**IN AND BEFORE THE OKLAHOMA STATE BOARD OF MEDICAL LICENSURE AND SUPERVISION STATE OF OKLAHOMA**



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| **STATE OF OKLAHOMA EX REL. THE OKLAHOMA BOARD OF MEDICAL LICENSURE AND SUPERVISION,** | ) | |
| **Plaintiff,** | ) | |
| **v.** | ) | **Case No. 05-08-2991** |
| **BILLY CONN BEETS, M.D., LICENSE NO. 21208** | ) | |
| **Defendant.** | ) | |

## FINAL ORDER OF SUSPENSION

This cause came on for hearing before the Oklahoma State Board of Medical Licensure and Supervision (the "Board") on November 3, 2006, at the office of the Board, 5104 N. Francis, Suite C, Oklahoma City, Oklahoma, pursuant to notice given as required by law and the rules of the Board.

Elizabeth A. Scott, Assistant Attorney General, appeared for the plaintiff and defendant appeared in person and through counsel, Daniel Gamino.

The Board *en banc* after hearing arguments of counsel, reviewing the exhibits admitted and the sworn testimony of witnesses, and being fully advised in the premises, found that there is clear and convincing evidence to support the following Findings of Fact, Conclusions of Law and Orders:

## Findings of Fact

1. The Board is a duly authorized agency of the State of Oklahoma empowered to license and oversee the activities of physicians and surgeons in the State of Oklahoma pursuant to 59 Okla. Stat. §480 *et seq.* The Board has jurisdiction over this matter, and notice has been given in all respects in accordance with law and the rules of the Board.

2. Defendant, Billy Conn Beets, M.D., holds Oklahoma license no. 21208.

## Patient BDK

3. On or about June 7, 2005, Defendant treated Patient BDK, a two (2) month old boy with Medicaid insurance. Defendant's chart reflects that he diagnosed the child with Acute Bronchitis. Based upon this diagnosis, Defendant issued **eleven (11) prescriptions** to Patient BDK. These prescriptions include **Zofran, Patanol, Zymar, Zyrtec, Ibuprofen, Cipro HC, Antipyrine with Benzocaine, Omnicef, Terconazole, Ciclopirox and Xopenex**, at a total cost of **$1,125.86**. Defendant's chart on this patient reveals that Patient BDK was overmedicated and received multiple medications for the same alleged condition. Additionally, Patient BDK was given Zofran, a drug given to patients on chemotherapy or radiation, which should not be given to any child under the age of four (4). Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

4. On or about June 14, 2005, Patient BDK returned to Defendant for a routine infant check-up, at which time he was prescribed **Elidel** for cradle cap, at a total cost of **$359.11**.

5. On or about July 25, 2006, Defendant treated Patient BDK for Otitis media and Otitis externa. Based upon this diagnosis, Defendant issued **five (5) prescriptions** to Patient BDK. These prescriptions include **Omnicef, Cipro HC, Ciprodex, Ibuprofen and Antipyrine with Benzocaine**, at a total cost of **$277.26**. Defendant's chart on this patient reveals that Patient BDK was overmedicated, received multiple medications for the same condition, and was exposed to multiple unnecessary medications. Defendant's chart additionally reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

## Patient BSK

6. On or about June 20, 2005, Defendant treated Patient BSK, a nine (9) month old boy with Medicaid insurance. Defendant's chart reflects that the patient was "pulling at ears" and coughing. The only vital signs in the chart are the child's height, weight, and temperature of 98.1. Based upon this, Defendant diagnosed the child with Otitis media, acute upper respiratory infection and allergic rhinitis, and issued **ten (10) prescriptions** to Patient BSK. These prescriptions include **Zofran, Cipro HC, Auralgan Otic, Patanol, Zymar, Zyrtec, Omnicef, Ciclopirox, Terconazole, and Ibuprofen**, at a total cost of **$862.16**. Defendant's chart on this patient reveals that Patient BSK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Additionally, Patient BSK was given Zofran, a drug given to patients on chemotherapy or radiation, which should not be given to any child under the age of four (4). Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

## Patient CBK

7. On or about March 8, 2005, Defendant treated Patient CBK, a fifteen (15) year old girl with Medicaid insurance. Defendant's chart reflects that the patient complained of pain (from a car wreck four (4) years earlier), migraines, indigestion, nausea, a rash and muscle spasms. Based upon the patient's complaints, Defendant issued **six (6) prescriptions** to Patient CBK. These prescriptions include **Imitrex, Zyvox, Zofran ODT, Skelaxin, Prevacid and Etodolac**, at a total cost of **$2,208.75**. The patient was given Imitrex without a diagnosis of migraines. Additionally, Patient CBK was given Zofran, a drug given to patients on chemotherapy or radiation. No diagnoses were substantiated by any physical findings. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

8. On or about April 14, 2005, Defendant again treated Patient CBK. Defendant's chart reflects that the patient complained of fatigue, nausea, asthma and allergies. Based upon the patient's complaints, Defendant issued **fourteen (14) prescriptions** to Patient CBK. These prescriptions include **Zofran ODT, Methylprednisolone, Astelin, Advair Diskus, Nasonex, Duoneb, Xopenex, Patanol, Maxair Autohaler, Aerochamber, Omeprazole, Imitrex, Singulair and Loratadine**, at a total cost of **$1,334.58**. Defendant's chart on this patient reveals that Patient CBK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. The patient was given Imitrex without a diagnosis of migraines. Additionally, Patient CBK was given Zofran, a drug given to patients on chemotherapy or radiation. The patient chart reflects on all physicals that the lungs were "CTA", yet the patient was given multiple redundant asthma medications. No diagnoses were substantiated by any physical findings. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

9. On or about May 3, 2005, Defendant again treated Patient CBK. Defendant's chart reflects that the patient complained of headaches and nausea and requested refill on all medications. Based upon this, Defendant issued **five (5) prescriptions** to Patient CBK. These prescriptions include **Zyvox, Zofran ODT, Skelaxin, Prevacid and Etodolac**, at a total cost of **$2,037.67**. No diagnoses were substantiated by any physical findings. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

10. Defendant's chart reflects that on or about May 27, 2005, the patient's mother requested refills on all "chronic meds". The patient chart contains no reference to what prescriptions were authorized by Defendant in response to this request. Pharmacy records reflect that on this date, Defendant authorized **ten (10) prescriptions** to Patient CBK for **Imitrex,**

**Zofran ODT, Astelin, Advair Diskus, Singulair, Maxair Autohaler, Patanol, Xopenex, Duoneb and Nasonex**, at a total cost of **$1,560.46.** No patient visit is noted in the chart. Defendant's chart on this patient reveals that Patient CBK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. The patient was given Imitrex without a diagnosis of migraines. Additionally, Patient CBK was given Zofran, a drug given to patients on chemotherapy or radiation. The patient chart reflects on all physicals that the lungs were "CTA", yet the patient was given multiple redundant asthma medications. No diagnoses were substantiated by any physical findings. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

11. Defendant's chart reflects that on or about July 5, 2005, Defendant authorized **eleven (11) prescriptions** to Patient CBK for **Omeprazole, Zofran ODT, Loratadine, Nasonex, Duoneb, Xopenex, Patanol, Maxair Autohaler, Singulair, Advair Diskus and Astelin**, at a total cost of **$1,633.80.** No patient visit is noted in the chart, and the patient was a "no show" at her previously scheduled appointment. Defendant's chart on this patient reveals that Patient CBK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. The patient was given Imitrex without a diagnosis of migraines. Additionally, Patient CBK was given Zofran, a drug given to patients on chemotherapy or radiation. The patient chart reflects on all physicals that the lungs were "CTA", yet the patient was given multiple redundant asthma medications. No diagnoses were substantiated by any physical findings. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

**Patient KMK**

12. On or about June 3, 2005, Defendant treated Patient KMK, a fifteen (15) year old girl with Medicaid insurance. Defendant's chart reflects that the patient requested a full physical, had a sty on her eye, complained of knee pain and wanted to be checked for anemia. No vital signs are reflected in the chart, nor were any tests ordered. Defendant then diagnosed the patient with allergic rhinitis and issued **twelve (12) prescriptions** to Patient KMK. These prescriptions include **Arava, Methylprednisolone, Levaquin, Floxin, Antipyrine with Benzocaine, Zofran ODT, Singulair, Flonase, Astelin, Patanol, Zymar and Loratadine**, at a total cost of **$1,913.46**. Defendant's chart on this patient reveals that Patient KMK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Additionally, Patient KMK was given Zofran, a drug given to patients on chemotherapy or radiation, when the patient had no complaints of nausea. The patient was also given Arava, a drug given for Rheumatoid Arthritis, without any documented need for the drug. The chart reflects that the "ENT" were clear, yet Defendant prescribed Flonase and Loratadine. The chart reflects that the chest was "CTA", yet Defendant prescribed Singulair. Defendant's chart reveals that he did not establish a legitimate medical need for all of these

medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

**Patient KPK**

13. On or about May 5, 2005, Defendant treated Patient KPK, a seven (7) year old girl with Medicaid insurance. Defendant's chart reflects that the patient complained of a sore throat and sinus drainage. No vital signs other than a temperature of 98.4 were recorded. Defendant then diagnosed the patient with an upper respiratory infection and issued **nine (9) prescriptions** to Patient KPK. These prescriptions include **Zofran, Singulair, Claritin, Patanol, Flonase, Astelin, Orapred, Omnicef and Ibuprofen**, at a total cost of **$775.61**. Defendant's chart on this patient reveals that Patient KPK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Additionally, Patient KPK was given Zofran, a drug given to patients on chemotherapy or radiation. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

14. On or about June 27, 2005, Patient KPK received **five (5) prescriptions** from Defendant: **Astelin, Singulair, Claritin, Patanol and Flonase**, at total cost of **$307.65**. Defendant's chart on this patient contains no documentation of these prescriptions and no documentation of any office visit. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

**Patient MPK**

15. On or about May 5, 2005, Defendant treated Patient MPK, an eleven (11) year old boy with Medicaid insurance. Patient MPK is the brother of Patient KPK in paragraphs 13-14 above. Defendant's chart reflects that the patient was requesting Adderall and complained of some wheezing. No vital signs are noted in the chart other than temperature. Defendant then diagnosed the patient with ADHD and issued **eight (8) prescriptions** to Patient MPK. These prescriptions include **Amphetamine Salt Combo, Loratadine, Orapred, Singulair, Flonase, Patanol, Astelin and Maxair Autohaler**, at a total cost of **$631.08**. Defendant's chart on this patient reveals that Patient JGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. No diagnosis of any respiratory symptoms was made, but multiple medications were given for this. The chart contains no diagnosis to support the prescriptions for Patanol and Astelin. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

16. Defendant's chart reflects that on or about June 27, 2005, Defendant authorized **five (5) prescriptions** to Patient MPK for **Patanol, Astelin, Maxair Autohaler, Singulair and Flonase**, at a total cost of **$387.24**. No patient visit is noted in the chart, nor is there any notation that a telephone request for the medications was ever made. The patient chart contains no reference to these prescriptions. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

**Patient JGK**

17. On or about May 12, 2005, Defendant treated Patient JGK, a twelve (12) year old boy with Medicaid insurance. Defendant's chart reflects that the patient requested a checkup and complained of a rash and allergies. No vital signs were recorded in the chart. Defendant then diagnosed the patient with depression, allergic rhinitis and contact dermatitis and issued **nine (9) prescriptions** to Patient JGK. These prescriptions include **Zofran ODT, Patanol. Flonase, Loratadine, Singulair, Astelin, Orapred, Triamcinolone Acetonide and Ibuprofen**, at a total cost of **$705.94**. Defendant's chart on this patient reveals that Patient JGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Additionally, Patient JGK was given Zofran, a drug given to patients on chemotherapy or radiation, yet the patient had no complaints of vomiting. Further, while the physical exam notes that the patient's eyes are clear, Defendant prescribed Patanol and Astelin. The patient's "ENT" are noted to be clear, yet Defendant prescribed Flonase and Loratadine. The patient's chest is noted to be "CTA", yet Defendant prescribed Singulair. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

18. On or about May 19, 2005, Patient JGK received one (1) prescription for Amitriptyline HCL from Defendant based upon his claim that "Prozac makes him violent". The only vital signs recorded are the patient's weight and temperature.

19. Defendant's chart reflects that on or about June 14, 2005, Defendant authorized six (6) prescriptions to Patient JGK for **Flonase, Singulair, Astelin, Patanol, Triamcinolone Acetonide and Ibuprofen**, at a total cost of **$318.03**. No patient visit nor any reason for the medications is noted in the chart.

20. On or about June 21, 2005, Defendant treated Patient JGK. Defendant's chart reflects that the patient "needs anti-anxiety" medications. No vital signs are noted in the chart. Defendant then diagnosed the patient with Bipolar Disorder and issued **twelve (12) prescriptions** to Patient JGK. These prescriptions include **Clonidine HCL, Buspirone HCL, Ibuprofen, Zymar, Cipro HC, Patanol, Loratadine, Flonase, Astelin, Singulair, Antipyrine with Benzocaine and Zofran ODT**, at a total cost of **$602.85**. Defendant's chart on this patient

reveals that Patient JGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Additionally, Patient JGK was again given Zofran, a drug given to patients on chemotherapy or radiation, yet the patient had no complaints of vomiting. Further, while the physical exam notes that the patient's eyes are clear, Defendant prescribed Patanol and Astelin. The patient was diagnosed with and treated for Bipolar Disorder with no documentation to support this diagnosis. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

21. Defendant's chart reflects that on or about July 21, 2005, Defendant authorized four (4) prescriptions to Patient JGK for **Flonase, Singulair, Astelin, and Patanol.** No patient visit nor any reason for the medications is noted in the chart.

## Patient TGK

22. On or about May 12, 2005, Defendant treated TGK, a ten (10) year old boy with Medicaid insurance. Patient TGK is the brother of Patient JGK in paragraphs 17-21 above. Defendant's chart reflects that the purpose of the visit was a checkup, and that the patient had a past medical history of Dyslexia, ADD and allergic rhinitis. No vital signs are noted in the chart. Defendant then diagnosed the patient with ADD and allergic rhinitis and issued **eight (8) prescriptions** to Patient TGK. These prescriptions include **Methylphenidate HCL, Zofran ODT, Ibuprofen, Patanol, Astelin, Singulair, Flonase and Loratadine**, at a total cost of **$635.13**. Defendant's chart on this patient reveals that Patient TGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Defendant's chart reflects that the patient's eyes were clear, yet he prescribed Patanol and Astelin. The chart notes that the "ENT" are clear, yet he prescribed Flonase and Claritin. The patient's chest is noted to be "CTA", yet he prescribed Singulair. The chart does not reflect any vomiting, yet the patient was prescribed Zofran. The chart contains no findings to support a diagnosis of ADD or allergies, yet medications were prescribed for these conditions. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

23. On or about May 18, 2005, Defendant issued a prescription for **Strattera** to Patient TGK. Defendant's chart contains no reference to this prescription, nor to any telephone call or patient visit relating to this prescription. Defendant's chart reveals that he did not establish a legitimate medical need for this medication, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

24. Defendant's chart reflects that on or about June 14, 2005, Defendant authorized "refills". The chart contains no reference as to what prescriptions were refilled or the reason why

they were refilled. Pharmacy records reflect that Defendant issued **five (5) prescriptions** on this date to Patient TGK for **Patanol, Astelin, Ibuprofen, Singulair and Flonase**, at a total cost of **$326.97**. No patient visit is noted in the chart, nor is there any notation that a telephone request for the medications was ever made. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

25. Defendant's chart reflects that on or about July 14, 2005, Defendant again authorized "refills". The chart contains no reference as to what prescriptions were refilled or the reason why they were refilled. Pharmacy records reflect that Defendant issued **four (4) prescriptions** on this date to Patient TGK for **Patanol, Astelin, Singulair and Flonase**, at a total cost of **$301.14.** No patient visit is noted in the chart, nor is there any notation that a telephone request for the medications was ever made. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

**Patient SGK**

26. On or about May 12, 2005, Defendant treated SGK, an eight (8) year old girl with Medicaid insurance. Patient SGK is the sister of Patient TGK and Patient JGK in paragraphs 17-25 above. Defendant's chart reflects that the purpose of the visit was a checkup, and that the patient had a past medical history of allergies. No vital signs are noted in the chart. Defendant then diagnosed the patient with allergic rhinitis and issued **seven (7) prescriptions** to Patient SGK. These prescriptions include **Zofran ODT, Ibuprofen, Patanol, Astelin, Singulair, Flonase and Loratadine**, at a total cost of **$620.04**. Defendant's chart on this patient reveals that Patient SGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Defendant's chart reflects that the patient's eyes were clear, yet he prescribed Patanol and Astelin. The chart notes that the "ENT" are clear, yet he prescribed Flonase and Claritin. The patient's chest is noted to be "CTA", yet he prescribed Singulair. The chart does not reflect any vomiting, yet the patient was prescribed Zofran. The chart contains no findings to support a diagnosis of allergies, yet medications were prescribed for this condition. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

27. Defendant's chart reflects that on or about June 14, 2005, the patient called for refills. The chart contains no reference as to what prescriptions were refilled or the reason why they were refilled. Pharmacy records reflect that Defendant issued **five (5) prescriptions** on this date to Patient SGK for **Patanol, Astelin, Ibuprofen, Singulair and Flonase**, at a total cost of **$326.97**. No patient visit is noted in the chart. Defendant's chart on this patient reveals that Patient SGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Defendant's chart reveals that he did not

establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

28. Defendant's chart reflects that on or about July 14, 2005, the patient again called for refills. The chart contains no reference as to what prescriptions were refilled or the reason why they were refilled. Pharmacy records reflect that Defendant issued **four (4) prescriptions** on this date to Patient SGK for **Patanol, Astelin, Singulair and Flonase**, at a total cost of **$301.14.** No patient visit is noted in the chart. Defendant's chart on this patient reveals that Patient SGK was overmedicated, received multiple medications for the same alleged condition, and was exposed to multiple unnecessary medications. Defendant's chart reveals that he did not establish a legitimate medical need for all of these medications, that he did not perform an adequate physical examination, and that he did not maintain an office record which accurately reflects the evaluation, treatment and medical necessity of treatment of the patient.

29. Based upon complaints from these and other patients, the Oklahoma Health Care Authority ("OHCA") conducted an investigation of Defendant. After reviewing Defendant's records, on or about September 23, 2005, the OHCA terminated Defendant's Medicaid contract based upon the following findings:

a. Defendant's prescribing behavior was inappropriate;
b. Defendant's medical recordation did not substantiate the prescriptions he had prescribed;
c. Diagnoses made by Defendant did not comport with any physical exam documentation made regarding many patients he had seen;
d. Defendant violated the Medicaid recipient's freedom of choice by insisting they utilize the pharmacy contained in his clinics;
e. Defendant's clinical documentation was poor; and
f. Defendant's prescribing patterns show abuse or misuse of Medicaid Program funds.

30. Defendant is guilty of unprofessional conduct in that he:

A. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(13) and OAC 435:10-7-4(39).

B. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509(18) and 435:10-7-4(41).

## Conclusions of Law

1. The Board has jurisdiction and authority over the Defendant and subject matter herein pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act (the "Act") and its applicable regulations. The Board is authorized to enforce the Act as necessary to protect the public health, safety and welfare.

2. Defendant is guilty of unprofessional conduct in that he:

A. Violated any provision of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board in violation of 59 O.S. §509(13) and OAC 435:10-7-4(39).

B. Failed to maintain an office record for each patient which accurately reflects the evaluation, treatment, and medical necessity of treatment of the patient in violation of 59 O.S. §509(18) and 435:10-7-4(41).

3. The Board further found that the Defendant's license should be **SUSPENDED** based upon any or all of the violations of the unprofessional conduct provisions of 59 O.S. §509 (13) and (18) and OAC 435: 10-7-4 (39) and (41).

## Order

IT IS THEREFORE ORDERED by the Oklahoma State Board of Medical Licensure and Supervision as follows:

1. The license of Defendant, Billy Conn Beets, M.D., Oklahoma license no. 21208, is hereby **SUSPENDED INDEFINITELY** as of the date of this hearing, November 2, 2006. Defendant's license shall remain suspended until he (a) completes an evaluation as to his competency and his ability to practice safely at a facility approved in advance by the Board Secretary, and (b) provides a copy of the evaluation to the Board Secretary, at which time he may appear before the Board to seek reinstatement of his license.

2. Promptly upon receipt of an invoice, Defendant shall pay all costs of this action authorized by law, including without limitation, legal fees and costs, investigation costs, staff time, salary and travel expenses, witness fees and attorney's fees.

3. Defendant's suspended license shall not be reinstated unless Defendant has reimbursed the Board for all taxed costs and expenses incurred by the State of Oklahoma.

Dated this 16 day of November, 2006.

Gerald C. Zumwalt, M.D., Secretary
Oklahoma State Board of
Medical Licensure and Supervision

**CERTIFICATE OF SERVICE**

I certify that on the 16 day of November, 2006, I mailed, via first class mail, postage prepaid, a true and correct copy of this Order to Daniel Gamino, 3315 N.W. 63rd Street, Oklahoma City, OK 73116 and to Billy Conn Beets, 1300 N.W. 156th Terrace, Edmond, OK 73013.

Janet Swindle