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BOARD NEWS

Rulemaking Hearing: June 29, 2012 - "Electronic Filing/Signature-Related" Rules

At its May 8 meeting, the Board proposed adopting permanent amendments to its administrative rules. These proposals respond to recommendations presented by the Board's "technology" advisory committee, which considered comments received from parties, practitioners, and staff during the Board's "rule review" process.

Notice of this rulemaking action was filed with the Secretary of State's office. Electronic copies of these rulemaking materials are available on WCB's website (under the category "Laws & Rules"): www.wcb.oregon.gov. Copies will also be distributed to parties and practitioners on WCB's mailing list.

A rulemaking hearing for these proposed rule amendments has been scheduled for June 29, 2012 at 9:30 a.m. at the Board's Salem office (2601 25th St. SE, Ste. 150, Salem, OR 97302-1280). Any written comments submitted in advance of the hearing may be directed to Debra Young, the rulemaking hearing officer. Those comments may be mailed to the above address, faxed to 503-373-1600, e-mailed to rulecomments.wcb@state.or.us or hand-delivered to a permanently staffed Board office (Salem, Portland, Eugene, Medford).

Among some of the proposed rule changes are; (1) expansion of "filing" and "service" of requests for hearing/review to include electronic transmission by means of WCB's website portal (a system which the Board will be testing in the coming months, with a goal of having it available by Fall 2012); (2) expanding "filing/service" by means of "electronic transmission" to include extension requests of the briefing schedule (as well as a motions for waiver of such rules under OAR 438-011-0030); (3) defining "signatures" to include those provided in writing, by FAX, by scanning, by website portal, or by other electronic means; and (4) expand the means for receiving announcement of a CDA approval order (for CDAs involving represented workers) to include WCB's website portal (for "registered users," such as attorneys, insurers, self-insured employers, claim administrators, and processing agencies), and posting notice of the approval on the Board's website (unrepresented claimants would continue to receive notification of the CDA approval by means of the postcard method).

Office Closures - Furlough Days

As part of its strategy to address its own budget cuts, Oregon's state government will close most agencies on various Fridays falling throughout the current two-year budget period. Those remaining Fridays are as follows:

- Friday, August 17, 2012
- Friday, October 19, 2012
- Friday, November 23, 2012
- Friday, January 18, 2013
- Friday, April 19, 2013
- Friday, May 24, 2013

Administrative Rule Review Update

As previously announced, the Board Members are conducting a plenary review of the rules of practice and procedure found in Chapter 438 of the Oregon Administrative Rules. In conducting this review, the Members plan to discuss comments regarding the Board's administrative rules that have been received from the workers' compensation community. (Summaries of those comments have been posted on WCB's website.) Those discussions are continuing.

At those meetings, the Members will not be proposing the adoption of any new or amended rules. Instead, following their discussion of these "rule review" comments, the Members may choose one or more of the following options: (1) take no further action concerning the comment; (2) refer the comment to staff for further research or to draft language for future consideration as a possible rule amendment; (3) defer action for further deliberation concerning the comment or rule; or (4) refer the comment, concept, or rule to an advisory committee for a recommendation.

Summaries of the decisions reached at its previous "rule review" meetings have been included in previous issues of the Board's News & Case Notes.

Below is a summary of the Board's decisions at its May 8, 2012 meeting, which concerned the following matter:

OAR 438-009-0022 (Required Information in a Claim Disposition Agreement). The Members further discussed section (2), which concerns proposed dispositions regarding "non-English comprehending" claimants. After doing so and considering written and oral comments from the public and its staff, the Members decided to refer the matter to an advisory committee.

Help is Available for Health Care Providers

Did you know that the Medical Section of the Workers' Compensation Division (WCD) has an online workers' compensation guide for health care providers on its website? Or that the WCD Medical Section has an outreach team available to answer questions from health care providers about medical services and billing and to provide free in-office training for providers? If you, your client, or a health care provider needs help understanding the workers' compensation rules and procedures relating to medical services, the WCD Medical Section can help. The Medical Section is charged with improving the delivery and affordability of medical services in the workers' compensation community and offers training and education, develops outreach tools and resources, and works closely with health care providers and other stakeholders to write Oregon administrative rules. The Medical Section can help you learn

how to get providers' bills paid, file a medical dispute, reduce errors, navigate the WCD website, and more. For questions about workers' compensation, to schedule free training, or to submit rules issues, contact the Medical Section at 503-947-7606 or email wcd.medicalquestions@state.or.us.

CASE NOTES

Claim Processing: "268(10)" - "Suspended" PPD During ATP - "Post-ATP" TTD Continues if Condition Not "Med Stat" - PPD Redetermined at Claim Closure

PPD suspended during "ATP" was subsumed in "post-ATP" Notice of Closure "redetermination."

Timothy R. Gilbert, 64 Van Natta 818 (May 2, 2012). Applying ORS 656.268(9) 2003 (since renumbered (10)) and OAR 436-060-0040(4), the Board held that, because a carrier continued to pay temporary disability (TTD) benefits after the completion of claimant's authorized training program (ATP) because the record indicated that he was not medically stationary, the carrier was not required to resume the payment of permanent disability (PPD) benefits awarded by a "pre-ATP" Notice of Closure, and, once claimant's PPD award was redetermined at the "post-ATP" claim closure, the carrier was not obligated to pay the remaining balance of the "pre-ATP" final PPD award. Following a Notice of Closure that awarded 34 percent unscheduled PPD, claimant began an ATP. During his seven month participation in the ATP, the carrier suspended its PPD payments and paid TTD benefits. Also, because it considered claimant's condition to not be medically stationary, the carrier continued to pay TTD benefits until claim closure. When the "post-ATP" Notice of Closure awarded a total of 37 percent unscheduled PPD, claimant requested reconsideration. Thereafter, an Order on Reconsideration reduced claimant's unscheduled PPD award to 28 percent and found that claimant's condition was medically stationary as of an earlier date than determined in the "post-ATP" Notice of Closure. Thus, the reconsideration order authorized the carrier to offset the "post-ATP" overpaid TTD against claimant's PPD award. After a prior ALJ's order increased claimant's unscheduled PPD award to 29 percent, the carrier adjusted its offset. Following an aggravation claim, claimant was eventually awarded a total of 43 percent unscheduled PPD. Claimant then requested a hearing, challenging the carrier's failure to pay his entire "pre-ATP" PPD award between the completion of the ATP and the issuance of the "post-ATP" Notice of Closure. (Claimant did not seek any additional TTD or PPD benefits, but rather claimed that the carrier's actions were unreasonable because it had prematurely recovered a nonexistent "overpayment.")

The Board disagreed with claimant's contention that the carrier's conduct had been unreasonable. Citing *former* ORS 656.268(9) (now (10)), the Board stated that any unpaid PPD payments due under a "pre-ATP" Notice of Closure shall be suspended if a claimant becomes enrolled and actively engaged in an ATP. Relying on OAR 436-060-0040(4), the Board noted that a carrier must resume any suspended PPD award on the completion or ending of an ATP, unless the claimant is not then medically stationary. Finally, referring to *Fox v. Ross Bros. & Co., Inc.*, 175 Or App 265, 272-73 (2001), the Board

observed that, when a "post-ATP" Notice of Closure issues before a carrier's obligation to resume payment of a "pre-ATP" PPD award ripens, a carrier is not required to pay the remainder of the PPD award, which has been redetermined.

Carrier authorized to pay "post-ATP" TTD because claimant not medically stationary.

Turning to the case at hand, the Board found that the carrier was authorized under OAR 436-060-0040(4) to continue paying TTD following the ATP because the medical evidence indicated that claimant's condition was not medically stationary. Likewise, the Board determined that the carrier was entitled to continue its suspension of claimant's PPD payments of the "pre-ATP" PPD award.

Applying the *Fox* rationale, the Board concluded that the suspended "pre-ATP" PPD award was subsumed in the "post-ATP" redetermined PPD award (as granted by the "post-ATP" Notice of Closure, Order on Reconsideration, and prior litigation order). Under such circumstances, the Board held that the carrier was not required to pay the suspended "pre-ATP" PPD benefits and also was entitled to offset overpaid TTD benefits against claimant's PPD award when the "post-ATP" reconsideration order modified claimant's "medically stationary" date.

Costs: "Post-ALJ Award of Costs" Cost Bill - Record Insufficiently Developed

Clay M. Harper, 64 Van Natta 902 (May 10, 2012). Applying ORS 656.386(2), and OAR 438-015-0019, the Board held that, when a "post-ALJ compensability decision" cost bill dispute was presented on the written record and a subsequent ALJ had not clarified the issues or identified the admitted exhibits, and when a carrier conceded that it had received a signed cost bill from claimant's counsel (something that it had not previously conceded), it was appropriate to remand the case to the ALJ for further development of the record (including considering the admission of medical reports and other materials that had been admitted in the earlier "compensability" proceeding which had resulted in the prior ALJ's cost award). Following a hearing regarding a compensability denial, an earlier ALJ had set aside the denial and awarded costs, if any, incurred in finally prevailing over the denial. After the compensability decision became final, claimant's counsel submitted a cost bill to the carrier. When the carrier declined to pay the cost bill, claimant's counsel requested a hearing. After the parties agreed to present their positions on the written record, the ALJ denied claimant's counsel's request for reimbursement for litigation costs, noting that the copy of the cost bill submitted into the record had not been signed. *See* OAR 438-015-0019(3)(b). Thereafter, claimant's counsel sought reconsideration, asserting that the carrier would acknowledge that it received a signed cost bill. In response, the carrier presented several medical reports admitted during the "compensability" proceeding, which it contended indicated that the physicians addressed several conditions that had not been found compensable in the earlier litigation. When the ALJ declined to reopen the record for any further evidence, claimant's counsel requested Board review. On review, the carrier conceded that it had received a signed cost bill from claimant's counsel.

The Board held that remand was warranted. Citing OAR 438-007-0025, and *Ted D. Strong*, 60 Van Natta 2155 (2008), the Board stated that an ALJ's decision to reopen the record for the admission of evidence is reviewed for an abuse of discretion. Furthermore, relying on *Amber M. Castle*, 61 Van Natta 941, 943, n 3 (2009), the Board noted that it had previously expressed concerns regarding procedural issues that can result from "written record" hearings which have been presented without clarification of the issues or a specific approach for admission of exhibits before the submission of closing arguments. Finally, considering that a cost bill is directly attributable to a prior litigation order (which had granted costs under ORS 656.386(2) and OAR 438-015-0019(1)), the Board observed that it was reasonable to admit any admitted exhibit in the compensability litigation into the subsequent "cost bill" litigation.

Because cost bill is directly attributable to compensability litigation that resulted in "cost award," reasonable to admit exhibits from prior litigation.

Turning to the case at hand, the Board reasoned that the carrier's "on review" concession regarding its receipt of an executed cost bill raised significant questions whether the ALJ would have declined to reopen the record had the carrier made such a concession before the ALJ. The Board further noted that that both parties had previously sought the admission of several exhibits that had been exhibits during the "compensability" litigation. Under such circumstances, the Board concluded that it was appropriate to return the case to the ALJ for further consideration of claimant's "record reopening" request in light of the carrier's "post-order" concession, as well as the other matters discussed in its order.

DCS: Objection to ALJ Approval - Record Insufficiently Developed - Remand Justified

Jennifer L. Degregorio, 64 Van Natta 927 (May 15, 2012). Applying ORS 656.295(5), and ORS 656.289(4), the Board held that, because no record had been developed regarding claimant's objection to an ALJ's approval of her Disputed Claim Settlement (DCS), it was appropriate to remand the case to the ALJ for further proceedings. Within 30 days of an ALJ's order approving a DCS between claimant and a carrier, claimant requested Board review of the ALJ's order.

Citing *Dorothy J. Carnes*, 59 Van Natta 1928 (2007), the Board stated that a DCS may be set aside based on extraordinary circumstances; *e.g.*, evidence of misrepresentation, fraud or other illegal activity. Furthermore, relying on *Deborah Kolb-Witt*, 62 Van Natta 2107 (2010), the Board noted that remand is appropriate when the record is insufficiently developed to determine the circumstances surrounding the execution of a DCS.

Because no record developed based on claimant's appeal of ALJ's "DCS approval" order, appropriate to remand for further proceedings.

Turning to the case at hand, the Board found that the record consisted of claimant's appeal of the ALJ's order approving the DCS. Because no record existed on which to determine the circumstances surrounding the execution of the DCS, the Board found that the record was insufficiently developed to resolve claimant's objection to the ALJ's approval of the DCS. Consequently, the Board remanded the case to the ALJ for further proceedings.

In reaching its decision, the Board emphasized that it was not vacating the ALJ's approval order. Instead, the Board explained that it was allowing the parties to develop a record on which the ALJ could determine whether the grounds for overturning an approved DCS had been satisfied.

Extent: Arbiter's Impairment Findings - "SLR" Validity Test - Sole Reason for Invalidity Finding - Not Sufficient Ground to Disregard Arbiter's Findings

Jimmy D. Herrera, 64 Van Natta 984 (May 23, 2012). Applying OAR 436-35-0007(11), the Board held that, when the sole basis for a medical arbiter's assessment that claimant's low back impairment findings were invalid was based on his failure of a "straight leg raising" (SLR) validity test, it was appropriate to consider the arbiter's findings when evaluating claimant's permanent disability. During a medical arbiter examination following a request for reconsideration from a Notice of Closure, an arbiter reported impairment findings for claimant. However, stating that there "was a marked discrepancy between seated and supine straight leg raising and the straight leg raising validity test was invalid," the arbiter attributed claimant's findings to unrelated conditions. When an Order on Reconsideration reduced claimant's permanent disability award to zero, claimant requested a hearing, contending that the arbiter's "invalidity" opinion should be disregarded because it was solely based on a failed SLR validity test.

The Board agreed with claimant's contention. Citing OAR 436-035-0007(5), the Board stated that, where a medical arbiter is used, impairment is established based on objective findings of the arbiter, except where a preponderance of the medical evidence demonstrates that different findings by the attending physician are more accurate and should be used. Relying on OAR 436-035-0007(11) and *Jamie Scott*, 59 Van Natta 1241, 1244 (2007), the Board noted that the SLR validity test cannot be the sole basis for invalidating lumbar range of motion impairment findings.

Because no explanation that "invalidity" determination was based on anything other than "SLR validity" test, "ROM" findings were considered valid.

Turning to the case at hand, the Board acknowledged that the arbiter had reported "a discrepancy between seated and supine straight leg raising." Nevertheless, absent an explanation from the arbiter indicating that such an observation differed from "SLR test" results, the Board found the record insufficient to establish that the basis for the arbiter's "invalidity conclusion" was something other than the "SLR test." Furthermore, reasoning that the arbiter's conclusion that claimant's impairment findings were unrelated to his accepted condition was based on the "invalidity" determination, the Board disregarded the arbiter's "unrelated" determination.

Consequently, the Board concluded that the arbiter's reduced range of motion findings were valid and ratable under the Director's disability standards. *See Terry L. Loper*, 64 Van Natta 412, 417-18 (2012). Furthermore, determining that the attending physician's findings were not more accurate, the Board relied on the arbiter's findings in rating claimant's permanent impairment.

Finally, citing *SAIF v. Miguez*, 249 Or App 388 (2012), the Board acknowledged the court's analysis that, under OAR 436-035-0007(12), an examining physician who makes an "invalid impairment finding" must provide a "written opinion, based on sound medical principles, explaining why the findings are invalid." However, noting that it had already disregarded the arbiter's "invalidity" opinion (based on its sole reliance on a failed SLR validity test), the Board reasoned that it was unnecessary to apply the *Miguez* rationale.

Preexisting Condition: "005(24)" - Accepted Spondylosis/Fusion Surgery - Contributed to Disability/Need for Treatment - Not Mere Susceptibility

Theron E. Hutchings, 64 Van Natta 948 (May 18, 2012). Applying ORS 656.005(24), ORS 656.266(2)(a), and ORS 656.262(6)(c), the Board upheld a carrier's "ceases" denial of a combined C5-6 and C6-7 cervical spondylosis condition, finding that even if claimant's spondylosis condition had subsequently been eliminated by means of a fusion surgery, it continued to contribute to his disability or need for treatment by means of the fusion and, as such, constituted a "preexisting condition" component of the previously accepted combined condition. Following its acceptance of claimant's cervical strain injury, the carrier also accepted a combined condition, consisting of the strain and a preexisting C5-6 and C6-7 spondylosis condition. When the carrier then issued a denial contending that the strain had ceased to be the major contributing cause of the combined condition, claimant requested a hearing. Asserting that cervical fusion surgery had eliminated the spondylosis, claimant argued that the carrier's denial was invalid.

The Board disagreed with claimant's contention. Citing ORS 656.266(2)(a), and *SAIF v. Kollias*, 233 Or App 499, 505 (2010), the Board stated that, if the carrier asserts that a claimant suffers from a "combined condition," the carrier bears the burden to establish a "combined condition" by proving that the claimant suffers from a preexisting condition, as defined by ORS 656.005(24), and that the claimant's condition is a combined condition. Relying on ORS 656.005(24)(a), the Board noted that, for injury claims, a "preexisting condition" must be an injury, disease, congenital abnormality, personality disorder, or similar condition that contributes to disability or need for treatment. Referring to *Washington County-Risk v. Jansen*, 248 Or App 335 (2012), the Board remarked that, in combined condition injury claims, the carrier bears the burden to prove that the otherwise compensable injury ceased to be the major contributing cause of the combined condition.

Surgery to remove "otherwise compensable injury" portion of "combined condition" remained component of combined condition.

Turning to the case at hand, the Board determined that, even if it accepted claimant's assertion that the spondylosis had been eliminated by the fusion surgery, it would still find that the requirements for a "preexisting condition" and a "ceases" denial of a combined condition had been satisfied. Relying on *Judith K. Burch*, 62 Van Natta 1713 (2010), the Board noted that, when a subsequent knee replacement surgery had removed the "otherwise compensable" ACL tear, it had held that a carrier remained responsible for

an accepted combined condition (composed of the ACL tear and a preexisting degenerative joint disease) because the ACL tear had been the cause of the knee replacement and, as such, remained the cause of treatment for the knee replacement.

Because fusion surgery performed to treat accepted spondylosis condition, the cause of claimant's disability/need for treatment due to that surgery could also be attributed to the accepted spondylosis.

Applying the *Burch* rationale, the Board found that all medical experts had opined that the fusion surgery was performed to treat claimant's spondylosis condition. Consequently, the Board reasoned that, insofar as the cause of claimant's disability or need for treatment could be attributed to the fusion, the cause of that disability or need for treatment could also be attributed to the spondylosis. Accordingly, the Board concluded that the carrier's "ceases" denial concerning the combined spondylosis condition was valid.

Because fusion resulted in progressive breakdown of disc facet complexes, fusion constituted a cause of disability/need for treatment, not mere susceptibility.

Finally, the Board rejected claimant's assertion that his spondylosis/fusion did not constitute a "preexisting condition" because it merely rendered him more susceptible to injury. *See* ORS 656.005(24)(c). The Board acknowledged that a physician used the term "susceptibility" when explaining the consequences of claimant's fusion on his adjacent discs. Nevertheless, noting that the physician also opined that the fusion resulted in a progressive breakdown of the disc facet complexes above and below the fusion that amounted to the major contributing cause of claimant's disability and need for treatment for his combined spondylosis/fusion condition, the Board concluded that the fusion actually caused, rather than merely created a susceptibility, to his disability and need for treatment.

Responsibility: "LIER" - "Self-Employment" Period Found "Presumptively" Responsible

Joseph C. Ashworth, Dcd, 64 Van Natta 972 (May 22, 2012). Applying the "last injurious exposure rule" (LIER) in determining responsibility for an occupational disease claim for a deceased worker's mesothelioma condition, the Board held that, because "presumptive responsibility" was assigned during a period of the worker's self-employment and because it was neither impossible for his self-employment to have contributed to his condition nor was another employment exposure the sole cause of his condition, his beneficiary was not entitled to benefits because responsibility rested with his self-employment (for which he had chosen not to obtain coverage). For some 30 years, claimant worked as a millwright, then worked a few years at a frozen food company, in addition to some 12 years at a motel that he owned and operated. Some 18 years after leaving the motel, he was diagnosed with mesothelioma and died soon thereafter. His spouse initiated a claim against these employers, who denied compensability and responsibility. When the ALJ found that the claim was compensable, but that responsibility rested with the decedent's self-employment (for which he had not obtained coverage), the surviving spouse requested Board review.

The Board affirmed the ALJ's decision. Citing *AIG Claim Services v. Rios*, 215 Or App 615, 619 (2007), the Board stated that, under the LIER, presumptive responsibility of an occupational disease is assigned to the carrier during the last period of employment when conditions could have contributed to the worker's disability. Relying on *Agricomp Ins. v. Tapp*, 169 Or App 208, 211,

rev den, 331 Or 244 (2000), the Board noted that the "onset of disability" is the triggering date for determining the last potentially causal employment, which is the time when the worker first seeks medical treatment (if such treatment occurs before the worker experiences temporary disability due to the claimed condition).

Turning to the case at hand, the Board found that the last potentially causal employment before the deceased worker first sought medical treatment for his condition was his self-employment at the motel. Consequently, the Board determined that presumptive responsibility rested with the worker's self-employment.

After considering the medical evidence, the Board was not persuaded that it was impossible for the worker's "self-employment" period to have caused his claimed condition and that another employment was not the sole cause of his condition. Accordingly, the Board held that responsibility remained with the deceased worker's self-employment. *Lewis D. Vanover*, 64 Van Natta 206, 210 n 4 (2012); *Lisa M. Korczak*, 60 Van Natta 1778, 1779 (2008). Because the worker had chosen not to obtain coverage during his self-employment, the Board concluded that he had taken the risk of not receiving workers' compensation benefits for a work-related condition and, as such, his spouse was not entitled to benefits. *See The New Portland Meadows v. Dieringer*, 157 Or App 619, 622 (1998); *UPS v. Likos*, 143 Or App 486 (1996); *Korczak*, 60 Van Natta at 1780.

Because worker's self-employment was last employer that could have contributed to deceased worker's asbestosis, presumptive responsibility rested with self-employment.

In reaching its conclusion, the Board rejected the spouse's assertion that the burden of proof under LIER should not be placed on her to establish that it was impossible for the worker's self-employment to have caused his condition or that another employment was the sole cause of his condition. The Board recognized that the medical evidence indicated that the worker was not exposed to greater than ambient levels of asbestos (the substance that caused his death) during his self-employment. Nonetheless, because the record established that the worker's period of self-employment could have contributed to his condition and because his self-employment was the last potentially causal employment before the worker first sought medical treatment, the Board determined that presumptive responsibility under LIER rested with the worker for his self-employment. Moreover, because the record did not satisfy the "impossibility" or "sole cause" defenses under LIER, the Board held that responsibility remained with the worker's self-employment.

APPELLATE DECISIONS
COURT OF APPEALS

Subject Worker: Worker Leasing Company - "850(3)" - Covers *All* Lessor's Client's Workers

NCE Order: "740" - No ALJ "Claim Cost" Reimbursement Authority

DCBS v. Zurich American, 249 Or App 547 (May 2, 2012). On reconsideration of its former opinion, 246 Or App 702 (2011), the court adhered to its decision which held that a worker-leasing company was responsible for claimant's injury (incurred while employed by the leasing company's client), but modified its opinion that the Director had authority under ORS 656.307(3) to direct the insurer for the leasing company to reimburse a statutory claim agent under ORS 656.054 for its claim costs incurred while processing the claim before the leasing company was ultimately found responsible.

Leasing company considered employer for purposes of "noncomplying employer" determination because the "proof of coverage" requirement between the leasing company and the client had not been met for the client's subject workers.

Concerning its responsibility decision, the court adhered to its prior opinion that the leasing company was considered the employer for purposes of a "noncomplying employer" determination because the "proof of coverage" requirement between the leasing company and its client had not been met for the client's subject workers. In doing so, the court rejected DCBS's persistent thesis that both a worker-leasing company and its client are noncomplying employers whenever the requirements imposed by ORS 656.017 and ORS 656.407 have not been met by either of them. Instead, the court reiterated its prior explanation that the workers' compensation coverage requirement and concomitant obligation to comply with ORS 656.017 and ORS 656.407 for a leasing company's client's leased and subject employees are imposed on the worker-leasing company or the client, depending on the circumstances, but not on both of them.

On reconsideration, the court addressed DCBS's argument that its decision "unnecessarily burdens" DCBS's ability to enforce statutory obligations of employers, thereby undermining the efficient administration of its program. Responding that the argument should be more properly addressed to the legislature, the court further noted that the purported burden did not withstand scrutiny. Specifically, the court reasoned that the only apparent change that the Director would have to make in enforcing the law against noncomplying employers would be to ask employers whether they had leased workers and, if so, whether the employer had filed with the Director proof of workers' compensation coverage for its leased and subject workers.

Regarding the "reimbursement" issue, the court determined that it had erred in concluding that the Director had authority under ORS 656.307 to order the insurer for the worker leasing company to reimburse the statutory claim agent for its claim costs incurred before the responsibility determination issued.

ORS 656.307(3) does not authorize Director to order reimbursement between insurers outside the context of a responsibility proceeding under ORS 656.307(1).

On reconsideration, the court continued to reject DCBS's contention that ORS 656.054 gave the Director authority to order the responsible insurer of an alleged noncomplying employer to reimburse the statutory claim agent. Nonetheless, the court deleted its previous statement that considered whether the Director was authorized to order reimbursement pursuant to ORS 656.307. Citing *Specialty Risk Services v. Royal Indemnity Co.*, 213 Or App 620, 631 (2007), the court declared that ORS 656.307(3) does not provide authority for the Director to order reimbursement between insurers outside the context of a responsibility proceeding under ORS 656.307(1).