

1 **Clinical Practice Guideline: MEDEK Therapy**

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3 **Date of Implementation: September 15, 2016**

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5 **Product: Specialty**

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8 **GUIDELINES**

9 American Specialty Health (ASH) considers MEDEK Therapy unproven given the lack of
10 evidence to support this form of physical therapy.

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12 At this time, no evidence exists of its effectiveness in the peer reviewed literature. Studies
13 are needed to determine whether a clinically significant improvement is achieved through
14 the use of MEDEK Therapy.

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16 For more information, see the *Techniques and Procedures Not Widely Supported as*
17 *Evidence Based (CPG 133 – S)* policy.

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19 Patients must be informed verbally and in writing of the nature of any procedure or
20 treatment technique that is considered experimental/investigational or unproven, poses a
21 significant health and safety risk, and/or is scientifically implausible. If the patient decides
22 to receive such services, they must sign a *Member Billing Acknowledgment Form* (for
23 Medicare use *Advance Beneficiary Notice of Non-Coverage form*) indicating they
24 understand they are assuming financial responsibility for any service-related fees. Further,
25 the patient must sign an attestation indicating that they understand what is known and
26 unknown about, and the possible risks associated with such techniques prior to receiving
27 these services. All procedures, including those considered here, must be documented in the
28 medical record. Finally, prior to using experimental/investigational or unproven
29 procedures, those that pose a significant health and safety risk, and/or those considered
30 scientifically implausible, it is incumbent on the practitioner to confirm that their
31 professional liability insurance covers the use of these techniques or procedures in the event
32 of an adverse outcome.

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34 **DESCRIPTION/BACKGROUND**

35 MEDEK, a form of physiotherapy, refers to Metodo Dinamico de Estimulacion Kinesica
36 or Dynamic Method for Kinetic Stimulation (a.k.a. Cuevas MEDEK Exercise [CME]). It
37 was developed by a Chilean physical therapist, Ramon Cuevas in the 1970s and introduced
38 to North America by physical therapist Ester Fink. MEDEK is used for developing gross
39 motor skills in young children with physical disabilities and movement disorders (e.g.,
40 cerebral palsy, Down’s syndrome, hypotonia, muscular dystrophy, and developmental
41 motor delay). It assumes that movement affects the development of the brain. It does not
42 focus on modifying muscle tone, primitive reflexes or abnormal patterns of movement. It

1 focuses on training movements leading to sitting, standing, and walking. Muscles are
2 trained in postural and functional tasks rather than being exercised in isolation. Tight
3 muscles are stretched in dynamic situations. The motor developmental sequence is not
4 used. MEDEK assumes that different skills require different movement strategies. Unlike
5 other interventions, tasks are performed without the child’s attention, conscious thought or
6 co-operation. It is assumed that motivation will increase temporary performance only but
7 will not create a permanent change. The therapist’s task is to provoke automatic postural
8 reactions that contribute to the postural control needed for functional tasks. A child
9 receiving a MEDEK treatment is physically manipulated by the therapist to stretch out tight
10 muscles and train the muscles in groups, which leads to increased trunk control for the
11 child. Trunk control is necessary for sitting, standing and walking. Each exercise the patient
12 does is named and has a specific, functional purpose. Exercises are repeated until the
13 movement becomes automatic and the body reacts normally to situations where it is
14 required to keep its balance. MEDEK therapy begins on a table; then, if the child is able to
15 stand with ankle support, moves to the floor. Floor exercises involve seven pieces of
16 MEDEK equipment which can be arranged in ways to challenge the child’s sense of
17 balance. Practitioners claim that the effectiveness of MEDEK therapy depends on the level
18 of dysfunction, the amount of time spent in MEDEK therapy, and the age the patient begins
19 intervention. MEDEK practitioners recommend beginning MEDEK treatments very early
20 in the child’s life because lack of motor development as a young child snowballs as the
21 child gets older. Practitioners of MEDEK and clients and their parents who have
22 participated in this therapy claim better than expected improvement in motor skills.
23 However, well-designed clinical studies are needed to determine the effectiveness of
24 MEDEK.

25 **EVIDENCE REVIEW**

26 ASH is unaware of any peer reviewed literature published on MEDEK therapy as noted
27 with a thorough literature search.
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29 **PRACTITIONER SCOPE AND TRAINING**

30 Practitioners should practice only in the areas in which they are competent based on their
31 education, training and experience. Levels of education, experience, and proficiency may
32 vary among individual practitioners. It is ethically and legally incumbent on a practitioner
33 to determine where they have the knowledge and skills necessary to perform such services
34 and whether the services are within their scope of practice.
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36 It is best practice for the practitioner to appropriately render services to a member only if
37 they are trained, equally skilled, and adequately competent to deliver a service compared
38 to others trained to perform the same procedure. If the service would be most competently
39 delivered by another health care practitioner who has more skill and training, it would be
40 best practice to refer the member to the more expert practitioner.
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1 Best practice can be defined as a clinical, scientific, or professional technique, method, or
2 process that is typically evidence-based and consensus driven and is recognized by a
3 majority of professionals in a particular field as more effective at delivering a particular
4 outcome than any other practice (Joint Commission International Accreditation Standards
5 for Hospitals, 2020).

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7 Depending on the practitioner’s scope of practice, training, and experience, a member’s
8 condition and/or symptoms during examination or the course of treatment may indicate the
9 need for referral to another practitioner or even emergency care. In such cases it is prudent
10 for the practitioner to refer the member for appropriate co-management (e.g., to their
11 primary care physician) or if immediate emergency care is warranted, to contact 911 as
12 appropriate. See the *Managing Medical Emergencies (CPG 159 – S)* policy for
13 information.

14 **References**

15 Cuevas Medek Exercise. Retrieved on June 29, 2023 from [https://napacenter.org/the-
16 benefits-of-cme/](https://napacenter.org/the-benefits-of-cme/)

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19 Joint Commission International. (2020). Joint Commission International Accreditation
20 Standards for Hospitals (7th ed.): Joint Commission Resources