

Criteria-Based Core Privileging

A Guide to Implementation and Maintenance

Todd Meyerhoefer, MD, MBA, CPE, FACS

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Table of Contents

| | |
|--|------------|
| About the Author | vii |
| Introduction | ix |
| Chapter 1: Credentialing: The Prerequisite of Privileging | 1 |
| Principles and Guidelines of Credentialing..... | 3 |
| Key Points..... | 8 |
| Chapter 2: Criteria-Based Core Privileging: A Better Way to Privilege | 11 |
| Approaches to Privileging..... | 12 |
| Why Criteria-Based Core Privileging?..... | 21 |
| The Driver’s License Analogy..... | 23 |
| Selling Core..... | 24 |
| Evaluating Existing Privileging Practices | 25 |
| Chapter 3: Secure Support | 27 |
| Saying the Right Things | 28 |
| Continuing Education | 30 |
| Fallacies and Misconceptions..... | 32 |
| Chapter 4: Do Your Homework | 35 |
| Gathering Information Regarding Current Privileging Practices..... | 35 |
| Identifying Patterns..... | 37 |
| Creating the Core..... | 38 |
| Determining the Scope of the Privileging Project..... | 41 |
| Chapter 5: Design Draft Core Privilege Forms | 45 |
| Creating Draft Sets of Core Privileges..... | 45 |
| Determining Core Versus Noncore Privileges..... | 46 |
| Procedure Lists..... | 47 |
| Developing Criteria for Privileges | 48 |
| Reviewing the Drafts..... | 52 |
| Issues to Consider | 54 |

| | |
|---|------------|
| Chapter 6: Approve New/Revised Forms | 61 |
| Not Everyone Has to Approve the Form | 61 |
| Circumventing Problems With Numbers..... | 62 |
| Motivating the Unmotivated Department Chief or Designee | 63 |
| Chapter 7: Implementing Core Privileges | 65 |
| Chapter 8: Communicating and Advocating for the Privileging Delineation System | 73 |
| Defending the New Privileging System..... | 74 |
| When Practitioners Go Outside the Core..... | 75 |
| Chapter 9: Care and Maintenance | 77 |
| New Services and Technology..... | 78 |
| Revision of Forms..... | 80 |
| Chapter 10: Controversies and Challenges | 83 |
| Crossover Privileges | 83 |
| Can Different Specialties Use Different Criteria for the Same Privilege?..... | 86 |
| Board Certification..... | 87 |
| Privileging by the Numbers | 89 |
| Departments Don't 'Own' Privileges..... | 91 |
| Departmental Territorialism | 92 |
| Write-In Privilege Requests..... | 93 |
| Exercising Privileges Selectively | 93 |
| Lapsed Privileges | 94 |
| Low- or No-Volume Practitioners | 95 |
| Aging Practitioners | 96 |
| 'Who Did You Meet With, and Why Wasn't It Me?' | 96 |
| Privileges and Emergency Department Call | 97 |
| Appendix 1: Core Privileging Questions and Answers | 101 |
| Appendix 2: Criteria for Privileging Review | 109 |
| Appendix 3: Clinical Privilege White Paper | 111 |
| Appendix 4: Certified Registered Nurse Anesthetist Clinical Privileges | 127 |
| Appendix 5: Cardiac Surgery Clinical Privileges | 137 |
| Appendix 6: Physician Profile Report Draft and Provider History Report | 149 |

| | |
|--|------------|
| Appendix 7: Sample Dispute Resolution Policy..... | 155 |
| Appendix 8: New Privileges/Procedure/Technology Policy..... | 159 |
| Appendix 9: Sample New Technology/Procedure Briefing Form..... | 163 |
| Appendix 10: Clinical Privileges Task Force/Specialty Recommendations | 165 |
| Appendix 11: Clinical Privileges Delineation—General Policy | 167 |
| Appendix 12: Procedure for Processing Clinical Privilege Requests..... | 173 |
| Appendix 13: Instructions for the Applicant Regarding the Completion of Privilege Request Forms | 175 |
| Appendix 14: Request for Modification of Clinical Privileges | 177 |
| Appendix 15: Relevant CMS <i>Conditions of Participation</i>..... | 179 |
| Appendix 16: CMS Requirements for Hospital Medical Staff Privileging | 199 |

About the Author



Todd Meyerhoefer, MD, MBA, CPE, FACS, is vice president medical affairs and chief medical officer of Union Hospital in Dover, Ohio. He previously served as senior vice president of physician alignment for Akron (Ohio) General Health System and president of the health system's Partners Physician Group. An experienced physician executive, Meyerhoefer has held various medical staff leadership positions, including trauma committee chair and bylaws committee chair, and as a member of peer review, credentials, and utilization review committees.

In his current role, he is responsible for medical affairs, quality improvement, and physician relations. He advises on the growth and development of the hospital's employed physician group and serves on the board for the hospital's ambulatory surgery center. He helped reorganize and streamline medical staff office operations, implemented an electronic credentialing process that markedly improved staff productivity, and revamped the physician performance profile process to a digital platform. Meyerhoefer has twice developed and implemented a core privileging system.

Meyerhoefer previously served on the Ohio Committee on Trauma and is a current member of the Stark County Medical Society. He is a fellow of the American College of Surgeons and the American College of Physician Executives.

Meyerhoefer received his Doctor of Medicine from Northeast Ohio Medical University and his Master of Business Administration from Ashland University. Born in Chapel Hill, North Carolina, Meyerhoefer lives in Jackson Township, Ohio with his wife and has three grown children.

Introduction

My exposure to the intricacies of credentialing and privileging started right after I finished my general surgery residency and applied for privileges at my local community hospital. The general surgery residents had always done their own GI endoscopies as well as bronchoscopies, so I applied for these privileges at my new hospital. The hospital used the laundry list typical of that time, so no criteria were outlined, and there was the usual “other” section at the end of the form.

The majority of the list was granted without any issues—including the GI endoscopy privileges. However, the bronchoscopy privileges were a problem due to cross-specialty political issues. Although I could demonstrate extensive experience in bronchoscopies, there were no eligibility criteria listed for flexible bronchoscopy. I was counseled that putting up a fight might not be in my best interest as a new surgeon in town trying to build a practice. Along similar lines, it was intimated that having too active of a GI endoscopy practice would not benefit my surgical career. All politics being local, I did not contest the bronchoscopy privileges and never developed much of an endoscopy practice, choosing the surgical cases over the endoscopies. Although this decision may not sit well with some people, I was able to build a successful general surgical practice.

As I became more involved in the medical staff, I learned about many things, including credentialing and privileging. The typical laundry list application forms had not been changed for many years. Although my initial application experience demonstrated the value of using a criteria-based privileging system, it was difficult to garner much support for changing the system. There were many reasons, but probably the main one was a lack of available time that would be necessary to undertake this endeavor.

A health issue in late 2007 turned out to be the catalyst behind getting the core privileging project done. Due to my illness, I was not going to be able to return to the operating room. So after I recovered, I was hired by my hospital to work with the medical staff to convert the privilege forms from laundry list to criteria-based. I did a lot of reading and research in preparation for the project, including earlier versions of this book. In helping to update this book, I have aimed to modify and clarify the content with seasoning from the lessons I learned. Although the journey is not for the faint of heart, the destination is worth the effort.

This book is written from my perspective as a physician and my experiences in developing a criteria-based core privileging system at two separate organizations. If the reader is a physician, then I am assuming that you have the support of your medical staff office personnel. If the reader is a medical staff office professional, then your first step will be to get the support of your chief medical officer or vice president medical affairs (who is hopefully a physician). Without strong physician leadership for this change, the initiative is likely to be unsuccessful. If you are an organization that has already made the conversion to core, congratulations. I hope you may find some insights that will help you sustain your progress.

Chapter 1

Credentialing: The Prerequisite of Privileging

Competent healthcare practitioners are the foundation of quality healthcare. With today's mounting legal and regulatory pressures, heightened public awareness and accessibility to information, and increasing media coverage of healthcare issues, all healthcare organizations are under more scrutiny than ever when ensuring that those who provide patient care are currently competent to do so.

To ensure that only qualified, competent practitioners perform procedures and provide patient care, healthcare organizations must thoroughly review each applicant's qualifications for initial appointment and reappointment to the medical staff and continuously evaluate his or her qualifications for clinical privileges. In the hospital environment, this process of collecting, reviewing, and assessing practitioners' qualifications for membership/clinical privileges is commonly referred to as credentialing. The term is also used to refer to the process of assessing a practitioner's qualifications for membership on the medical staff only, meaning the practitioner applies for membership on the medical staff without any clinical privileges because he or she is taking an administrative role or has an outpatient practice and does not wish to exercise privileges at the hospital. Conversely, some practitioners are granted privileges but may not be eligible for membership on the medical staff, such as locum tenens or advanced practice professionals (nurse practitioners, physician assistants). These providers still must undergo the credentialing process.

Practitioners who wish to provide services to patients must apply for clinical privileges—that is, permission to perform specific procedures or treat specific conditions. In addition to physicians (e.g., doctors of medicine or osteopathy, dentists, oral and maxillofacial surgeons, and podiatrists), most hospitals also allow certain nonphysician practitioners or advanced practice professionals to apply for clinical privileges (e.g., advanced registered nurse practitioners, physician assistants, and clinical psychologists). The process that hospitals follow to grant clinical privileges is often called privilege delineation, delineation of privileges, or just privileging.

To evaluate the regulatory requirements and accreditation standards related to credentialing and privileging of healthcare practitioners, begin with the Medicare *Conditions of Participation (CoP)*. Hospitals must comply with federal requirements set forth in the Medicare *CoPs* to receive Medicare or Medicaid payment. Essentially, the *CoPs* require the governing body to ensure that the medical staff, via its medical staff bylaws, has criteria in place for evaluating and determining clinical privileges for individuals based on individual character, competence, training, experience, and judgment.

In 2004, the Centers for Medicare & Medicaid Services (CMS) modified its guidelines regarding the medical staff privileging to clarify the definition of “physician” and also address “non-physician practitioners.” A letter from CMS to state surveyors explaining the new guidelines can be downloaded and found in Appendix 16. These non-physician practitioners include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, anesthesiology assistants, and registered dietitians. These practitioners are typically granted privileges but are not members of the medical staff. The medical staff, however, is still expected to exercise oversight through credentialing and competency review. Relevant credentialing and privileging responsibilities of the governing body and the medical staff are further discussed in this chapter, and requirements regarding privileging systems can be found in Appendix 15.

The ultimate goal of every credentialing and privileging system is to ensure quality patient care. In order to be able to continue to provide that care, compliance with requirements of the CMS *CoPs* is necessary. Accreditation agencies such as The Joint Commission, the Healthcare Facilities Accreditation Program, the National Committee for Quality Assurance, the Accreditation Association for Ambulatory Health Care, and Det Norske Veritas verify this compliance for the government and other regulatory agencies.

Principles and Guidelines of Credentialing

Credentialing starts with clear policies and procedures. As stated earlier, the ultimate goal of credentialing is to ensure safe, quality patient care, and credentialing policies and procedures should reflect that goal. As you begin to develop or update your credentialing policies and procedures, there are certain principles and steps you should keep in mind.

Follow the 5 Ps

For years, The Greeley Company has recognized that a strong, risk-adverse process for credentialing and privileging is a result of well-constructed and well-implemented policies and procedures. “Our Policy is to follow our Policy. In the absence of a Policy, our Policy is to develop a Policy.” In other words, “the 5 Ps” coincide with Step 1 of credentialing: Create good policies and procedures. Credentialing specialists, medical staff leaders, and hospital administration should always follow and support established policies and procedures and document that they have done so.

Credentialing consists of four steps

Step 1: Create good policies and procedures

In this first step of the credentialing process, hospitals and medical staff organizations create the medical staff bylaws and accompanying policies and procedures that define the credentialing process. Organized medical staffs incorporate into these policies recommended criteria that will be used to make decisions regarding the granting of medical staff appointment/clinical privileges, which the governing board of the hospital then approves. These criteria will enable hospitals to eliminate from consideration those applications that would inevitably face denial if allowed to go through the complete credentialing process.

To avoid unnecessary application denials and the subsequent responsibility to report such denials to the National Practitioner Data Bank (NPDB), every hospital should include in its medical staff bylaws/policies the minimum criteria that each applicant requesting medical staff membership/clinical privileges must meet before the organization will process his or her application. Determining the criteria in advance also makes the credentialing and privileging process more objective. Hospitals should communicate these criteria to all potential applicants, instructing them to apply only if they meet the minimum criteria.

Step 2: Gather information

During this step, medical staff services department (MSSD) personnel review the completed application and ensure that it is complete. “Complete” usually means that all information has been provided (i.e., there are no unaddressed questions on the application) and that the documents provided (e.g., certificate of insurance) are appropriate and authenticated. Representatives of the MSSD then conduct primary source verification in accordance with established procedures, which is crucial in determining the authenticity of the information provided by the applicant. MSSD personnel verify each piece of information on the application with its primary source (e.g., medical school for medical degree). The hospital should clarify with the applicant any discrepancies between the information on the application and the information obtained from primary sources before sending the application to the next stage. No application should move to the next step until it is complete and the hospital has received all the information it needs to properly evaluate the applicant’s qualifications. In addition to verifying primary source information, the information gathering must include obtaining evidence of current clinical competence. This is typically accomplished through contacting several peer references and obtaining, if available, quality information from previous healthcare organizations where the applicant has practiced. Medical staff leaders may get involved by contacting peer references directly or conducting a clinical interview with the applicant to assess his or her skills and knowledge.

Step 3: Evaluate and recommend

During this stage, the appropriate department chairs, the credentials committee (if applicable), and the medical executive committee evaluate the application and its supporting documentation, which is contained in the credentials file. This evaluation should focus on whether the information in the completed application adequately demonstrates that the applicant meets the criteria for membership and requested privileges as established in the policies and procedures. There must be evidence of sufficient information within the credentials file to make a decision related to granting, limiting, or denying membership or clinical privileges.

Step 4: Review and grant

During this step, the governing board reviews all recommendations concerning the application and makes the final decision to grant or deny medical staff membership/privileges.

Credentialing exists to protect patients

Credentialing has no master other than the patient. Determining the competency of practitioners to treat patients through a comprehensive credentialing and privileging process is one of the most important functions of the organized medical staff and hospital governing board. Hospitals and organized medical staffs should ask whether any given decision is in the best interest of the patient when developing credentialing policies and procedures.

No one works without a ticket

Regardless of any individual's role in a hospital or healthcare setting, credentialing or some form of vetting of that individual takes place either through HR via an employment agreement (e.g., a job description) or contract or through the medical staff privileging process or an equivalent process. Accrediting agencies, regulatory bodies (state and federal), and internal organizational policies define this process as applicable to each individual organization.

Excellent credentialing requires clear criteria consistently applied

Credentialing is a series of checks and balances, supported by policies, procedures, and defined qualifications for membership and clinical privileges. Established eligibility criteria provide an objective mechanism for the medical staff to make their recommendations in a consistent fashion. It is important for hospitals and medical staffs to treat similar practitioners in a similar manner.

Before granting privileges, solve the competency equation

Competency equation =

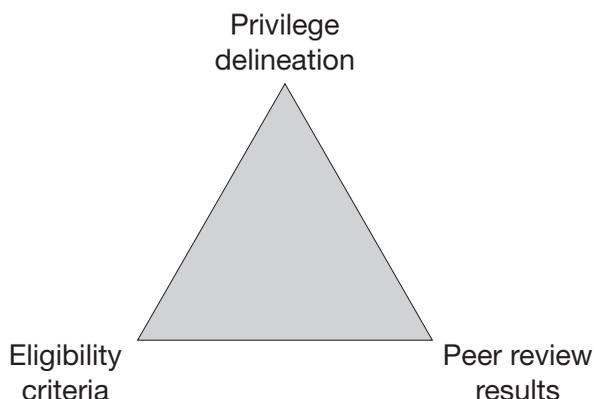
Have you done enough of it recently?

+ When you did it, did you do it well?

Hospitals and their medical staffs should require that every application include data regarding the number and types of clinical activities the practitioner performed, that these clinical activities reflect the scope of the privileges being requested, and the time periods during which he or she performed these activities. Confirmation of competency

includes obtaining appropriate current peer references, gathering quality data (if available), and monitoring the practitioner's performance for all new requests for privileges. Without sufficient clinical information that shows the applicant to be clinically competent to perform the procedures or privileges requested, the application should be considered incomplete and should not be processed.

To match competency with privileges, use the competency triangle



This concept is built on the quality triangle developed by Donabedian, which states that quality equals three parts: structure, process, and outcomes. The Greeley Company adaptation of the competency triangle defines quality as privilege delineation (structure), eligibility criteria (process), and peer review results (outcomes).

Each side of the triangle supports the other. It is therefore important to maintain appropriate balance. For example, if there are concerns about the quality of care based on outcomes, then the privileging delineation and eligibility criteria should be examined to see whether adjustments need to be made.

Don't confuse membership with privileges

Too often, medical services professionals, medical staffs, hospital administration, and governing board members confuse appointment to the medical staff with the granting of clinical privileges. Medical staff appointment simply permits an individual

to participate in the medical staff organization. Typically, the type of appointment is linked to certain rights or prerogatives, such as voting or the ability to hold office. However, clinical privileges specify the particular clinical activities that an individual may exercise in the hospital or healthcare setting based on his or her education, training, and current experience. An individual practitioner can be appointed to the medical staff but have no clinical privileges (e.g., an honorary or emeritus staff member). Likewise, an individual practitioner can be granted clinical privileges without being appointed to the medical staff (e.g., a locum tenens, advanced practice professional, or telemedicine provider). It needs to be made clear that appointment to the medical staff does not mean that a practitioner has been granted clinical privileges.

Don't deny unnecessarily

Do not be forced to deny medical staff appointment or clinical privileges because of inadequate education, training, and experience. A good credentialing process should start with threshold eligibility criteria that are consistently applied to each new applicant for membership and clinical privileges. It is important to clearly identify what criteria are applicable to membership and what criteria are applicable to specific clinical privileges. Do not accept applications for membership or clinical privileges from applicants who do not meet your criteria. However, if you accept and begin processing an application from a practitioner who is found not to meet your requirements, you may discontinue the application process. In this case, the practitioner would then be informed that he or she does not meet eligibility requirements and, therefore, that the application process has been discontinued.

Establishing threshold eligibility criteria will save you from having to go through a fair hearing process with the applicant and from having to file a report with the National Practitioner Data Bank. These actions are not required when a practitioner is found to not meet eligibility requirements. Only in cases where an application is denied because of concerns related to competence or conduct must an NPDB report be made. Development of threshold eligibility requirements is the most effective step that a hospital can take to avoid going through time-consuming, expensive fair hearing proceedings. Further, clearly stated membership and privileging requirements are fair to applicants.

Place the burden on the applicant

Some hospitals and their medical staffs feel compelled to expend significant administrative and staff time verifying the clinical competence or qualifications of practitioners applying for medical staff appointment or clinical privileges. Every hospital and its medical staff should make clear in policy and in practice that the applicant is responsible for providing the hospital with the information it needs to make a decision regarding granting appointment or clinical privileges. A hospital should not spend a lot of time trying to verify information on an application or coaxing reluctant references to respond; doing so wastes valuable time and labor.

Beware the two types of credentialing errors: Information errors and decision errors

Credentials committees should strive to avoid the following two types of errors:

- **Information errors.** Information existed that could have been known but wasn't, and the information would have impacted a credentialing decision.
- **Decision errors.** The necessary information was known, but leaders failed to make the wise decision.

A key factor to successful decision-making and the ability to bring about resolutions to difficult issues is having an experienced credentials team led by a medical staff leader who is knowledgeable about the credentialing and privileging process and all of its intricacies. Experienced credentials committees effectively avoid both types of credentialing errors.

Key Points

Send only complete applications to department chairs or the credentials committee for review

Administrative personnel sometimes feel compelled to send an application to department chairs or to the credentials committee even though the application is incomplete. Frequently the pressure comes from physicians who want their new partner approved so he can take call or by the hospital's employed physician group that signed a physician to an employment agreement but neglected to make it contingent on successful appointment to the medical staff. Regardless of the reason, it is important to follow your policies. Well-written policies and procedures defining what makes an

application complete as well as the method for declaring an application incomplete, therefore deeming it not eligible to begin or continue processing, are critical. If all information required by your policies has not been received, the application should not be presented for review to medical staff leaders. Remember that the burden is on the applicant to provide all information requested to make a determination about the applicant's eligibility for medical staff membership/clinical privileges.

Because there is no reason to deny is not a good enough reason to grant

Some credentials committees and medical staff leaders may recommend clinical privileges because they feel obliged or a sense of duty to do so unless the applicant is proven incompetent to perform the privileges requested. However, high-functioning medical staff leaders understand that their real obligation is to the patient and use restraint in recommending appointment and clinical privileges. They recognize that the burden is on the applicant to provide evidence of competence for all clinical privileges requested, and they understand that it is not the credentials committee's obligation to prove incompetence. In essence, their job is to actively, not passively, make a recommendation regarding appointment and privileges.

Go beyond accreditation standards

At present, The Joint Commission, HFAP, DNV GL, and NCQA standards provide excellent starting points for the credentialing activities of hospitals and other healthcare organizations. However, medical staff leaders and credentialing professionals who take credentialing and privileging seriously go beyond the minimum requirements of accreditation and regulatory requirements and incorporate best practices into their verification methods. Best practices in verification are important, because court cases (for example *Kadlec Medical Center v. Lakeview Anesthesia Associates* and *Johnson v. Misericordia*) have proven that hospitals and other organizations place themselves and their patients at risk if they follow only minimum requirements.

The Greeley Evolving Credentialing Standard 2015 Edition (www.greeley.com) has many useful suggestions for the credentialing process. Review these credentialing verification best practices and discuss them with your credentials committee and medical staff leadership. If you agree with them, modify and adopt them in your organization. The

high care standards we set for practitioners require us to devote time and effort to going beyond minimum credentialing requirements.

Continually improve credentialing practices and procedures

Hospitals and their medical staffs sometimes feel that they should not upgrade credentialing policies and procedures, arguing that it is unfair to require new applicants to meet more rigorous requirements than existing members. However, the issue at hand is not whether the change is fair, but whether the change is in the best interest of patient care. The practice of medicine, and therefore the medical education and clinical experience of applicants, changes constantly. Thus, the criteria for clinical privileges must reflect those changes.

Use all resources at your disposal

Hospitals and medical staffs face increasingly complex credentialing issues, such as new medical techniques, new procedures, and privilege requests from nonphysician practitioners. When faced with such issues, a hospital and its medical staff should use all of the internal resources at its disposal or seek out external consultants when it needs specific expertise. Hospitals and their medical staffs should also use all available technology (e.g., credentialing and privileging software, the Internet, etc.) to gather the information that is necessary to make an informed decision.

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A criteria-based core privileging system ensures consistency, flexibility, efficiency, and objectivity. However, transitioning to core privileges can be a daunting and overwhelming task. ***Criteria-Based Core Privileging: A Guide to Implementation and Maintenance*** helps take the hassle out of that transition. Acting as a how-to guide, this book provides the necessary steps for medical staff professionals and physician leaders to successfully adopt a criteria-based system. In addition, it lays out a road map to overcome the biggest challenges along the way, including obtaining buy-in from physicians and hospital leaders.

This book will help you:

- Develop a criteria-based core privileging system that is flexible, efficient, consistent, and objective
- Identify key tips on how to obtain staff buy-in
- Identify a clear path of transition to criteria-based privileging
- Discuss how to apply criteria-based privileging to various practitioner categories
- Handle privileging requests for new procedures and technology

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