prior to the treatment being initiated or rendered. To gain an approval request, contact the VA facility that authorized the original treatment/service.
Please note: In some circumstances, VA might not pay for additional services not approved or not included in the authorization form. See the authorization form for contact information.

Developing Emergencies

When emergent care is necessary during the provision of VA authorized care/treatment, pre-approval is not required for Emergency Room/Hospitalization while the treatment is being rendered at an approved non-VA facility or non-VA medical care provider outpatient visit. The non-VA facility/service provider must notify the referring VA immediately to coordinate care that deviates from the approved care plan. **Unauthorized urgent/emergent hospital admissions should be reported to the nearest VA within 24 hours when possible; notification should not exceed 72 hours.**

Should the Veteran require a higher level of care that cannot be provided at the current non-VA facility, VA must be notified to facilitate the transfer of the Veteran to a VA medical facility or to authorize the transfer to a second non-VA facility at VA's expense. If VA has capacity and provides the appropriate level of service, a transfer to the VA hospital will be facilitated when the Veteran is stable to transfer. If the Veteran refuses transfer, VA payment will cease and the Veteran will be liable for additional physician and facility charges.

Sample Authorization, VA Form 10-7078

Department of Veterans Affairs — AUTHORIZATION AND INVOICE FOR MEDICAL AND HOSPITAL SERVICES

Issuing Office
VA Medical Center
123 Veteran Blvd
Anywhere, USA 12345

1. Date of Issue: Feb 02, 2011

2. Veteran's Name:

Name of Physician or Station

3. Address:

4. Veteran's Claim No.:

4A. SSN:

5. Authorization Valid

Name of VA Referring Provider
NPI:

From: Feb 01, 2011
To: Feb 03, 2011

PART 1. - SERVICES AUTHORIZED

6. Services shown below are authorized for the period indicated in Item 5 above. (See Special Provisions below.)

7. Fee: $

8. Fee Schedule or Contract

9. Authority: 17.46(b)

9A.:

10. Estimated Amount: $100.00

11. Fiscal Symbols

12. Authorized by (Name and Title)

Upon acceptance of this authorization the provider agrees to accept VA payment as payment in full for the services described herein. As such, you may not bill the Veteran or any other entity for any portion of the care authorized by VA.

SPECIAL PROVISIONS: Acceptance of this authorization to render service is governed by the following:

1. Services are hereby authorized by VA under the provisions of 38 U.S.C. [§]1703. Payment will be rendered in accordance with this statute and federal regulation 38 CFR [§] 17.55 and 17.56. When there is no contract or negotiated agreement in place with the non-VA provider, VA will pay claims in accordance with established regulations.

2. ACCEPTANCE OF THIS AUTHORIZATION AND PROVIDING OF SUCH TREATMENT OR SERVICES SUBJECTS YOU, THE PROVIDER OF CARE, TO THE PROVISIONS OF PUBLIC LAW 93-579, THE PRIVACY ACT OF 1974, TO THE EXTENT OF THE RECORDS PERTAINING TO THE VA AUTHORIZED TREATMENT OR SERVICES OF THIS VETERAN.

3. Fees or rates listed represent maximum allowance for services specified. In no event should charges be made to the VA in excess of usual and customary charges to the general public for similar services.

4. Payment by the VA is payment in full for authorized services rendered.

5. Unless otherwise approved by the VA, services are limited in type and extent to those shown on this authorization. If services are not initiated for any reason, return a copy of the authorization to the issuing office with a brief explanation.

6. Documentation of treatment and services should be forwarded to the Authorizing station within 14 days of service.

7. When submitting claims for payment you must include the NPI and Taxonomy Code of the rendering practitioner, and the NPI and Taxonomy Code of your organization. If, under the HIPAA NPI Final Rule [http://www.cms.hhs.gov/NationalProvIdentStand], your organization is an "atypical" provider furnishing services such as taxi, home and vehicle modifications, insect control, habilitation, and respite services and is therefore ineligible for an NPI, it is important that you indicate "Ineligible for NPI" on your claim form.

By Federal regulation, VA is the primary and exclusive payer for medical care it authorizes. As such, you may not bill the Veteran or any other party for any portion of the care authorized by the VA. Federal law also prohibits payment by more than one federal agency for the same episode of care; consequently any payments made by the Veteran, Medicare, or any other Federal agency must be refunded to the payer by your facility. Acceptance of this authorization is to accept VA payment as payment in full for the services described herein.

All questions relating to this authorization should be referred to the issuing VA Office

VA Form 10-7078

Unauthorized Care

Unauthorized care is when a Veteran obtains care, outside the VA health care system, without prior authorization. In limited circumstances, VA may pay for care that is unauthorized. However, Veterans who obtain non-emergency, unauthorized care, run the risk of having to pay for all or part of the care they obtain.

Veterans who require emergency care, in accordance with the prudent layperson standard, are directed to the nearest emergency facility. **If emergency care requires a hospital admission, VA must be notified as soon as possible within 72 hours.**

Timely filing limits apply to emergency care not previously authorized, and the requirements vary depending on whether or not the Veteran's care was related to a VA adjudicated service-connected disability (see the section on Claims and Payments). It is essential that the non-VA facility contact the VA medical facility as soon as possible to make them aware of the emergency treatment.

Prudent Layperson Definition of Emergency Care

The following prudent layperson definition of emergency care is used when processing non-VA emergency care claims:

> When such care or services are rendered in a medical emergency of such nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health. This standard would be met if there were an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Claims and Payments

This section includes instructions which apply to submitting claims to a VA medical facility for payment consideration. Please note the following legal restrictions apply to VA payments:

- VA is prohibited from contracting with, remunerating, or accepting products and services from individuals and entities excluded from participating in federally funded programs. Exclusions can be found on the *Exclusions Program page* of the Department of Health and Human Service's Office of Inspector General website.
- VA is the primary and exclusive payer for non-VA medical care it authorizes. As such, non-VA medical care providers may not bill the Veteran or any other party for any portion of the non-VA medical care authorized by VA.
- Federal law also prohibits payment by more than one Federal agency for the same episode of care; consequently, any payments made by the Veteran, Medicare, or any other Federal agency must be refunded to the payer by the non-VA medical care provider/facility.

Electronic Claim Submission

VA accepts and encourages electronic health care claims that satisfy criteria established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The standard transactions that are included within HIPAA regulations consist of standard electronic formats for enrollment, eligibility, payment and remittance advice, claims, health plan premium payments, health claim status, referral certification and authorization.

VA contracts with Emdeon® to provide clearing house services for electronic medical care claims. To register or submit an EDI claim to your local VA health care facility, visit the *Emdeon Payer Lists website* or call 1-800-845-6592.

While registering, you will need the Non-VA Medical Care Program Payer IDs which include:

- 12115 for submission of medical claims
- 12116 for submission of dental claims
- 00231 for submission of any inquiry transaction

Paper Claim Submission

To submit claims for payment, complete the appropriate form and provide the codes or the treatment rendered just as you would when completing a Medicare claim. Submit the claim to the Non-VA Medical Care Program Office of the VA facility that issued the authorization.

Claim Filing Instructions for Preauthorized Care*

Claims submitted to VA for payment consideration must include a completed original CMS 1500 and/or CMS 1450 (UB-04) billing forms to include, at a minimum, the following Veteran and provider information:

- Veteran name (include middle initial)
- Veteran address (include zip code)
- Veteran full Social Security Number
- Provider name
- National Provider Identifier (NPI) number
- Provider taxonomy code(s), if known
- Tax Identification Number (TIN) / Employee Identification Number (EIN)
- Professional status of provider (MD, PhD, CRNA, etc.)
- Physical address where care was provided
- Remit to (mailing) address where payment should be sent
- All appropriate medical coding
- All other health insurance information

On a case-by-case basis, if required medical documentation is needed to process the non-VA medical care claim, it should be communicated by VA at the time of the preauthorization; however, authorized inpatient care, whether emergent or non-emergency, requires submission of the discharge summary.

**VA reserves the right to return a claim with a request for additional information.*

Claim Filing Instructions for Unauthorized/Emergency Care*

- Submit all required information as stated above
- Submit all medical records, reports, and treatment documents

**VA reserves the right to return a claim with a request for additional information.*

Required Documents for Claims Submission

<table>
<tr><th colspan="3">If the care is: PREAUTHORIZED</th></tr>
<tr><th>And the service is:</th><th>Submit claim:</th><th>Documents should include:</th></tr>
<tr><td>Facility Charges
(Inpatient and Outpatient)</td><td rowspan="2">As soon as possible after the care is completed, but no later than 6 years from the date of service</td><td>• 837 EDI claim or UB-04 and itemized statement of charges
• Hospital Discharge Summary or Outpatient Treatment Records / Progress Notes</td></tr>
<tr><td>Physician Charges & Other Professional Services, Including Ambulance
(Inpatient or Outpatient)</td><td>• 837 EDI claim, UB-04 or CMS 1500 and itemized statement of charges
• Outpatient Hospital Emergency Treatment Records / Progress Notes</td></tr>
<tr><th colspan="3">If the care is: EMERGENCY (SERVICE-CONNECTED CONDITION)</th></tr>
<tr><th>And the service is:</th><th>Submit claim:</th><th>Documents should include:</th></tr>
<tr><td>Emergency Medical Care Facility Charges
(Inpatient and Outpatient)</td><td rowspan="2">As soon as possible but no later than 2 years from date of service</td><td>• 837 EDI claim or UB-04, and itemized statement of charges
• Hospital Discharge Summary or Emergency Department Notes / Progress Notes</td></tr>
<tr><td>Physician Charges & Other Professional Services, Including Ambulance
(Inpatient or Outpatient)</td><td>• 837 EDI claim or CMS 1500 and itemized statement of charges
• Emergency Department Notes / Progress Notes</td></tr>
<tr><th colspan="3">If the care is: EMERGENCY (NON-SERVICE-CONNECTED CONDITION)</th></tr>
<tr><th>And the service is:</th><th>Submit claim:</th><th>Documents should include:</th></tr>
<tr><td>Emergency Medical Care Facility Charges
(Inpatient and Outpatient)</td><td rowspan="2">Within 90 days after the most recent of the following:
• Date of discharge; or
• Date of Veteran’s death; or
• The date the Veteran finally exhausted, without success, action to obtain payment or reimbursement for the treatment from a third party.</td><td>• 837 EDI claim or UB-04 and itemized statement of charges
• Hospital Discharge Summary or Outpatient Treatment Records / Progress Notes
• Certification of no other Payer for the services billed</td></tr>
<tr><td>Physician Charges & Other Professional Services, Including Ambulance
(Inpatient or Outpatient)</td><td>• 837 EDI claim or CMS 1500 and itemized statement of charges
• Outpatient Treatment Records / Progress Notes
• Certification of no other Payer for the services billed</td></tr>
</table>

Filing Deadlines

VA Non-VA Medical Care Programs have different claim filing deadlines depending on how the claim is being considered for payment:

- **Authorized Care** (Title 38 United States Code (U.S.C.) § 1703) claims must be submitted within 6 years from the date of service.
- **Unauthorized emergency care for service-connected Veteran claims** (Title 38 U.S.C. § 1728) must be filed within 2 years after the date the care or services were rendered, or within 2 years of the date the Veteran was notified by VA of the adjudication of a service-connected disability.
- **Unauthorized emergency care for non service-connected Veteran claims** (Title 38 U.S.C. § 1725) must be submitted within 90 days of the following:
    - Date of service;
    - Date of discharge from a non-VA facility;
    - Date of death, only if the death occurred during transportation to a facility for emergency treatment or if the death occurred during the stay in the facility that included the provision of the emergency treatment; or
    - The date the Veteran finally exhausted, without success, action to obtain payment or reimbursement for the treatment from a third party.

Payment Denials and Disagreements

Non-VA medical care providers who disagree with the VA decision to deny payment for a claim have the right to request reconsideration of the claim. Non-VA medical care providers disagreeing with the initial decision to deny the claim in whole or in part may submit a reconsideration request in writing to the referring Non-VA Medical Care Office within 1 year. The request must state why the provider believes the decision is in error and must include any new and relevant information not previously considered.

The request for reconsideration may include a request for a meeting with the immediate supervisor of the initial VA decision-maker, the claimant, and the claimant's representative (if the claimant wishes to have a representative present). Such a meeting shall only be for the purpose of discussing the issues and shall not include formal procedures (e.g., presentation, cross-examination of witnesses, etc.). The meeting will be taped and transcribed by VA if requested by the claimant and a copy of the transcription shall be provided to the claimant.

At the completion of the review, the immediate supervisor of the initial VA decision-maker shall issue a written decision that affirms, reverses, or modifies the initial decision.

The final decision of the immediate supervisor of the initial VA decision-maker will inform the claimant of further appellate rights for an appeal to the Board of Veterans' Appeals.

Payments for Veterans with Insurance

In situations where a Veteran has coverage under Medicare or any other health plan, Federal law prohibits providers from receiving payment from both VA and the other health plan for the same services. Non-VA medical care providers may not bill any other payer for care authorized by VA.

If a Veteran chooses to use VA benefits, the Veteran is responsible for paying applicable VA co-payments; however, VA payment for non-VA medical care is payment in full, and the non-VA medical provider is prohibited by law from billing the Veteran or the Veteran's other health plan for charges beyond VA payment.

If a Veteran chooses to have a claim submitted to another health plan in lieu of VA benefits, the Veteran is responsible for paying any co-payment or deductible required by their other health insurance to the non-VA medical care provider. Except in specific instances, VA will not pay deductibles, co-payments, or the balance of the facility charges to the non-VA facility.

Non-VA Facility/Provider Registration

All providers need to be registered in VA's payment system in order for the VA to process payments for services. To register, a Standard Form (SF) 3881 and Form W-9 need to be completed. Once completed, return them to your local VA medical facility via mail where they can upload your information into their computer system and forward your form to the center that processes the reimbursement. Please contact the Non-VA Medical Care Office at your local VA medical facility for more information.

You can find the forms online:

- SF 3881*, ACH Vendor/Miscellaneous Payment Enrollment Form*, from the U.S General Services Administration Forms Library
- W-9*, Request for Taxpayer Identification Number and Certification*, from the Internal Revenue Service website

Electronic Payments for Non-VA Providers

The U.S. Department of Treasury published a final rule on Electronic Funds Transfer (31 C.F.R. 208) on Dec. 21, 2010. This rule requires that all federal payments be made electronically. This requirement includes payments made to non-VA medical and dental providers.

To enroll in Electronic Funds Transfer (EFT), a non-VA medical care provider needs to complete an SF 3881 (see link above) and fax it to (512) 460-5221. Please call the VA Financial Services Center at (512) 460-5049 for more information.

Electronic Explanation of Benefits (EOB)

The Provider Portal gives non-VA medical care providers access to EOBs and Authorization information sent by VA. All EOB information can be printed and saved. Please go to the *Provider Portal website* for login instructions. For additional issues and information about the Provider Portal, contact the VA Financial Services Center (FSC) Customer Service Help Desk by phone at 1-877-353-9791 or by email at *vafsccshd@mail.va.gov*

Additional Payment Information

For services on or after February 15, 2011, the Veterans Health Administration adopted Medicare's payment methodology for all outpatient facility and professional medical services. Additionally, on or after June 1, 2014, non-contracted home health and hospice claims are also paid via Medicare's payment methodology. For reimbursement purposes, VA does not distinguish between Medicare participating and non-participating providers.

Medical Documentation

Prior to the appointment/admission, please inform the referring VA point of contact and the Veteran if he or she needs to provide you with medical information to support your treatment. Local VA medical facility procedures will direct how non-VA medical care providers can obtain radiology films, discs, lab values, and medical records, including:

- Labs
- Clinical notes
- Medical records
- Previous test/imaging results needed
- Procedure prep information
- Medical clearances needed

Non-VA Medical Care Managers and transfer coordinators may be in contact with the non-VA medical care provider for extended care, home care, durable medical equipment, and rehabilitation services that can be arranged through the VA for post-hospitalization care needs and transitioning back to the VA primary care provider.

Medical documentation should contain the Veteran's name, last four digits of the Veteran's social security number or date of birth on each page of the documentation, be signed by the non-VA medical care provider, and returned to VA. Relevant clinical documentation includes, as applicable, the information listed below.

- Initial assessment and reassessments appropriate for clinical condition, including (but not limited to)
    - Relevant medical history and physical examination, including inventory of body systems
    - Vital signs
    - Pain assessment (using 0-10 scale)
- Initial and final diagnoses/diagnostic impressions
- List of all medications and recommended/ordered durable medical equipment/prosthetics
- Instructions given to Veteran
- Recommended follow-up

Additional Considerations

Durable Medical Equipment (DME)

Requests for DME include the purchase or renting of medical equipment necessary to improve function of a diseased, deteriorating or injured body part. Such equipment includes wheelchairs, hospital beds, oxygen equipment, and nebulizers.

DME items are not routinely authorized or paid through the Non-VA Medical Care Program. DME should be requested from and provided by the authorizing VA medical facility's prosthetics or physical medicine department. Providers are encouraged to make prior arrangements and coordinate DME needs for their Veteran patients with the referring VA medical facility. The referring VA medical facility is responsible for generating a written VA consult to initiate this process.

Maternity Care

The Veterans Health Administration is authorized to provide comprehensive pre-natal, intra-partum, and post-partum care as part of the Uniform Benefits Package for eligible women Veterans. The following eligibility requirements apply to maternity benefits:

- The woman Veteran must be eligible and enrolled in VA care
- The VA provider should confirm the diagnosis of pregnancy and clinically decide if the request is appropriate
- A non-VA Referral Authorization for non-VA maternity care must be issued by the referring VA medical facility

The eligible Veteran has no additional payment responsibility to the provider of non-VA maternity benefits care for services that have been authorized in advance by VA.

Questions about maternity care for a specific Veteran are best answered by the authorizing VA medical facility. Contact the Non-VA Medical Care Office or the Women Veterans Program Manager at that facility for further assistance.

VHA Coverage for Newborn Care

Title 38 U.S.C. § 1786 gives VA the authority to pay for post-delivery care for the newborn children of women Veterans receiving maternity care furnished by VA. The benefit is limited to post-delivery and care provided immediately after birth and not more than 7 days following the birth. Contact the Non-VA Medical Care Office or the Women Veterans Program Manager at the Veteran's VA medical facility if you need further information or assistance.

Prescriptions Written by Non-VA Physicians

Non-VA physicians may prescribe medication as a part of treatment for medical care authorized by VA. In general, all prescriptions must be filled at a VA pharmacy. Prescriptions must meet the VA National Formulary guidelines, which can be found on the *VA Pharmacy Benefits Management Services Web page*.

When it is medically necessary to start the medication promptly, and it is not possible to obtain the medication from the VA pharmacy, VA may reimburse up to a 10-day supply with no refills. The remainder of the prescription should be submitted to the VA Pharmacy Service to be filled.

Dependent Programs

In addition to purchasing health care for Veterans, the VA Purchased Care Program also manages programs for dependents of Veterans. These programs operate differently than the Purchased Care/Fee program for Veterans. If you need additional information about dependent programs, please visit the following websites:

- *CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs)*
- *Spina Bifida Health Care Benefits Program*

Points of Contact

Name of VA Medical Center

VAMC Street Address

City, State	00000	(000) 000-0000

VAMC Main Hospital: (000) 000-0000

To notify VA of Veteran emergency/hospitalization: (000) 000-0000

VAMC Fee Office: (000) 000-0000

Billing: (000) 000-0000

Utilization Review: (000) 000-0000

Eligibility Office: (000) 000-0000

Prosthetics Department: (000) 000-0000

Pharmacy Service: (000) 000-0000

Women Veterans Program Manager: (000) 000-0000

Did you know the Veterans Health Administration…?

- Created the nicotine patch to help people stop smoking
- Performed the first successful liver transplant
- Pinpointed genes for HIV, diabetes, and obesity susceptibility
- Identified schizophrenia gene and developed a unique preventive drug
- Created the bionic ankle
- Contributed to the development of the CAT (or CT) scan
- Developed new drugs and treatment for diseases such as AIDS/HIV, diabetes Alzheimer's, and osteoporosis
- Originated the use of Bar Code Medical Administration to prevent inpatient prescription errors
- Created the first enterprise-wide Electronic Health Record
- Jointly performed the first U.S. hand transplant with University of Pittsburgh
- Since 2007, rescued more than 18,000 Veterans in serious danger of suicide through Veterans Crisis Line and counseled more than 490,000 callers

This guide is current as of October 2014.

SAVE PRINT