PUBLICATION OF REDACTED VERSION
OF THE OEIG FOR THE AGENCIES UNDER THE GOVERNOR
INVESTIGATIVE REPORT

Case # 19-00385

Subject(s): Kimberly Taylor-Sykes

Below is the redacted version of an investigative summary report issued by the Executive Inspector General for the Agencies of the Illinois Governor. Pursuant to section 20-50 of the State Officials and Employees Ethics Act (Act) (5 ILCS 430/20-50), a summary report of an investigation is required to be issued by an executive inspector general when, and only when, at the conclusion of investigation, the executive inspector general determines reasonable cause exists to believe a violation has occurred. If a complaint is not to be filed with the Commission for adjudication of the alleged violation, the Act further requires the executive inspector general to deliver to the Executive Ethics Commission (Commission) a statement setting forth the basis for the decision not to file a complaint and a copy of the summary report of the investigation and of the response from the ultimate jurisdictional authority or agency head regarding the summary report. 5 ILCS 430/20-50(c-5). The Act requires that some summary reports be made available to the public and authorizes the Commission to make others available. 5 ILCS 430/20-52. Before making them available, however, the Commission is to redact from them information that may reveal the identity of witnesses, complainants, or informants and may redact "any other information it believes should not be made public." 5 ILCS 430/20-52(b).

Some summary reports delivered to the Commission may contain a mix of information relating to allegations with respect to which the executive inspector general did and did not determine reasonable cause existed to believe a violation occurred. In those situations, the Commission may redact information relating to those allegations with respect to which the existence of reasonable cause was not determined.

The Commission exercises its publication responsibility with great caution and seeks to balance the sometimes-competing interests of transparency and fairness to the accused and others uninvolved. To balance these interests, the Commission has redacted certain information contained in this report and identified where said redactions have taken place and inserted clarifying edits as marked. Publication of a summary report of an investigation, whether redacted or not, is made with the understanding that the subject or subjects of the investigation may not have had the

opportunity to rebut the report's factual allegations or legal conclusions before issuance of the report. Moreover, there has not been, nor will there be, an opportunity for the subject to contest or adjudicate them before the Commission. The subject merely has the opportunity to submit a response for publication with the report.

The Commission received this report and a response from the ultimate jurisdictional authority and/or agency in this matter from the Agencies of the Illinois Governor Office of Executive Inspector General ("OEIG"). The Commission, pursuant to 5 ILCS 430/20-52, redacted the OEIG's final report and responses and mailed copies of the redacted version and responses to the Attorney General, the Executive Inspector General for the Agencies of the Illinois Governor, and each subject.

The Commission reviewed all suggestions received and makes this document available pursuant to 5 ILCS 430/20-52. By publishing the below redacted summary report, the Commission neither makes nor adopts any determination of fact or conclusions of law for or against any individual or entity referenced therein.

– THE REDACTED VERSION OF THE EIG'S SUMMARY REPORT
BEGINS ON THE NEXT PAGE –

I. INTRODUCTION

In February 2019, the OEIG learned that Amtrak's Inspector General uncovered an insurance fraud scheme whereby several Amtrak employees provided [Chiropractor 1] with their and their family members' personally identifiable information in exchange for money, then [Chiropractor 1] billed Amtrak's insurance for services he did not actually provide to these individuals. The OEIG learned that during the course of Amtrak's investigation, Amtrak investigators discovered that CTA employees may also have been participating in the scheme, including CTA Bus Operator Kimberly Taylor-Sykes. Given this, on March 4, 2019, the OEIG opened this investigation to determine Ms. Taylor-Sykes' and other CTA employees' involvement in [Chiropractor 1]'s insurance fraud scheme.

II. INVESTIGATION

As part of the investigation, the OEIG obtained and reviewed documents relating to CTA's insurance plan, employee personnel files, insurance claims submitted by [Chiropractor 1] on behalf of CTA employees and their family members, and Explanations of Benefits (EOBs) related to these claims. In addition, investigators interviewed several individuals, including [CTA Employee 21]; Ms. Taylor-Sykes; and several other CTA employees, detailed further below.

A. [Chiropractor 1]

[Chiropractor 1] has been a licensed chiropractic physician in Illinois since 1992, but his license is currently suspended.[1] At all times relevant to the investigation, [Chiropractor 1] operated his own practice, [Private Business 1], in [City 1], Illinois.[2]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52][3] [4]

B. CTA's Insurance Plan and Related Rules, Policies, and Information

On April 15, 2020, investigators interviewed [CTA Employee 21]. [CTA Employee 21] stated that she has been with the CTA since [Redacted] and is responsible for overseeing the administration of the CTA's employee benefit programs, including its employee insurance program, as well as its leave management programs, such as programs relating to the Family and Medical Leave Act (FMLA) and short term disability.

[CTA Employee 21] stated that the CTA contracts with [Health Insurance Company] ([Health Insurance Company]) for a health insurance plan for its employees. [CTA Employee 21] explained that the CTA self-insures its insurance plan, meaning that [Health Insurance Company] bills the CTA for a portion of the claims submitted on behalf of its employees and their dependents and the CTA pays this cost "out-of-pocket." [CTA Employee 21] said that the CTA deducts a set

[1] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[2] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[3] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[4] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].

amount from each insured employee's paycheck in order to offset the CTA's own contribution to any claims made for the employee or his or her dependent, but the CTA otherwise bears 100% of the cost itself. [CTA Employee 21] stated that as a result, any bill from [Health Insurance Company] for an employee that exceeds the amount withheld from the employee's paycheck by CTA for insurance purposes is paid with the CTA's own money.

[CTA Employee 21] said that during initial orientation, all new CTA employees are provided with a folder containing various insurance information, including a CTA [Health Insurance Company] Plan Summary (Plan Summary) for the specific plan they have chosen. [CTA Employee 21] added that employees in union positions are also given this information at a separate pre-hire meeting.

According to each Plan Summary, most charges for Chiropractic Care Services—that is, "charges made for diagnostic and treatment services[5] utilized in an office setting by chiropractic Physicians"—are Covered Expenses under the CTA's insurance plan.[6] The Plan Summaries specifically provide that certain Chiropractic Care Services, such as services of a chiropractor that are not within the scope of his or her practice and "maintenance or preventive treatment consisting of routine, long term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status," are not covered under the CTA's insurance plan.[7]

Generally, to receive reimbursement from [Health Insurance Company] for a service covered by an individual's plan, a health care provider must submit a claim form detailing the patient's name and date of birth, diagnosis, service provided, date of service, charge for each service provided, the insured's identification number, and various other information.[8] Once [Health Insurance Company] processes a claim, the insured receives an EOB detailing the charges submitted for the services allegedly provided to the patient, the amount owed by the patient, the type of service received, and the date of service, among other things.[9] With respect to claims, the Plan Summaries specifically state that "any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information; or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act."[10] In addition, [Health Insurance Company]'s Customers' Rights and Responsibilities Statement says it is the insured's responsibility to provide honest and complete information to [Health Insurance Company] and to review and understand the information received about his or her health benefit plan.[11] The Rights and Responsibilities Statement further notes that customers may contact Customer Service for claim-related questions or concerns.[12] During her OEIG interview, [CTA Employee 21] similarly

[5] The Plan Summary states that chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function.
[6] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[7] *Id.*
[8] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[9] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[10] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[11] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52].
[12] *Id.*

stated that it is the CTA's expectation that employees review EOB letters and contact [Health Insurance Company] with any questions or concerns about filed claims.

Finally, CTA's General Rule Book provides that employees may not falsify any written or verbal statement,[13] and says that employees are prohibited from conducting themselves in any manner that is unbecoming of a CTA employee.[14] During her interview, [CTA Employee 21] stated that she believes a CTA employee or dependent giving their information to a medical provider to submit false claims would be a violation of these CTA policies, as the prohibition on falsification of written statements covers written or verbal statements relating to CTA's medical plan and such behavior would be conduct unbecoming an employee. Further, [CTA Employee 21] said this conduct "definitely would" be problematic and such matters would be referred to CTA's legal department. [CTA Employee 21] added that the CTA is a "steward[] of taxpayer dollars, so [we] definitely would find it a problem" if employees or their dependents were providing information to be used for false insurance claims. [CTA Employee 21] noted that a medical provider submitting false claims on behalf of CTA employees and/or their dependents for services not rendered would cause the CTA to spend its own money that it would otherwise not have been liable for.

C. Investigation Regarding Kimberly Taylor-Sykes and [CTA Employee 22]

Kimberly Taylor-Sykes was a CTA Bus Operator from November 18, 1993 until her retirement on July 31, 2020. From 1996 on, Ms. Taylor-Sykes operated out of CTA's [Location 1]. During her employment, Ms. Taylor-Sykes had insurance through the CTA and from January 1, 2014 until her retirement in 2020, Ms. Taylor-Sykes was insured through [Health Insurance Company]. [Individual 1], was also insured under Ms. Taylor-Sykes' [Health Insurance Company] health plan during this time.

[CTA Employee 22] began employment with the CTA as a Bus Servicer in [Redacted] and retired on [Redacted]. During his time with the CTA, [CTA Employee 22] had insurance through the CTA, including through [Health Insurance Company] from at least [Redacted] through [Redacted]. Ms. Taylor-Sykes and [CTA Employee 22] [Redacted].

During their employment, both Ms. Taylor-Sykes and [CTA Employee 22] signed forms acknowledging their receipt of CTA's General Rule Book.[15]

1. FBI Interview of Amtrak Employee A

On January 24, 2019, the Federal Bureau of Investigations (FBI) conducted an interview of Amtrak Employee A as part of its investigation into [Chiropractor 1]'s insurance fraud scheme. During the OEIG's investigation, the FBI provided investigators with a summary of Amtrak Employee A's interview.

[13] CTA General Rule Book Governing All Employees §14(j) (eff. August 15, 2014).
[14] *Id*. at §14(e).
[15] During her interview, Ms. Taylor-Sykes acknowledged that she was familiar with the CTA General Rule Book and that it applied to her when she was a Bus Operator for the CTA.

During the FBI interview, Amtrak Employee A stated that they met [Chiropractor 1] through Ms. Taylor-Sykes and went to [Chiropractor 1]'s office for the first time in February 2014. Amtrak Employee A said that Ms. Taylor-Sykes instructed them to provide a copy of their driver's license and insurance and they "would get some money from [Dr.] [Chiropractor 1]." Amtrak Employee A said that thereafter, they provided these documents to Ms. Taylor-Sykes.

Amtrak Employee A stated that after providing Ms. Taylor-Sykes the documents, they visited [Chiropractor 1]. Amtrak Employee A said that during this first visit, [Chiropractor 1] told them that he would bill Amtrak Employee A's insurance and "give some money back" to Amtrak Employee A. Amtrak Employee A stated that they knew [Chiropractor 1] was billing for services he did not provide.[16] Amtrak Employee A said [Chiropractor 1] would call and inform them that he had a package for Amtrak Employee A. Amtrak Employee A stated that [Chiropractor 1] gave them "odd amounts of money" in cash and they were not sure how [Chiropractor 1] calculated the amounts he was giving to them. Amtrak Employee A estimated that they stopped receiving payments from [Chiropractor 1] around 2015. Amtrak Employee A noted that Ms. Taylor-Sykes informed them that [Chiropractor 1] stopped paying patients because the CTA and Amtrak investigators were investigating him.

2. Review of Relevant Documents

According to claim information obtained from [Health Insurance Company], [Chiropractor 1] billed Ms. Taylor-Sykes' insurance for 19 visits between January 2018 and October 2018. During these visits, [Chiropractor 1] diagnosed Ms. Taylor-Sykes and billed her insurance for visits themselves as well as treatments and therapeutic procedures. In total, [Chiropractor 1] submitted claims totaling $4,800 for the services he allegedly provided to Ms. Taylor-Sykes and was paid $1,176.51 by [Health Insurance Company]. Further, these documents reflect that the out-of-pocket cost that Ms. Taylor-Sykes would have been responsible for totaled $1,730.83 for these alleged visits. Finally, documents reflect that [Health Insurance Company] mailed Ms. Taylor-Sykes EOBs for claims [Chiropractor 1] submitted on her behalf, and she did not appeal any of these claims.

Similarly, records show that [Chiropractor 1] billed [CTA Employee 22]'s insurance for 51 visits between February 2016 and October 2018. During these visits, [Chiropractor 1] diagnosed [CTA Employee 22]. Along with the standard visit charge, [Chiropractor 1] billed [CTA Employee 22]' insurance for treatments and therapeutic procedures. In total, [Chiropractor 1] submitted claims totaling $10,380 for the services allegedly provided to [CTA Employee 22] and was paid $2,120.12 by [Health Insurance Company]. Further, these documents reflect that the out-of-pocket cost that [CTA Employee 22] would have been responsible for totaled $4,914.35 for these alleged visits. Finally, documents reflect that [Health Insurance Company] mailed [CTA Employee 22] EOBs for the claims [Chiropractor 1] submitted on his behalf, and he did not appeal any of these claims.

Finally, [Chiropractor 1] billed Ms. Taylor-Sykes' insurance for 42 visits for [Individual 1], between February 2016 and April 2018. Claims submitted by [Chiropractor 1] indicate that during these visits, he diagnosed [Individual 1], and along with the standard visit charge,

[16] Amtrak Employee A estimated that they did see [Chiropractor 1] approximately four times for actual treatment.

[Chiropractor 1] billed Ms. Taylor-Sykes' insurance for treatments and therapeutic procedures for [Individual 1]. In total, [Chiropractor 1] submitted claims totaling $9,275 for the services allegedly provided to [Individual 1] and was paid $1,951.04 by [Health Insurance Company]. Further, these documents reflect that the out-of-pocket cost that [Individual 1] (or Ms. Taylor-Sykes) would have been responsible for totaled $3,794.88 for these alleged visits. Finally, documents reflect that [Health Insurance Company] mailed Ms. Taylor-Sykes EOBs for the claims [Chiropractor 1] submitted on [Individual 1]'s behalf, and neither [Individual 1], nor Ms. Taylor-Sykes as the primary insured party, appealed any of these claims.

The EOBs sent to [Redacted] for Ms. Taylor-Sykes, [CTA Employee 22], and [Individual 1] reflect that [Chiropractor 1] is an out-of-network provider under their insurance plans. The EOBs also outline the steps to take to start and complete the appeal process for a claim they wanted to appeal.

3. Interview of Kimberly Taylor-Sykes

On May 10, 2021, OEIG investigators interviewed Ms. Taylor-Sykes. Ms. Taylor-Sykes stated that she saw [Chiropractor 1] for chiropractic services for several years, though she could not recall when she began seeing him. Ms. Taylor-Sykes said she saw [Chiropractor 1] three times a week on some occasions, and less frequently on other occasions. Ms. Taylor-Sykes said that she does not believe her [Health Insurance Company] medical plan covered the costs of [Chiropractor 1]'s services, but she provided him with her insurance card and paid him in cash for some time. Ms. Taylor-Sykes said that [CTA Employee 22] and [Individual 1] also saw [Chiropractor 1] for treatment for injuries based on her referral. Ms. Taylor-Sykes said that [CTA Employee 22] and [Individual 1] saw [Chiropractor 1] less often than she did.

Ms. Taylor-Sykes denied that she saw [Chiropractor 1] a total of 19 times between January 3, 2018 and October 15, 2018 as her insurance data reflects,[17] saying this was "not right" because she was seeing another doctor for a back injury during this time—not [Chiropractor 1]. Ms. Taylor-Sykes said she does not know why [Chiropractor 1] submitted claims showing he provided services to her on these dates and she was unaware he was doing this. Similarly, Ms. Taylor-Sykes denied that [CTA Employee 22] saw [Chiropractor 1] a total of 52 times between February 22, 2016 and October 15, 2018, as the claim data reflects, and explained that [CTA Employee 22] would not have seen [Chiropractor 1] that frequently because he found [Chiropractor 1] to be "creepy." Ms. Taylor-Sykes said she also does not believe that [Individual 1] saw [Chiropractor 1] 42 times between February 23, 2016 and April 27, 2018 as the claim data reflects.

Ms. Taylor-Sykes acknowledged that she received EOBs from [Health Insurance Company] indicating that claims had been filed on her behalf and [Individual 1]'s behalf by [Chiropractor 1]. Ms. Taylor-Sykes said that on a couple of occasions, the EOBs indicated that she or [Individual 1] may owe [Chiropractor 1] a "ridiculous" balance, so she brought the EOBs to [Chiropractor 1]'s office and confronted him about the charges. Ms. Taylor-Sykes said

[17] Despite Ms. Taylor-Sykes' assertion that she saw [Chiropractor 1] for several years and the fact that insurance data for [CTA Employee 22]—whom she referred to [Chiropractor 1] after receiving treatment from him herself—dates back to at least 2016, the OEIG was not provided with any claim data for Ms. Taylor-Sykes aside from this time period in 2018.

[Chiropractor 1] explained that the balances were due to her not having reached her deductible and told her "not to worry about it." Ms. Taylor-Sykes said she never contacted [Health Insurance Company] regarding any of these EOBs. Further, Ms. Taylor-Sykes said she could not recall if she ever received any bills from [Chiropractor 1] for his services and does not recall receiving any bills for services he provided to [CTA Employee 22] or [Individual 1]. Ms. Taylor-Sykes said [Chiropractor 1] never offered to not charge her, [CTA Employee 22], or [Individual 1] for any of the services he provided in exchange for using their information to submit claims on their behalf except on the few occasions he told her to not worry about the balances listed on the EOBs. Ms. Taylor-Sykes said [Chiropractor 1] also did not give her anything of value to use her information or [CTA Employee 22]' or [Individual 1]'s to submit claims on their behalf, and she did not work with him or have any knowledge he submitted claims for services he did not provide on her behalf, [CTA Employee 22]'s behalf, and [Individual 1]'s behalf. Ms. Taylor-Sykes stated that she provided her insurance information, [CTA Employee 22]'s information, and [Individual 1]'s information to [Chiropractor 1] only because she saw him for services and denied she provided that information to file claims for services they did not receive.

Ms. Taylor-Sykes stated that in addition to [CTA Employee 22] and [Individual 1], she referred a former CTA employee to [Chiropractor 1] and may have also referred a CTA Bus Operator, Employee 1, as well. Ms. Taylor-Sykes said she referred these CTA employees to [Chiropractor 1] because [Chiropractor 1] provided good treatment, filled out Family and Medical Leave Act (FMLA) paperwork, and gave people time off from work. Ms. Taylor-Sykes also stated that [Chiropractor 1] gave her $100 to $250 for referring individuals to him. Ms. Taylor-Sykes said [Chiropractor 1] paid her a total of approximately $700 for referrals. Ms. Taylor-Sykes said she also referred her [Redacted] to [Chiropractor 1], as well as other individuals who had been in car accidents.

4. Other CTA Employees

a. Review of CTA Employee Claim Information

In addition to Ms. Taylor-Sykes, [CTA Employee 22], and [Individual 1], the OEIG identified 62 other individuals for whom [Chiropractor 1] billed a CTA employee's insurance: 56 employees, five non-employee dependents, and four individuals with an unknown connection to the CTA.[18] [Chiropractor 1] submitted claims for a total of 2,574 visits for these individuals and was paid $131,042.69 by [Health Insurance Company][19] for services allegedly provided.

As part of the investigation, the OEIG examined [Chiropractor 1]'s claims for a sample of these CTA employees and their family members, when applicable. Specifically, investigators reviewed relevant documentation for the 10 CTA employees for whom [Chiropractor 1] submitted

[18] [Health Insurance Company] records reflect that the policyholders under whose plan these four remaining individuals were billed are CTA employees. However, the OEIG could not determine whether these individuals themselves were the policyholders or if they are related to CTA employees whose insurance plan they may have been covered under.

[19] During her interview, [CTA Employee 21] stated that [Health Insurance Company] pays the claims submitted by healthcare providers and requests reimbursement from CTA each week.

the highest amount in claims, as well as any dependents on these employees' insurance plans.[20] Those 10 individuals and their dependents include:

- Employee 2 (Former Bus Mechanic) and non-employee dependent 1;
- Employee 3 (Bus Service Supervisor);
- Employee 4 (Former Bus Operator);
- Employee 5 (Former Bus Operator);
- Employee 6 (Mechanical Unit Assembler) and non-employee dependent 2;
- Employee 7 (Former Bus Operator);
- Employee 8 (Former [Executive]);
- Employee 9 (Bus Operator);
- Employee 10 (Former Bus Operator); and
- Employee 11 (Bus and Truck Mechanic) and non-employee dependent 3.

Relevant information learned from these documents follows:

- [Chiropractor 1] submitted claims totaling $158,202 for these 10 CTA employees. [Chiropractor 1] submitted another $45,550 in claims for confirmed dependents of these employees.
- [Chiropractor 1] submitted claims for 672 visits for the CTA employees. He submitted claims for 193 visits for their dependents.
- The total out-of-pocket cost for each employee's alleged visits to [Chiropractor 1] was between $3,809.17 and $6,156.83; the out-of-pocket cost for all of these employees combined would have totaled $54,479.13. The out-of-pocket cost for each dependent's alleged visits to [Chiropractor 1] was between $537.82 and $5,463.04; the out-of-pocket cost for all of these dependents combined would have totaled $16,489.80.
- Generally, [Chiropractor 1] submitted claims reflecting that he saw each individual every day or every other day during multiple periods of time.

In addition, OEIG investigators also noted the following when reviewing the above-listed employees' claims and claims data for other CTA employees:

- [Chiropractor 1] was an out-of-network doctor under their [Health Insurance Company] insurance plans.

[20] In addition to obtaining documents from CTA and [Health Insurance Company], on November 16, 2020, the OEIG issued a subpoena to [Chiropractor 1] for documentation to verify his treatment of these CTA employees and their dependents. [Chiropractor 1] never produced any documents in response to the OEIG's subpoena for medical and billing records.

- On 49 days that [Chiropractor 1] allegedly provided services to Employee 12 (Bus Operator), they were scheduled to work from 10:30 a.m. to 7:30 p.m.[21]
- On eight days that [Chiropractor 1] allegedly provided services to Employee 1, [Medical Provider 1], a medical provider in New York, also allegedly provided Employee 1 services.[22] The services [Medical Provider 1] allegedly provided to Employee 1 were similar to the services [Chiropractor 1] allegedly provided.
- On the same day [Chiropractor 1] allegedly provided services to Employee 5, they also received medical care at [Medical Provider 2] in [City 2], Illinois.[23]
- On 34 days that [Chiropractor 1] allegedly provided services to a former Bus Operator, Employee 13, the [Medical Provider 3] also allegedly provided Employee 13 the same or similar services.

b. Interview of CTA Employees

OEIG investigators interviewed several CTA employees on the following dates about the claims [Chiropractor 1] filed on their behalf, including: [24]

- Employee 1 – December 17, 2020;
- Employee 11 – January 19, 2021;
- Employee 12 (Bus Operator) – December 16, 2020;
- Employee 14 (Bus Operator) – April 30, 2021;
- Employee 15 (Bus Service Supervisor) – March 11, 2021;
- Employee 16 (Bus Operator) – March 29, 2021;
- Employee 17 (Bus Service Supervisor) – February 9, 2021;
- Employee 18 (Bus Operator) – April 28, 2021;
- Employee 19 (Bus Operator) – April 23, 2021; and
- Employee 20 (Bus Operator) – March 30, 2021.

These employees stated the following during their respective interviews:

- Each admitted that they were treated by [Chiropractor 1], but denied they were treated by him as many times as the claims filed on their behalf indicate. Those with

[21] During their interview, Employee 12 said they never saw [Chiropractor 1] at night and was not at work when they went to see him. Employee 12 also said they saw [Chiropractor 1] in the afternoons and after their work hours and that [Chiropractor 1]'s office was 15 minutes from their home and the [Location 2].
[22] During their interview, Employee 1 said they were unfamiliar with [Medical Provider 1] in New York and have never seen any physicians in New York.
[23] [Medical Provider 2] is approximately 130 miles southwest of [Chiropractor 1]'s office.
[24] The OEIG originally hoped to interview the top 10 billed employees (Employees 2-11), however, the OEIG discovered that all but Employee 11 were either deceased, retired, or no longer working for the CTA. Thus, the OEIG pursued interviews with other individuals who also had claims filed by [Chiropractor 1] as well as employees who worked at the [Location 1] with Ms. Taylor-Sykes.

dependents similarly denied that their dependents saw [Chiropractor 1] as frequently as the claim data suggested.[25]

- Each admitted that they gave personal information, such as their driver's license or other identification, and their [Health Insurance Company] insurance plan information to [Chiropractor 1].

- Each admitted that they received EOBs for the claims submitted by [Chiropractor 1] on their behalf but did not read or appeal them.

- Each admitted they did not receive any bills from [Chiropractor 1].[26]

- Each denied that [Chiropractor 1] ever offered to not charge them for services or that he ever offered them anything of monetary value in exchange for using their information to file insurance claims on their behalf.

- Each denied they were involved in [Chiropractor 1]'s insurance fraud scheme or knew he was filing claims for services he did not provide them or their dependents' behalf.

Further, each individual, except for Employee 11 and Employee 15, stated that they either currently work at the [Location 1]—where Ms. Taylor-Sykes worked—or worked there at some point in their time with the CTA. Employee 1 and Employee 18 specifically stated that Ms. Taylor-Sykes referred them to [Chiropractor 1]. The other individuals said they were referred to [Chiropractor 1] by other CTA employees or even others not affiliated with the CTA.

D. [The Commission has exercised its discretion to redact this heading pursuant to 5 ILCS 430/20-52.]

1. [The Commission has exercised its discretion to redact this heading pursuant to 5 ILCS 430/20-52.]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52][27] [28]

[25] During her interview, investigators inadvertently showed Employee 17 data that suggested their dependent, non-employee dependent 4, saw [Chiropractor 1] 64 times in a two-year period when the claim data actually reflects that non-employee dependent 4 saw [Chiropractor 1] only 58 times. Still, Employee 17 denied that non-employee dependent 4 saw [Chiropractor 1] every other day as the true claim data suggested or as frequently as the claim data suggested in a two-year period.

[26] Five employees said, however, that they paid [Chiropractor 1] co-payments.

[27] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]

[28] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]

- [The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.][29] [30] [31]
- [The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.][32].

2. [The Commission has exercised its discretion to redact this heading pursuant to 5 ILCS 430/20-52.]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.][33]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.][34]

III. ANALYSIS

A. Investigation Regarding Kimberly Taylor-Sykes

The OEIG investigated whether former CTA Bus Operator Kimberly Taylor-Sykes participated in [Chiropractor 1]'s insurance fraud scheme by recruiting or enhancing [Chiropractor 1]'s clientele. During the investigation, the OEIG reviewed claims submitted by [Chiropractor 1] for Ms. Taylor-Sykes, [CTA Employee 22], and [Individual 1], and found that [Chiropractor 1] submitted claims to [Health Insurance Company] for $24,455 worth of medical services he allegedly provided to them during 112 visits over the course of several years; in the end, [Chiropractor 1] was paid $5,247.67 by [Health Insurance Company] for these services and the CTA subsequently reimbursed [Health Insurance Company] in full for these payments. In addition, per [Health Insurance Company] records, Ms. Taylor-Sykes and her family would have been responsible for paying [Chiropractor 1] a significant amount of their own money for all of the alleged services he provided, as well. Ms. Taylor-Sykes stated neither she, [CTA Employee 22], nor [Individual 1] saw [Chiropractor 1] as many times as he submitted claims for, but she denied participating in or even knowing of [Chiropractor 1]'s scheme. There is evidence, however, that Ms. Taylor-Sykes' denial is dubious, and at the very least, the evidence demonstrates conduct unbecoming.

Amtrak Employee A told the FBI that they learned of [Chiropractor 1] through Ms. Taylor-Sykes telling them to provide their driver's license and insurance card in order for them to receive money from [Chiropractor 1]. According to Amtrak Employee A, they then provided these documents to Ms. Taylor-Sykes and began receiving money from [Chiropractor 1] thereafter. There is also evidence that Ms. Taylor-Sykes had reason to believe [Chiropractor 1] was over-

[29] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]
[30] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.].
[31] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]
[32] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]
[33] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]
[34] [The Commission has exercised its discretion to redact this footnote pursuant to 5 ILCS 430/20-52.]

billing. Ms. Taylor-Sykes said that she and [redacted] received EOBs describing the claims [Chiropractor 1] submitted on their behalf and clearly read them closely enough to know that she or [Individual 1] possibly owed [Chiropractor 1] a "ridiculous" amount of money, and yet she did not do anything about this other than to accept [Chiropractor 1]'s statement that she should "not to worry about" paying the claims in question. Even with this understanding of her own inaccurate billing records, Ms. Taylor-Sykes admitted to referring CTA employees and other individuals to [Chiropractor 1] and accepting $100 to $250 from [Chiropractor 1] each time she referred CTA employees, leading her to being paid approximately $700. Additionally, records show that 21 CTA employees who were billed for alleged services by [Chiropractor 1] worked at the same garage, at the same time Ms. Taylor-Sykes was working there.

While Ms. Taylor-Sykes, ultimately, denied participation in or even knowledge of [Chiropractor 1]'s scheme, Ms. Taylor-Sykes did know that [Chiropractor 1] would provide money to whomever gave him their driver's license and insurance information. She was also aware of the "ridiculous" balance on the EOBs, and the fact that [Chiropractor 1] told her she did not need to pay him. Furthermore, the fact that so many CTA employees who saw [Chiropractor 1] were from the same garage as Ms. Taylor-Sykes, and that she was making "referrals" and receiving a significant amount of money for these referrals, are all strong indicators that Ms. Taylor-Sykes knew more than she admitted. At the very least, Ms. Taylor-Sykes should not have been accepting money for referrals to a provider, who is ultimately paid with CTA funds, having reason to believe that he was not properly billing her. Ms. Taylor-Sykes' acceptance of money in exchange for referring other CTA employees to [Chiropractor 1], at minimum, constitutes conduct unbecoming of a CTA employee, and thus, the allegation that Ms. Taylor-Sykes violated CTA's General Rule Book is **[REDACTED]**.[35]

During the investigation, the OEIG learned that in addition to Ms. Taylor-Sykes and [redacted], 62 other CTA employees and their dependents—including 21 individuals who worked at the same garage as Ms. Taylor-Sykes—purportedly saw [Chiropractor 1] for services at some point between at least 2016 and 2018. During this time, [Chiropractor 1] submitted 2,574 claims on these individuals' behalf and was paid $131,042.69 by [Health Insurance Company] for the services he allegedly provided, which the CTA then reimbursed [Health Insurance Company] for. Notably, claim data showed that [Chiropractor 1] was an out-of-network health care provider for all of these individuals and that they each would have owed him a significant amount of their own money; the majority were allegedly treated for the same and similar few conditions; and generally, [Chiropractor 1] submitted claims reflecting that he saw each person every day or every other day during several periods of time. The claim data also showed that [Chiropractor 1] claimed to have provided services to several employees on the same days and for similar services that other medical providers also claimed to have seen the employees.

During their interviews with OEIG investigators, many of the CTA employees admitted to seeing [Chiropractor 1] for medical services. Each individual denied seeing [Chiropractor 1] as many times, and as frequently, as the claims filed on their behalf indicate, but each also denied even knowing that [Chiropractor 1] filed false claims on their behalf. Although they acknowledged

[35] The OEIG concludes that an allegation is "[REDACTED]" when it has determined that there is reasonable cause to believe that a violation of law or policy has occurred, or that there has been fraud, waste, mismanagement, misconduct, nonfeasance, misfeasance, or malfeasance.

receiving EOBs for the claims submitted, each said they simply did not look at them. In addition, each employee denied providing their identification and medical cards so [Chiropractor 1] could file false claims on their behalf, and denied receiving any compensation or any offer from [Chiropractor 1] to not charge for medical services so he could file false claims on their behalf. Without more, no further findings are being made.

B. [The Commission has exercised its discretion to redact this heading pursuant to 5 ILCS 430/20-52.]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.]

[The Commission has exercised its discretion to redact this paragraph pursuant to 5 ILCS 430/20-52.]

IV. [REDACTED] AND RECOMMENDATIONS

As a result of its investigation, the OEIG concludes that there is **REASONABLE CAUSE TO ISSUE THE FOLLOWING [REDACTED]:**

- **[REDACTED]** – Kimberly Taylor-Sykes conducted herself in a manner that is unbecoming of a CTA employee in violation of the CTA General Rule Book by accepting money for referring other CTA employees to [Chiropractor 1].
- **[The Commission has exercised its discretion to redact this sentence pursuant to 5 ILCS 430/20-52.]**

Given Ms. Taylor-Sykes' retirement from the CTA, the OEIG recommends that the CTA place a copy of this report in Ms. Taylor-Sykes' personnel file and that she not be rehired. Further, Ms. Taylor Sykes should not have been able to benefit from referring people to [Chiropractor 1] and the current policies do not prohibit or discourage these types of financial gain. Therefore, the OEIG further recommends that the CTA consider expanding its Conflict of Interest and/or Solicitation or Receipt of Money for Advice or Assistance policies. In particular, the CTA should consider language that would prohibit a CTA employee or their family members from soliciting or accepting any money or other thing of value in return for referring other CTA employees for services that would involve, whether directly or indirectly, CTA funding or insurance. While [Chiropractor 1] is not currently practicing medicine and is unlikely to resume practicing, the OEIG nevertheless recommends that the CTA work with [Health Insurance Company] to ensure [Chiropractor 1] is not able to submit claims on behalf of any CTA employees going forward and work to ensure that any other possible instances of insurance fraud are swiftly detected. Finally, the OEIG recommends that CTA train and educate employees about potential insurance fraud and questionable referral or kickback programs, as well as the importance of reading their EOBs or other medical benefit documentation so they can be alert for red flags and report it to CTA and [Health Insurance Company] accordingly.

No further investigative action is warranted and this case is considered closed.

Date: November 22, 2021

Office of Executive Inspector General
for the Agencies of the Illinois Governor
69 W. Washington St., Suite 3400
Chicago, IL 60602

Alexa Vouros
Assistant Inspector General

Jasmine Velazquez
Supervising Investigator #133

Office of Executive Inspector General
for the Agencies of the Illinois Governor
www.inspectorgeneral.illinois.gov

AGENCY OR ULTIMATE JURISDICTIONAL AUTHORITY RESPONSE FORM

Case Number: 19-0385 Return 20 Days After Receipt

Please check the box that applies. (Please attach additional materials, as necessary.)

☐ We have implemented all of the OEIG recommendations. Please provide details as to actions taken:

☒ We will implement some or all of the OEIG recommendations but will require additional time to do so.
We will report to OEIG within 45 days from the original return date.

☐ We do not wish to implement some or all of the OEIG recommendations. Please provide details as to what actions were taken, if any, in response to OEIG recommendations:

[redacted]
Signature

CTA, Deputy General Counsel, Compliance, Policy & Appeals
Print Agency and Job Title

Stephen L. Wood
Print Name

December 10, 2021
Date

TO: Office of the Executive Inspector General

FROM: Thomas McKone
Chief Administrative Officer

DATE: February 7, 2022

RE: OEIG Case No. 19-0385 – FINAL REPORT RESPONSE

The above-referenced final report (Final Report) involves allegations that former Bus Operator Kimberly Taylor-Sykes participated in her chiropractor [redacted]'s insurance fraud scheme by recruiting new patients in return for a finder's fee. [redacted]. With respect to Ms. Taylor-Sykes, the OEIG's investigation did not find that she was directly involved in [redacted]'s insurance fraud scheme. However, the OEIG found that she conducted herself in a manner that is unbecoming of a CTA employee because she accepted $700 for referring other CTA employees to [redacted] and she knew that her billing records regarding [redacted] were inaccurate insofar as they made charges to the insurer for medical services that she had not received and when she asked about them, he told her that she personally would not have to pay for any of the services not received.

CTA concurs with the finding made by the OEIG in this Final Report, namely that Ms. Taylor-Sykes conducted herself in a manner that is unbecoming of a CTA employee in violation of the CTA General Rule Book by accepting money for referring other CTA employees to [redacted] when she was aware that he engaged in practices that were indicative of insurance fraud. This is CTA's response detailing the actions CTA has taken with regards to the four recommendations the OEIG made in its Final Report about this case.

CTA's Response to the OEIG's Recommendations

Given Ms. Taylor-Sykes' retirement from the CTA, the OEIG recommends that the CTA place a copy of this report in Ms. Taylor-Sykes' personnel file and that she not be rehired.

Ms. Taylor-Sykes retired from the CTA effective August 1, 2020. A copy of this Final Report has been placed in Ms. Taylor-Sykes's permanent personnel file.

The OEIG further recommends that the CTA consider expanding its Conflict of Interest and/or Solicitation or Receipt of Money for Advice or Assistance policies. In particular, the CTA should consider language that would prohibit a CTA employee or their family members

from soliciting or accepting any money or other thing of value in return for referring other CTA employees for services that would involve, whether directly or indirectly, CTA funding or insurance.

With respect to the OEIG's recommendation that CTA consider expanding its Conflict of Interest and/or Solicitation or Receipt of Money for Advice or Assistance policies, currently, Section 2.5 of the CTA's Ethics Code prohibits solicitation or receipt of money for advice or assistance. Particularly, this section states that "No officer or employee, or the spouse, domestic partner or minor child of any of them, or any immediate family member residing with the officer or employee, shall solicit or accept any money or other thing of value including, but not limited to, gifts, favors, services or promises of future employment, in return for advice or assistance on matters concerning the operation or business of the CTA; provided, however, that nothing in this Section shall prevent an officer or employee or the spouse or domestic partner of an officer or employee from accepting compensation for services wholly unrelated to the officer's or employee's CTA duties and responsibilities and rendered as part of an approved non-CTA employment, occupation or profession." While, in this case, the payment (referral fee) is not being provided in exchange for "advice or assistance on matters concerning the operation or business of CTA," CTA will include in future ethics training classes that this provision could prohibit receiving referral fees in connection with medical care or other services paid by CTA insurance.

While [redacted] is not currently practicing medicine and is unlikely to resume practicing, the OEIG nevertheless recommends that the CTA work with [redacted] to ensure [redacted] is not able to submit claims on behalf of any CTA employees going forward and work to ensure that any other possible instances of insurance fraud are swiftly detected.

With respect to the OEIG's recommendation that the CTA work with [redacted] to ensure [redacted] is not able to submit claims on behalf of any CTA employees going forward, CTA has worked with [redacted] to place a permanent flag on [redacted] in [redacted]'s payment system. While [redacted]'s chiropractor's license remains indefinitely suspended, if he does resume practice in the future, the flag requires [redacted] to more highly scrutinize [redacted]'s claim submissions. The flag requires him to send in additional medical records to support his claims, and [redacted] may use those documents to determine if the claim is fraudulent.

With respect to the OEIG's recommendation that CTA work to ensure that any other possible instances of insurance fraud are swiftly detected, the CTA met with [redacted] representatives to discuss such efforts. [redacted] informed the CTA that it utilizes robust investigation methods to detect and prevent insurance fraud schemes from taking place in the future. [redacted] employs a team of data scientists who regularly meet with an outside vendor, [redacted], to identify emerging trends and providers of interest. Furthermore, [redacted] conducts its own analysis on providers of interest. When [redacted] investigates a provider for fraud, it regularly places a hold on outgoing payments associated with claims from that provider and involves law enforcement in its investigation. If [redacted] affirmatively finds that a provider committed insurance fraud, it decides on a case-by-case basis either to deny all new claims from a provider or to hold payments to a provider until they send in additional medical documentation. As such, [redacted] continuously monitors the actions of medical providers to prevent fraud and return stolen money back to the CTA.

CTA discussed the details of [redacted]'s fraud scheme with [redacted]'s Special Investigations Unit and found that, under the data analytics system used during the relevant time period, the dollar amount involving CTA employees and their dependents was not high enough to trigger [redacted]'s fraud alert metrics as most other cases involve significantly larger amounts of money. However, since 2020, [redacted] has successfully integrated, among other things, artificial intelligence into its existing data analytics system to detect fraud, and under the new system, instances of fraud at dollar amounts similar to [redacted]'s scheme would trigger [redacted]'s fraud detection metrics.

Finally, the OEIG recommends that CTA train and educate employees about potential insurance fraud and questionable referral or kickback programs, as well as the importance of reading their Explanation of Benefits (EOBs) or other medical benefit documentation so they can be alert for red flags and report it to CTA and [redacted] accordingly.

CTA employees receive an EOB after [redacted] processes a claim from a medical provider. The EOB details important billing information for the insured employee, such as the charges submitted for the services allegedly provided to the patient, the amount owed by the patient, the type of service received, and the date of service. Every EOB includes a warning at the top of the first page, which states if an employee has any questions about the EOB, they should call [redacted]'s Customer Service at the number immediately above the warning or on the back of their [redacted] ID card.

As part of CTA's discussions with [redacted] regarding [redacted]'s insurance fraud scheme, CTA reviewed the enrollment process as well as the insurance claim process. During this review, [redacted] provided CTA with a document developed by its Special Investigations Unit that explains what CTA employees can do to detect, avoid, and prevent health care fraud. This document gives CTA employees various actions they can take to prevent fraud and provides concrete examples of what health care fraud may look like in practice. The document warns CTA employees to be wary of services that are free and encourages them to closely review their EOBs and other medical documents. Additionally, the document warns CTA employees that fraud may exist when a provider or other person offers money to visit a specific doctor or clinic, or to refer others to make such visits. Finally, the document encourages CTA employees to report suspected instances of fraud and provides the [redacted] Special Investigations Unit email and physical address, and [redacted]'s customer service number to report potential fraud.

CTA will send this document to employees via email and will post it at CTA locations. CTA will also provide and explain this document alongside the other materials new CTA employees receive during the CTA Benefit Group's pre-hire meeting where CTA explains its health insurance options.

No further action will be taken on this matter and CTA considers this complaint closed.

cc: [redacted], CTA Chief of Staff
[redacted], OEIG