Transfer Record & Equipment Request

The documentation that gets a lift approved — and the evidence that your back is carrying something it should not be.

DAY TO DAY DEMENTIA

Why this exists

Almost every caregiver has been handed a sheet about lifting with your legs. It is worth knowing that this advice has been tested and does not hold up: a Cochrane review covering **20,101 workers** found that training in manual handling did not prevent back pain or back-related disability, and was no better than back belts or than nothing at all.

What does reduce injury is equipment. And equipment, in this country, is gated behind documentation.

The rule you are up against

> Medicare's coverage determination for patient lifts says a lift is covered *"if transfer between bed and a chair, wheelchair, or commode is required and, without the use of a lift, the beneficiary would be bed confined."*

Read the logic of that. As long as someone can still be hauled into a chair by an exhausted spouse, the person is not bed confined — and the lift is not medically necessary. The rule pays for the equipment at roughly the point the dangerous transfers are ending.

Which is why the clinical note has to describe **the transfer itself**, not the diagnosis. In the 2024 reporting period, insufficient documentation accounted for **91.8%** of improper payments on patient lift claims. The paperwork is the whole game.

How to use it

- Fill in **page 2** for one ordinary week. Not the worst week — an ordinary one.
- Record what actually happens, in plain words. "Took 40 minutes, he grabbed the doorframe, I took his full weight twice."
- Take it to the face-to-face visit. A face-to-face visit with the prescribing clinician is *required* for coverage.
- Use the script on **page 3**. Ask for it to go in the note, and ask which code is being billed.

One ordinary week of transfers

Person's name _____ Week beginning _____ Their approx. weight _____

DATE	TRANSFERS THAT DAY	PEOPLE NEEDED	COULD THEY BEAR WEIGHT?	DID IT FAIL OR NEARLY?	WHAT HAPPENED — RESISTANCE, TIME TAKEN, PAIN TO YOU

THE TRANSFERS THAT HAPPEN EVERY DAY

TRANSFER	TIMES PER DAY	WHAT MAKES THIS ONE HARD
Bed to chair or wheelchair		
Chair to toilet or commode		
On and off the toilet		
In and out of the shower or tub		
Repositioning in bed		
Up from the floor after a fall		

THE CAREGIVER'S SIDE — THIS BELONGS IN THE RECORD TOO

Pain or injury you now have	
When it started, and what caused it	
Your own age and any conditions	
Who else is available to help, and when	

Say plainly to your own doctor that you are lifting an adult who cannot assist, several times a day. That sentence belongs in your medical record — it supports equipment now, and a claim of your own later.

What to say at the appointment

Read the record back rather than summarizing it. Specifics are what get written down.

Instead of	“It’s getting hard to move him.”
Say	“He is 250 pounds and cannot bear weight. I am transferring him six times a day on my own. Twice this week the transfer failed partway. I have injured my back. Without a lift, can he be transferred safely at all?”

FIVE QUESTIONS WORTH ASKING OUT LOUD

- “Can you document in the note what a transfer actually requires — how many people, and whether he can bear weight?”
- “Which lift code are you ordering, and does the supplier stock it?”
- “Can we get an occupational or physical therapy home safety evaluation?”
- “Has anything ruled out pain as the reason he resists being moved?”
- “If this is denied, what would need to change for it to be approved?”

> **The pain question matters more than it sounds.** New or increased resistance to being moved is a common presentation of undiagnosed pain — a compression fracture, a joint, an infection — in someone who can no longer report it in words. It is worth ruling out before it is managed as a behavior.

If Medicare says no

- **Medicaid waiver programs** — often cover equipment Medicare will not
- **VA benefits**, if there is any service history at all
- **Area Agency on Aging** — many run loan closets
- **Local equipment lending libraries**, often run by churches or civic groups
- **Secondhand** — used hoists turn up at a fraction of retail
- **Hospice**, which supplies equipment directly once someone is enrolled

Know the codes before you ask

CODE	WHAT IT IS
E0630	Hydraulic or mechanical lift — the manual, crank-operated kind
E0635	Electric patient lift
E0639	Moveable room to room, with disassembly and reassembly
E0640	Fixed system — the ceiling or wall track kind

All four are covered when the basic criterion is met. If you are told flatly that electric or ceiling-mounted lifts are never covered, that is not what the policy says — ask which code they are billing. A face-to-face visit with the prescribing clinician and a Standard Written Order to the supplier are both required.

WHAT TO BUY FIRST IF YOU ARE PAYING YOURSELF

- **Slide sheets** — cheap, and they turn repositioning in bed from hauling into sliding. The most underrated item on the list.
- **A bed that raises and lowers** — working at the wrong height is a large part of why bed care hurts.
- **A gait belt** — for steadying and guiding, not for hoisting. If you are taking their weight through it, it is the wrong tool.

> **The threshold nobody names.** There is a point where no belt, board or technique makes a one-person transfer safe, and the task has quietly become a two-person job in a house with one person in it. Reaching that point is not a failure of strength or willingness. It is a stage of the disease, and it calls for more hands — paid help for the transfer hours, an adult day program, or a conversation about residential care you are allowed to start before a crisis forces it.

NOTES — WHO YOU CALLED, WHAT THEY SAID, WHAT HAPPENS NEXT

Date & who I spoke to	
What they said	
What I need to do next	
Date to follow up	