**Alaska Administrative Code**
**Chapter 55. Fishermen's Fund**

**8 AAC 55.010. Benefits.**

(a) To be eligible for benefits from the fund, a person must be a fisherman who, at the time an injury is sustained, is licensed in the person's own name by the state to engage in commercial fishing under AS 16.05.480 or AS 16.43, and who is actually so engaged in Alaska water or is occupied in the state preparing or dismantling boats or gear used in commercial fishing.

(b) Unless required as a result of accidental bodily injury caused by the fishing endeavor, benefits may not be awarded for:

(1) the services of a dentist;

(2) dental prosthetic appliances or the fitting of them;

(3) eye refractions and hearing examinations;

(4) eye glasses or the fitting of them; or

(5) hearing aids or the fitting of them.

(c) Benefits may not be awarded for an injury

(1) if the injury does not arise out of an accident directly connected with commercial fishing;

(2) caused by the fishermen's willful intent to injure or kill self or another;

(3) caused by the fishermen's intoxication, or caused by the fishermen being under the influence of drugs unless the drugs were taken as prescribed by a treating physician; in this paragraph,

(A) "drugs" has the meaning given in AS 23.30.395;

(B) "intoxication" has the meaning given in 8 AAC 20.010; or

(4) if the fisherman has knowingly falsified a material fact directly connected with the fisherman's claim against the fund.

(d) Benefits may not be awarded unless the following conditions are either met or, in a review under AS 23.35.040(a)(1), excused by the council for just cause:

(1) the fisherman receives initial treatment no later than 120 days after the date of injury;

(2) the claim is submitted no later than one year after the date of initial treatment;

(3) the fisherman responds no later than 90 days after receipt of an inquiry seeking clarification of any item on a claim, or of any item on a billing for services performed or goods supplied;

(4) there is no unexplained gap in treatment of more than three months;

(5) the provider submits price lists and fee determinations to the administrator no later than 30 days after receipt of a request.

(e) Transportation to return a fisherman to the fisherman's home may be allowed to the extent that the costs are in addition to those that the fisherman would normally have encountered had the fisherman not been injured.

(f) The department may require information regarding insurance coverage, including an insurance benefits statement, and may hold a claim in abeyance pending the receipt of required information.

(g) A vessel owner may not recover reimbursement for a protection and indemnity insurance policy deductible payment unless the administrator receives

(1) proof of direct payment of medical benefits to or on behalf of the fisherman by the vessel owner, together with a copy of the declaration page of the policy setting out the policy coverage and limits; or

(2) proof of direct payment of medical benefits to or on behalf of the fisherman by the vessel owner's protection and indemnity insurance company, together with

(A) proof of payment of the policy deductible to the protection and indemnity insurance company by the vessel owner; and

(B) a copy of the declaration page of the policy setting out the policy coverage and limits.

(h) Provider bills must be submitted to the department in a format approved by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), unless the department accepts an alternate format that provides the same data in a form that the department can easily use.

(i) Provider bills must be accompanied by signed and dated chart notes.

(j) If an injury requires continuing and multiple treatments of a similar nature, the standards for payment for outpatient treatment for the injury are as follows:

(1) payment for a course of treatment may not exceed more than three treatments per week for the first month, two treatments per week for the second and third months, one treatment per week for the fourth and fifth months, and one treatment per month for the sixth through $12^{th}$ months;

(2) a provider shall furnish a written treatment plan if the course of treatment will require more frequent outpatient treatment than allowed under this subsection;

(3) the treatment plan shall be furnished to the administrator no later than 14 days after treatment begins;

(4) the treatment plan must include objectives, modalities, frequency of treatments, and reasons for the frequency of treatments. (Eff. 3/28/74, Register 49; am 4/11/81, Register 78; am 7/28/93, Register 127; am 3/22/2003, Register 165; am 7/13/2012, Register 203)

Authority: AS 23.35.050, AS 23.35.070, AS 23.35.100, AS 23.35.145, AS 23.35.150

**8 AAC 55.015. Compelling reasons for extension of duration of care and for additional benefits.**

(a) If a fisherman suffers a compensable injury, the fisherman may request compensation for treatment that continues beyond one year from the date of initial allowance for compelling reasons. A request for an extension of duration of care must

(1) be submitted as a petition to the council under 8 AAC 55.025, and on the form prescribed by the department;

(2) explain why treatment cannot be completed within one year from the date of initial allowance; and

(3) include

(A) the fisherman's name and contact information;

(B) the name and contact information of the fisherman's primary care physician; and

(C) a written treatment plan from the primary care physician, citing medical evidence that supports the extended course of treatment.

(b) If a fisherman suffers a compensable injury, the fisherman may request additional benefits for compelling reasons. A request for additional benefits must

(1) be submitted as a petition to the council under 8 AAC 55.025, and on the form prescribed by the department;

(2) explain the fisherman's financial need, why a remedy cannot be obtained from the vessel owner, and additional benefits needed; and

(3) include

(A) a statement of financial assets and liabilities; and

(B) copies of the fisherman's federal income tax returns for the previous two years, including W-2 forms and supporting schedules.

(c) When considering under AS 23.35.130 or 23.35.140 a request for an extension of duration of care or additional benefits for compelling reasons, the council shall consider

(1) the severity of the fisherman's injury;

(2) the percentage of the fisherman's income derived from commercial fishing;

(3) the length of time that the fisherman has fished commercially in the state;

(4) the availability of relief from other sources;

(5) the chronic nature of the medical condition; and

(6) other facts relevant to the fisherman's request and presented to the council.

(d) In addition to considering the factors listed under (c)(1) – (6) of this section, the council may consider the financial condition of the fund if the total fund expenditures in the current fiscal year are expected to reduce the fund balance to less than 500 percent of the average total fund expenditures in the preceding three fiscal years. (Eff. 7/13/12, Register 203)

Authority: AS 23.35.050, AS 23.35.130, AS 23.35.140

**8 AAC 55.020. Claim proceedings.**

(a) A claim against the fund is commenced by filing an application with the department, on a form prescribed by the department.

(b) A separate claim must be filed for each separate and independent injury for which benefits are claimed.

(c) No later than 45 days after receipt of a completed claim, the administrator shall send a written notice to each fisherman whose claim is denied. The notice must state the reason why the payment cannot be made.

(d) The council shall review the administrator's denial of benefits no later than 180 days after the denial.

(e) A claimant shall promptly inform the administrator of any changes to the claimant's address. (Eff. 3/28/74, Register 49; am 4/11/81, Register 78; am 9/10/98, Register 147; am 12/30/99, Register 152; am 7/13/2012, Register 203)

Authority: AS 23.35.040, AS 23.35.050, AS 23.35.070, [AS 23.35.100], [AS 23.35.130], [AS 23.35.140]

**8 AAC 55.025. Petitions.**

(a) To request an extension of duration of care, additional benefits, assistance after discharge from a hospital, or additional transportation allowances, a fisherman must submit a petition to the department, for a determination from the council. If the petition is for

    (1) an extension of duration of care, the fisherman must comply with the requirements of 8 AAC 55.015(a);

    (2) additional benefits, the fisherman must comply with the requirements of 8 AAC 55.015(b);

    (3) assistance after discharge from the hospital, the fisherman must

        (A) submit the petition on the form prescribed by the department; and

        (B) include the dates during which hospitalization occurred;

    (4) for additional transportation allowances, the fisherman must

        (A) submit the petition on the form prescribed by the department;

        (B) verify that the additional transportation is only for the purpose of providing specialized medical skills that are unavailable at the nearest approved medical facility; and

(C) include a written statement from the fisherman's treating physician, that sets out the specialized medical skill required for the petitioner and the nearest place where it is available.

(b) No later than 180 days after the department receives a petition that complies with (a) of this section, the council shall make a determination with respect to the petition. No later than 45 days after the council's determination, the administrator shall notify, in writing, each petitioner or other party of the council's determination.

(c) A petitioner shall promptly inform the administrator of any changes to the petitioner's address. (Eff. 7/13/2012, Register 203)

Authority: AS 23.35.040, AS 23.35.050, AS 23.35.070, AS 23.35.090, AS 23.35.100, AS 23.35.130, AS 23.35.140

**8 AAC 55.030. Appeals.**

(a) The administrator shall send to the council for review a claim for benefits that the administrator has denied under 8 AAC 55.020(c).

(b) If the administrator has denied a fisherman's claim under 8 AAC 55.020(c),the administrator shall send a written notification of the time and place of the council's review to the fisherman, so that the fisherman receives the notification no later than 10 days before the date of the council's review. A fisherman may submit additional evidence and witnesses to the council in support of the fisherman's claim. The evidence may be presented in writing, by personal appearance, or by both methods.

(c) The administrator shall notify, in writing, a fisherman with a claim before the council, the vessel owner, and each provider of the council's decision.

(d) A fisherman may appeal the decision of the council. The council's decision is final unless appealed to the commissioner no later than 30 days after mailing of the notice of the council's decision. The appeal must be in writing and must include a description of the relief sought. The commissioner's decision will be based on a consideration of the whole record and will state the facts relied on. The decision of the commissioner may be appealed as provided under AS 44.62 (Administrative Procedure Act). (Eff. 3/28/74, Register 49; am 4/11/81, Register 78; am 9/10/98, Register 147; am 7/13/2012, Register 203)

Authority: AS 23.35.040, AS 23.35.050

**8 AAC 55.035. Right to subrogation.**

(a) If the department pays benefits from the fund, the department, to the extent of the value of the benefits, is subrogated to the rights of the fisherman for a claim against a third party arising from an injury, disability, occupational disease, or cardiovascular disease covered by AS 23.35.010 – 23.35.150 and this chapter and to the proceeds of an insurance policy covering an injury, disability, occupational disease, or cardiovascular disease covered by AS 23.35.010 – 23.35.150 and this chapter.

(b) If the department asserts a claim of subrogation against a fisherman, the department may hold future claims in abeyance pending resolution of the subrogated claim. (Eff. 12/26/86, Register 100; am 7/13/2012, Register 203)

Authority: AS 23.35.050

**8 AAC 55.900. Definitions.**

In this chapter, unless the context requires otherwise,

(1) “administrator” means the individual responsible for administration of claims against the fund;

(2) “commissioner” means the commissioner of labor and workforce development;

(3) “council” means the Fishermen’s Fund Advisory and Appeals Council;

(4) “department” means the Department of Labor and Workforce Department;

(5) “fund” means the fishermen’s fund (AS 23.35.060);

(6) “injury” means an injury, disability, or occupational disease for which benefits are payable under AS 23.35.070;

(7) “provider” means a person licensed under AS 08 or in the jurisdiction where services are provided to furnish medical or dental services. (Eff. 7/13/2012, Register 203)

Authority: AS 23.35.050