
In the Matter of the Compensation of
RONALD CRAWFORD, Claimant
WCB Case No. 07-03041
ORDER ON RECONSIDERATION
Ransom Gilbertson et al, Claimant Attorneys
James B Northrop, SAIF Legal, Defense Attorneys

Reviewing Panel: Members Lowell and Weddell. Member Lowell concurs.
Member Weddell specially concurs.

On July 18, 2008, we abated our June 26, 2008 Order on Review that set aside the SAIF Corporation's *de facto* denial of claimant's omitted medical condition claim for "intra-articular distal radius fracture left wrist," but did not award attorney fees or costs for prevailing over the denial. We took this action to address claimant's request for reconsideration of that portion of the order that did not award attorney fees or costs, and SAIF's cross-request for reconsideration of that portion of the order that set aside its *de facto* denial. Having received the parties' arguments, we proceed with our reconsideration.

De Facto Denial

On reconsideration, SAIF again contends that it need not accept claimant's omitted medical condition claim for a left wrist intra-articular distal radius fracture because it has already accepted a left wrist displaced distal radius fracture. In support of this position, SAIF cites Shakespeare's dictum that:

"What's in a name? That which we call a rose,
by any other name would smell as sweet." *Romeo and
Juliet*, Act II, scene 2.

As we explained in our prior order, claimant's request for acceptance of an intra-articular distal radius fracture was an omitted medical condition claim that SAIF was required to accept or deny within 60 days. ORS 656.262(7)(a); *Rose v. SAIF*, 200 Or App 654, 664 (2005). Under this framework, any response other than an acceptance operates as a denial. *Ann M. Carstens*, 57 Van Natta 2865, 2867 (2005); *see also SAIF v. Allen*, 320 Or 192, 208 (1994) (if a claim is not accepted or denied within the statutory time limit, the claim is deemed *de facto* denied); *Barr v. EBI Cos.*, 88 Or App 132, 134 (1987); *Penifold v. SAIF*, 49 Or

App 1015 (1980). Thus, just as a rose by any other name would smell as sweet, SAIF's response to claimant's omitted condition claim was a *de facto* denial under *Rose* and ORS 656.262(7)(a), regardless of how SAIF characterized its response.¹

As SAIF notes, a carrier is not required to accept claims for new or omitted medical conditions if the claimed "condition" is actually a symptom of, or treatment for, previously accepted conditions. In *Young v. Hermiston Good Samaritan*, 223 Or App 99 (2008), for example, the carrier had accepted a lumbar strain but denied a new/omitted medical condition claim for radiculopathy. The *Young* court noted that a claimant seeking benefits for a new or omitted condition must "clearly request formal written acceptance of a new medical condition or an omitted medical condition." 223 Or App at 107 (citing ORS 656.267(1)). Thus, the court reasoned, the claimant must establish that the claim was for a medical "condition," rather than symptom. *Id.* Because the claimant had not done so, the denial was upheld. *Id.*; see also *John J. O'Brien*, 58 Van Natta 2714 (2006) (denial of a claim for a symptom of an accepted condition was upheld because the symptom was not a "condition"); *Terrance W. Heurung*, 51 Van Natta 1272 (1999) (denial of a new medical condition claim upheld because it claimed a symptom of an accepted condition); *Steven J. Clum*, 51 Van Natta 1019 (1999) (where the claimant claimed a symptom of an accepted condition, the claim was analyzed as one for a "new medical condition" and the symptom was not required to be accepted); *Billy W. Wilson*, 50 Van Natta 1747 (1998) (new medical condition claim denial upheld because the claim was for a symptom rather than a condition).

In such cases, the claimants did not prove the compensability of new or omitted medical *conditions* because no new or omitted medical *conditions* were present. SAIF contends that similarly, the claimed intra-articular distal radius fracture was not *omitted*, and was therefore not an *omitted* medical condition, because it had already accepted a displaced distal radius fracture.

SAIF contends that we should only find that the intra-articular distal radius fracture was omitted if we find that claimant had two fractures, one of which had been included in the earlier Notice of Acceptance. However, whether a condition was "omitted" depends not on the number of conditions from which claimant suffered, but rather on whether it was "a condition that [was] in existence at the time of the notice, but [was] not mentioned in the notice or [was] left out." *Mark A. Baker*, 50 Van Natta 2333, 2336 (1998).

¹ SAIF characterized its response to claimant's omitted medical condition claim as a "No Perfected Claim" letter, and argued that it had not denied the claim "because [claimant's] request [did] not involve a condition other than the condition(s) initially (or previously) accepted." (Ex. 35).

Here, Dr. Ellis, who performed surgery on claimant's right wrist, provided the evidence regarding the relationship between the accepted condition and the claimed omitted condition. He was asked:

“Is the claimed condition of intra-articular distal radius fracture of the left wrist medically the same condition as the accepted displaced left distal radius fracture? Is there a realistic or material difference between the two terminologies, or are they just different names or descriptive terms for the same condition? Why or why not? Please fully explain.” (Ex. 39).

Dr. Ellis replied:

“The term intra-articular distal radius fracture is more precise becau[se] it describes the orientation of the fracture & illustrates how the fracture goes into the joint itself & is at higher risk to develop arthritis.” (*Id.*)

Dr. Ellis declined the invitation to opine that the omitted medical condition was the same as the accepted condition. Invited to describe them as different names or descriptive terms for the same condition, Dr. Ellis instead described the medical differences.

We are not an agency with specialized medical expertise and must base our findings on the record. *SAIF v. Calder*, 157 Or App 224, 228 (1998). Based on Dr. Ellis's expert medical opinion, we find that claimant's "intra-articular distal radius fracture left wrist" was omitted from SAIF's acceptance of a "displaced left distal radius fracture." Accordingly, we continue to find that it was a compensable omitted medical condition that SAIF should have accepted.

Attorney Fees/Costs

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees may not be awarded. *Stephenson v. Meyer*, 150 Or App 300, 303 (1997); *SAIF v. Allen*, 320 Or 192, 200 (1994).

ORS 656.386(1)(a) provides the statutory basis for recovery of attorney fees for prevailing in cases involving denied claims. Likewise, the statutory basis for recovery of expenses and costs for prevailing in cases involving denied claims is found in ORS 656.386(2)(a). A “denied claim,” for the purposes of ORS 656.386, is defined by ORS 656.386(1)(b), which states:

“(b) For purposes of this section, a ‘denied claim’ is:

“(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation;

“(B) A claim for compensation for a condition omitted from a notice of acceptance, made pursuant to ORS 656.262(6)(d), which the insurer or self-insured employer does not respond to within 60 days; or

“(C) A claim for an aggravation made pursuant to ORS 656.273(2) or for a new medical condition made pursuant to ORS 656.267, which the insurer or self-insured employer does not respond to within 60 days.”

In *Diana M. Randolph*, 58 Van Natta 1031, *on recons*, 58 Van Natta 2242 (2006), we addressed the applicability of ORS 656.386 to a carrier’s failure to respond to an omitted medical condition claim, brought pursuant to ORS 656.262(7)(a), with an acceptance or denial. Although we had found that the carrier had *de facto* denied the claim, we found that its failure to accept or deny the claim was not a “denial” for the purposes of ORS 656.386. 58 Van Natta at 2245.

In *Randolph*, the claimant requested that the carrier “issue formal written acceptance of * * * L4-5 nerve impingements and radiculopathies.” 58 Van Natta at 1033. Asserting that those conditions were encompassed within the accepted conditions, the carrier declined to formally accept them. *Id.* at 1032. At hearing, the claimant specified that the issue was whether her L4-5 condition was an omitted, rather than encompassed, condition that the carrier was required to accept. *Id.* at 1033. Following the hearing, the claimant cited *Rose* in support of her contention. *Id.* at 1034. Under such circumstances, we concluded that claimant’s request was one for acceptance of an omitted condition under

ORS 656.262(7)(a), rather than an objection to the Notice of Acceptance under ORS 656.262(6)(d),² and the carrier was consequently required to issue an acceptance or denial of the claimed omitted condition. *Id.* Thus, we found that the carrier had *de facto* denied the omitted condition claim. *Id.*

Despite the carrier's *de facto* denial, we found that the omitted medical condition claim had not been denied for purposes of ORS 656.386. *Id.* at 2245. Under ORS 656.386(1)(b)(B), a carrier denies an omitted medical condition claim if: (1) that claim is "made pursuant to ORS 656.262(6)(d)", and (2) the carrier "does not respond to [the claim] within 60 days." In *Randolph*, we concluded that because the claimant had made her claim under ORS 656.262(7)(a) rather than ORS 656.262(6)(d), her claim was not "made pursuant to ORS 656.262(6)(d)." 58 Van Natta at 2244. Further, because the carrier had responded with a clarification, the requirement that the carrier "not respond to [the claim] within 60 days" was not present.³ *Id.* at 2245 n 4.

We contrasted our holding in *Randolph* with our holding in *Ann M. Carstens*, 57 Van Natta 2865 (2005), where we had awarded an assessed attorney fee for overcoming a *de facto* denial. In *Carstens*, the claimant had requested acceptance of an omitted medical condition "pursuant to ORS 656.262(6)(d) and/or 656.262(7)(a)," and the carrier did not timely respond to the claimant's request. 57 Van Natta at 2865. Thus, we reasoned that the claimant in *Carstens* had made an omitted condition claim "pursuant to ORS 656.262(6)(d)," and the carrier "[did] not respond to [the claim] within 60 days." Whereas both elements were present in *Carstens*, we found neither element was present in *Randolph*. 58 Van Natta 2244-45. Accordingly, we did not award attorney fees in *Randolph*. *Id.* at 2246.

Here, as in *Randolph*, neither element of a "denied claim" under ORS 656.386(1)(b)(B) is present. Claimant pursued his claim under ORS 656.262(7)(a) rather than ORS 656.262(6)(d). Further, SAIF issued a response that, while not sufficient to fulfill its obligations under ORS 656.262(7)(a), offered clarification under ORS 656.262(6)(d). Accordingly, we find that although SAIF *de facto*

² ORS 656.262(6)(d) provides that a carrier may respond to a claimant's objection to a Notice of Acceptance by revising the notice or making other written clarification.

³ A statement that a previously-issued Notice of Acceptance encompasses a claimed omitted condition may satisfy a carrier's obligation to respond to an objection to the Notice of Acceptance with "written clarification" under ORS 656.262(6)(d). *Troupe v. Labor Ready, Inc.*, 191 Or App 258, 262 (2003).

denied claimant's omitted medical condition claim, its conduct was not a denial under ORS 656.386(1)(b)(B). Therefore, ORS 656.386, as applied under *Randolph*, does not allow the award of attorney fees, costs, or expenses for prevailing over a denial in this case.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our June 26, 2008 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Entered at Salem, Oregon on November 4, 2008

Member Lowell, concurring

I agree with the lead opinion's analysis of SAIF's *de facto* denial and the application of *Randolph* to the attorney fee issue. I offer this concurrence because, unlike the special concurrence, I agree with the Board's decision in *Randolph*.

Our interpretation of statutes is guided by *PGE v. Bureau of Labor and Indus.*, 317 Or 606, 610 (1993). We begin by examining the text and context of the relevant statutes to ascertain the legislature's intent. 317 Or at 610. The context of a statute is relevant at this first level of analysis and may include other provisions of the same statute and related statutes, *Id.* at 610-11, prior enactments and judicial interpretations of those and related statutes, *Owens v. Maas*, 323 Or 430, 435 (1996), and the historical context of the relevant enactments, *Goodyear Tire & Rubber Co. v. Tualatin Tire and Auto*, 322 Or 406, 415 (1995), *on recons.*, 325 Or 46 (1997). If those sources do not reveal legislative intent, we turn to the legislative history and maxims of statutory construction, found both in statutes and in case law, to aid us in our interpretation of the statute. *PGE*, 317 Or at 611-12.

Under the special concurrence's reasoning, any omitted condition claim to which the carrier does not timely respond with an acceptance or denial automatically falls within the definition of a "denied claim." Thus, the special concurrence reasons that claimant made his omitted condition claim pursuant to ORS 656.262(6)(d), and SAIF did not respond to the claim within 60 days. I disagree with both conclusions.

The context of the phrase "made pursuant to ORS 656.262(6)(d)" in ORS 656.386(1)(b)(B) indicates that it does not describe as sweeping a category as the special concurrence describes. Specifically, comparison of

ORS 656.386(1)(b)(B) with ORS 656.386(1)(b)(C) and examination of the historical development of ORS 656.386(1)(b) shows that an omitted condition claim “made pursuant to ORS 656.262(6)(d)” is a claim that seeks to invoke that paragraph’s obligation that the carrier “revise the notice [of acceptance] or to make other written clarification” in response to the claim.

As the special concurrence notes, ORS 656.267(1) describes the requirements for initiating omitted medical condition claims, and both ORS 656.262(6)(d) and ORS 656.262(7)(a) condition their requirements for the carrier’s response to the claim on the claim being initiated pursuant to ORS 656.267. ORS 656.267(1) also describes the requirements for initiating new medical condition claims, and ORS 656.262(7)(a) also requires the carrier to accept or deny new medical condition claims within 60 days.

ORS 656.386(1)(b)(B) does not, however, apply to omitted condition claims “made pursuant to ORS 656.267.” The legislature’s choice to describe within ORS 656.386(1)(b)(B) claims “made pursuant to ORS 656.262(6)(d)” rather than “made pursuant to ORS 656.267” is significant in light of the language of ORS 656.386(1)(b)(C), which describes as a denied claim a claim “for a new medical condition made pursuant to ORS 656.267” to which the carrier does not timely respond.

Generally, where the legislature uses different words or phrases in the same statute, the use of different words indicates that the words or phrases have different meanings. *State v. Adams*, 315 Or 359, 365 (1992); *cf. Knapp v. City of North Bend*, 304 Or 34, 41 (1987) (the use of the same word or term throughout the same statute generally indicates that the legislature intended the same meaning). Thus, the simple use of the phrase “made pursuant to ORS 656.262(6)(d)” in ORS 656.386(1)(b)(B), as opposed to the phrase “made pursuant to ORS 656.267” used in ORS 656.386(1)(b)(C), indicates that the two phrases describe different categories of claims. Because ORS 656.262(6)(d) describes only certain aspects of the processing of omitted condition claims, and ORS 656.267(1) describes omitted condition claims generally, I must conclude that claims “made pursuant to ORS 656.262(6)(d)” are a narrower category of claims than those “made pursuant to ORS 656.267.”

The significance of the difference between omitted condition claims “made pursuant to ORS 656.262(6)(d)” and omitted condition claims “made pursuant to ORS 656.267” is reinforced by the historical development of ORS 656.386(1)(b).

ORS 656.267 was created by Oregon Laws 2001, chapter 865, section 10. At the same time, ORS 656.262(6)(d) and (7)(a) were amended to refer to the requirements of ORS 656.267 for bringing omitted condition claims and to harmonize the time period for a carrier's response to claims for new medical condition claims, omitted condition claims, and aggravation claims at 60 days. Or Laws 2001, ch 865, § 7. ORS 656.386(1)(b)(C), which had referred to new medical condition claims made pursuant to ORS 656.262(7)(a) to which the carrier did not respond within 90 days, was amended to refer to new medical condition claims made pursuant to ORS 656.267 to which the carrier did not respond within 60 days. *Id.* at § 10. ORS 656.386(1)(b)(B), which already referred to omitted condition claims made pursuant to ORS 656.262(6)(d), was simultaneously amended to incorporate the 60-day time limit for the carrier's response. *Id.* However, ORS 656.386(1)(b)(B) was *not* amended, as was ORS 656.386(1)(b)(C), to refer to claims "made pursuant to ORS 656.267."

The 2001 legislature amended both ORS 656.386(1)(b)(B) and (C) in the same bill. In doing so, it chose to reference ORS 656.267 in ORS 656.386(1)(b)(C), but not in ORS 656.386(1)(b)(B). The differences in language reflect not only differences within the statute, but differences within a bill that amended both subparagraphs. This historical context magnifies the principle that differences in language indicate differences in meaning.

Having determined that omitted condition claims "made pursuant to ORS 656.262(6)(d)" are a narrower category of omitted condition claims than those "made pursuant to ORS 656.267," I turn to the question of whether claimant's claim was "made pursuant to ORS 656.262(6)(d)." That paragraph provides, in relevant part:

"An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, must first communicate in writing to the insurer or self-insured employer the worker's objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response."

Claimant's omitted condition claim stated, in relevant part:

"Please regard this correspondence as the worker's written request that the Notice of Acceptance be amended to include * * * intra-articular distal radius fracture left wrist. Please accept or deny these conditions within the 60 days as allowed by law, and notify this office in writing upon decision." (Ex. 30).

Claimant did not cite ORS 656.262(6)(d) in his request for acceptance. Further, claimant did not invite SAIF to revise the notice of acceptance "or make other written clarification in response," as is permitted by ORS 656.262(6)(d). Instead, claimant requested that SAIF "accept or deny" the omitted condition claim, a duty described in ORS 656.262(7)(a). The record does not indicate that claimant later invoked ORS 656.262(6)(d), either by citing it directly or by invoking SAIF's duty to revise the notice of acceptance or make other written clarification.

Under such circumstances, claimant's omitted condition claim was not "made pursuant to ORS 656.262(6)(d)."

Even if claimant's omitted condition claim was "made pursuant to ORS 656.262(6)(d)," it would not be a "denied claim," for purposes of ORS 656.386, unless the carrier "does not respond within 60 days." ORS 656.386(1)(b)(B). Here, SAIF timely responded to claimant's request by providing a written statement that his request "does not involve a condition other than the condition(s) initially (or previously) accepted." (Ex. 35).

SAIF "responded" to claimant's request in the ordinary meaning of the word. *See Webster's Third New Int'l Dictionary* 1935 (unabridged ed. 1993) (defining "respond" as "to say something in return: make an answer"); *PGE*, 317 Or at 611 (words of common usage are typically given their plain, natural, and ordinary meaning). The special concurrence reasons that SAIF was required to issue an acceptance or denial "notwithstanding" a statutory provision that allowed SAIF to "revise" or provide "clarification."

As noted, ORS 656.386(1)(b)(B) specifically mentions ORS 656.262(6)(d) rather than an obligation to accept or deny a claim under ORS 656.262(7)(a) or a more general provision regarding the processing of omitted medical condition claims. ORS 656.262(6)(d) allows the carrier to respond to an omitted condition

claim by either amending the Notice of Acceptance or by making other written clarification. Therefore, I interpret the legal obligation against which SAIF's "response" must be measured under ORS 656.386(1)(b)(B) to be its obligation, under ORS 656.262(6)(d), to respond to an omitted condition claim by amending the Notice of Acceptance or by making other written clarification.

A letter explaining that a condition is encompassed within the scope of the previous acceptance may be sufficient to satisfy this obligation, even if such a letter is not a model of clarity. *Troupe v. Labor Ready, Inc.*, 191 Or App 258, 262 (2003); *see also LaToy E. Hamilton*, 51 Van Natta 724 (1999) (declining to award attorney fees for a carrier's clarification that a claimed condition was encompassed within the accepted condition). Here, SAIF's timely response indicated that the claimed omitted condition was not different from a condition earlier accepted. This is a legally sufficient response under *Troupe*. Accordingly, I would not find, under ORS 656.386(1)(b)(B), that SAIF failed to respond.

Under the special concurrence's reasoning, *all* omitted condition claims, regardless of the procedural posture or the nature of claimant's request, are "made pursuant to ORS 656.262(6)(d)." At the same time, the special concurrence would find that ORS 656.262(7)(a), and its requirement that a carrier accept or deny an omitted condition claim, applies to *all* omitted condition claims. Finally, the special concurrence would find that *any* response to an omitted condition claim other than an acceptance or denial fails to "respond" to the claim under ORS 656.386(1)(b)(B).

Because the carrier would be obligated to issue an acceptance or denial in response to *all* omitted condition claims under ORS 656.262(7)(a), it would never have the option, provided for by ORS 656.262(6)(d) and *Troupe*, to "make other written clarification in response" to an omitted condition claim.

Ut res magis valeat quam pereat, the maxim that, where possible, we interpret statutes as to give effect to every section, clause, phrase, or word of the statutes, is a principle that has long governed statutory construction. *Blyth & Co., Inc. v. City of Portland*, 204 Or 153, 159 (1955); *Whiteaker v. Vanschoiack*, 5 Or 113, 113 (1873). It has also been codified by statute. ORS 174.010.

The special concurrence's reasoning would never give a carrier an option to respond to an omitted condition claim by clarifying that the condition had been encompassed within the Notice of Acceptance as permitted by ORS 656.262(6)(d), rather than by accepting or denying it. It would also consider the claim to have

been “made pursuant to ORS 656.262(6)(d)” even if that paragraph was irrelevant to the controversy at hand. And it would consider a carrier to have denied the claim any time it issued a clarification of its acceptance rather than a new acceptance, despite ORS 656.386(1)(b)(B)’s specific reference to ORS 656.262(6)(d), which allows just such a clarification. Under such circumstances, ORS 656.262(6)(d) and *Troupe* would have to be considered irrelevant.

The *Rose* court itself noted that *Troupe* addressed ORS 656.262(6)(d) rather than ORS 656.262(7)(a), and explained that the two cases addressed different requirements. 200 Or App at 664. In distinguishing cases in which ORS 656.262(7)(a) apply from cases governed by *Troupe*, in which ORS 656.262(6)(d) applies, the *Rose* court recognized the continuing relevance of ORS 656.262(6)(d) and *Troupe*. *Id.*

Given our obligation to give effect to ORS 656.262(6)(d) and the *Rose* court’s recognition that ORS 656.262(7)(a) and ORS 656.262(6)(d) address different situations, I cannot adopt the special concurrence’s reasoning. Accordingly, I offer this concurrence to explain why I continue to agree with our *en banc* holding in *Randolph*.

Member Weddell, specially concurring.

I agree with the lead opinion’s analysis of SAIF’s *de facto* denial. I also agree with the lead opinion’s conclusion that *Randolph* does not allow the award of attorney fees, costs, or expenses in this case. However, I offer this special concurrence regarding the *Randolph* rationale.

As the lead opinion notes, ORS 656.386(1)(a) and (2)(a) provide for awards of attorney fees, costs, and expenses in cases where a claimant prevails against a denial of a claim. Further, ORS 656.386(1)(b) statutorily defines what qualifies as a “denied claim” for purposes of ORS 656.386.

In *Randolph*, the Board held that the claimant’s omitted medical condition claim was not “made pursuant to ORS 656.262(6)(d)” and that the carrier did “respond to [the claim] within 60 days.” Because the present case presents facts analogous to those in *Randolph* with respect to the claimant’s claim and the carrier’s response, application of *Randolph* leads to the conclusion that attorney fees, costs, and expenses are not available in this case. However, I would reach a different result if I were addressing this issue on a clean slate.

First, *Randolph* found that the claimant had failed to make her claim “pursuant to ORS 656.262(6)(d)” because: (1) she invoked the requirements of ORS 656.262(7)(a), which requires that the carrier respond to an omitted medical condition claim by issuing an acceptance or denial; and (2) she did not seek to enforce the requirements of ORS 656.262(6)(d), which allows the carrier to respond to an omitted medical condition claim by “revis[ing] the notice or mak[ing] other written clarification in response.” 58 Or App at 1034. Here, applying this analysis, the lead opinion concludes that because claimant sought to enforce the requirements of ORS 656.262(7)(a) and not the requirements of ORS 656.262(6)(d), his claim was not “made pursuant to ORS 656.262(6)(d).”

Randolph determined which statutory provision the claim was made “pursuant to” by examining which statutory provision the claimant invoked during litigation. This approach, however, neglects the textual relationship between ORS 656.262(6)(d), ORS 656.262(7)(a), and ORS 656.267.

As the concurrence notes, when interpreting a statute, our first level of analysis is to evaluate the text and context of the statute itself. *PGE*, 317 Or at 610. The text of the statutes establishes that claimant’s omitted condition claim was “made pursuant to ORS 656.262(6)(d).”

ORS 656.267(1) provides that “[t]o initiate omitted medical condition claims under ORS 656.262(6)(d) * * * the worker must clearly request formal written acceptance of * * * an omitted medical condition.” In other words, under ORS 656.267(1), an omitted medical condition claim is made under ORS 656.262(6)(d) if the worker clearly requested formal written acceptance of the omitted medical condition.

As explained in the lead opinion, claimant clearly requested formal written acceptance of his omitted medical condition. Accordingly, ORS 656.267(1) provides that the claim has been “initiat[ed] * * * under ORS 656.262(6)(d).”

ORS 656.267(2)(a) provides that “[c]laims properly initiated for * * * omitted medical conditions * * * shall be processed pursuant to ORS 656.262.” This does not allow for an omitted medical condition claim to be processed pursuant to only those provisions of ORS 656.262 that the claimant cites. Instead, a properly initiated medical condition claim must be processed pursuant to all of ORS 656.262, including ORS 656.262(6)(d).

As explained above, claimant properly initiated his claim for his omitted medical condition. Accordingly, ORS 656.267(2)(a) provides that it must be processed pursuant to ORS 656.262(6)(d).

ORS 656.262(6)(d) itself provides, in relevant part:

“An injured worker who believes that a condition has been incorrectly omitted from a notice of acceptance, or that the notice is otherwise deficient, must first communicate in writing to the insurer or self-insured employer the worker’s objections to the notice pursuant to ORS 656.267. The insurer or self-insured employer has 60 days from receipt of the communication from the worker to revise the notice or to make other written clarification in response.”

In other words, a carrier’s obligations under ORS 656.262(6)(d) are invoked when the claimant makes a “[clear request for] formal written acceptance of * * * an omitted medical condition,” as described by ORS 656.267(1), in writing. Thus, the provisions of ORS 656.262(6)(d) are invoked when the claimant clearly requests, in writing, a formal written acceptance of an omitted medical condition. Citation to ORS 656.262(6)(d), or a request for “other written clarification,” is not necessary.

Here, as explained above, claimant made a clear written request for formal written acceptance of his omitted medical condition. Accordingly, ORS 656.262(6)(d) required SAIF to “revise the notice or make other written clarification in response.”

The text of ORS 656.267(1) provides that claimant’s omitted medical condition claim had been “initiated * * * under ORS 656.262(6)(d).” ORS 656.267(2)(a) then required SAIF to process the claim “pursuant to ORS 656.262,” including ORS 656.262(6)(d). ORS 656.262(6)(d) itself required SAIF to “revise the notice or make other written clarification” in response to the omitted condition claim. Based on the text of these statutory provisions, I conclude that claimant’s omitted medical condition claim was “made pursuant to ORS 656.262(6)(d).”

The lead opinion notes that claimant pursued his request under ORS 656.262(7)(a). As noted above, ORS 656.267(2)(a) provides that omitted condition claims be processed “pursuant to ORS 656.262,” including ORS 656.262(7)(a). Further, ORS 656.262(7)(a) provides that “written notice of

acceptance or denial of * * * omitted condition claims properly initiated pursuant to ORS 656.267 shall be furnished * * * within 60 days after the insurer or self-insured employer receives written notice of such claims.” This obligation to accept or deny the claim under ORS 656.262(7)(a) is what claimant sought to enforce, and is what we applied in setting aside SAIF’s *de facto* denial.

However, ORS 656.262(6)(d) and (7)(a) do not describe separate methods for invoking a carrier’s responsibilities to process an omitted condition claim. Instead, they describe actions that are required of the carrier when it is presented with an omitted condition claim. ORS 656.267 provides that an omitted medical condition claim invokes the requirements of both ORS 656.262(6)(d) and (7)(a), and ORS 656.262(6)(d) and (7)(a) likewise both provide that they apply to written omitted medical condition claims made pursuant to ORS 656.267. In other words, the statutory framework creates a single type of omitted medical condition claim, to which ORS 656.267, ORS 656.262(6)(d), and ORS 656.262(7)(a) all apply.

Thus, although ORS 656.386(1)(b)(B) refers to ORS 656.262(6)(d) rather than a broader provision regarding the processing of omitted condition claims, the text of the statutes, individually and in the context of the overall statutory scheme, unambiguously shows that the reference to omitted condition claims “made pursuant to ORS 656.262(6)(d)” describes all omitted condition claims. Because the text of the statutes is clear, the legislature’s choice to cite ORS 656.262(6)(d) in ORS 656.386(1)(b)(B), rather than another provision addressing omitted condition claims, signifies nothing. Accordingly, the two-part test that *Randolph* promulgated to distinguish between omitted condition claims “made pursuant to ORS 656.262(6)(d)” and other omitted condition claims was unnecessary.

In addition to finding that the claim was not “made pursuant to ORS 656.262(6)(d),” *Randolph* held that the carrier had responded for purposes of ORS 656.386(1)(b)(B) because it had provided a “clarification” of its notice of acceptance as permitted by ORS 656.262(6)(d). Applying the same rationale, the lead opinion finds that SAIF responded to claimant’s omitted condition claim, for purposes of ORS 656.386(1)(b)(B), because it “clarified” its position that the claimed omitted medical condition had been included in its earlier Notice of Acceptance.

Notwithstanding the provision of ORS 656.262(6)(d) that allows a carrier to “revise the notice [of acceptance] or make other written clarification in response” to an omitted medical condition claim, ORS 656.262(7)(a) required SAIF to respond to the omitted medical condition claim by issuing written notice of acceptance or denial.

ORS 656.386(1)(b)(B) does not limit its application to circumstances in which the carrier fails to comply with ORS 656.262(6)(d). Instead, it applies when the carrier “does not respond” to the claim within 60 days. Because a response to an omitted medical condition claim must include a timely acceptance or denial of the claim, and SAIF neither accepted nor denied the claim, SAIF did not provide a legally sufficient response to claimant’s omitted condition claim. Therefore, I would find that SAIF did not respond to the claim within 60 days. Under such circumstances, the conditions precedent to an award of attorney fees, expenses, and costs would appear to have been satisfied.

Nevertheless, the Board’s *en banc* decision in *Randolph* remains the controlling precedent. Therefore, in accordance with the principles of *stare decisis*, I follow the controlling precedent, which does not allow for an award of attorney fees, costs or expenses in this case. Consequently, I offer this special concurrence.