Medical Coverage Policy | Remote Electrical Neuromodulation for Migraines

EFFECTIVE DATE: 06|01|2026
POLICY LAST UPDATED: 02|18|2026

OVERVIEW
Migraine attacks due to episodic or chronic migraine require acute management. Some individuals may also require preventive migraine therapy. Current first-line therapy for treatment and prevention of acute migraine involves use of various pharmacologic interventions. Regular use of pharmacologic interventions can result in medication overuse and increased risk of progression from episodic to chronic migraine. Nonpharmacologic remote electrical neuromodulation (REN [e.g. Nerivio]) may offer an alternative to pharmacologic interventions for patients with migraine.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
Medicare Advantage Plans and Commercial Products
Remote electrical neuromodulation for chronic migraine is covered.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable Durable Medical Equipment (DME) benefits/coverage.

BACKGROUND
Migraine is a neurologic disease characterized by recurrent moderate to severe headaches with associated symptoms that can include aura, photophobia, nausea, and/or vomiting. Overall migraine prevalence in the United States is about 15% but varies according to population group. Prevalence is higher in women (21%), among American Indian/AlaskaNatives (22%), and among 18- to 44-year-olds (19%). Social determinants including low education level (18%), use of Medicaid (27%), high poverty level (23%), and being unemployed (22%) are also associated with higher rates of migraine.

Migraine is categorized as episodic or chronic depending on the frequency of attacks. Generally, episodic migraine is characterized by 14 or fewer headache days per month and chronic migraine is characterized by 15 or more headache days per month. Specific International Classification of Headache Disorders diagnostic criteria are as follows:

- Episodic migraine:
    1. Untreated or unsuccessfully treated headache lasting 4 to 72 hours
    2. Headache has at least 2 of the following characteristics:
        a. Unilateral location
        b. Pulsating quality
        c. Moderate or severe pain intensity
        d. Aggravation by or causing avoidance of routine physical activity
    3. At least 1 of the following during headache:
        a. Nausea and/or vomiting
        b. Photophobia or phonophobia.
- Chronic migraine:

1. Migraine-like or tension-type headache on 15 or more days per month for more than 3 months
2. At least 5 headache attacks without aura meet episodic migraine criteria 1 to 3, and/or at least 5headache attacks with aura meet episodic migraine criteria 2 to 3
3. On more than 8 days per month for more than 3 months, fulfilling any of the following criteria:
    a. For migraine without aura, episodic migraine criteria 2 and 3
    b. For migraine with aura, episodic migraine criteria 1 and 2
    c. Believed by the patient to be migraine at onset and relieved by a triptan or ergot derivative.

Migraine attacks, whether due to episodic or chronic migraine, require acute management. The goal of acute treatment is to provide pain and symptom relief as quickly as possible while minimizing adverse effects, with the intent of timely return to normal function. Pharmacologic interventions for treatment of acute migraine vary according to migraine severity. First-line therapy for an acute episode of mild or moderate migraine includes oral non-steroidal anti-inflammatory drugs (NSAIDs) or acetaminophen. Moderate to severe migraine can be treated through the use of triptans or an NSAID-triptan combination. Antiemetics can be added for migraine accompanied by nausea or vomiting, though certain antiemetic medications used as monotherapy can also provide migraine relief. Other pharmacologic interventions used to treat acute migraine include calcitonin-gene related peptide antagonists, which can be used in patients with an insufficient response or contraindications to triptans, lasmiditan, and dihydroergotamine. Migraine can be managed at home, although acute migraine is a frequently cited reason for primary care and emergency department visits. Regular use of pharmacologic interventions can result in medication overuse, which in turn could lead to rebound headache and increased risk of progression from episodic to chronic migraine.

Many individuals who suffer from migraine may also benefit from preventive migraine therapy, including those with frequent or long-lasting migraines, migraine attacks that diminish quality of life or cause significant disability despite acute treatment, contraindications to or failure of acute therapies, and risk of medication overuse headache. The main goals of preventive therapy are to reduce future attack frequency, severity, and duration, improve responsiveness to acute treatments, improve function and reduce disability, and prevent progression of episodic migraine to chronic migraine. For most adults with episodic migraines who may benefit from preventive therapy, initial therapy with an antiepileptic drug (divalproex sodium, sodium valproate, topiramate) or beta-blockers (metoprolol, propranolol, timolol) is recommended. Frovatriptan may be beneficial as initial therapy for prevention of menstrually associated migraine. Antidepressants (amitriptyline, venlafaxine), alternative beta-blockers (atenolol, nadolol), and additional triptans (naratriptan, zolmitriptan for menstrually associated migraine prevention) may be considered if initial therapy is unsuccessful. For preventive treatment of pediatric migraine, many children and adolescents who received placebo in clinical trials improved and most preventive medications were not superior to placebo. Possibly effective preventive treatment options for children and adolescents may include amitriptyline, topiramate, or propranolol.

Remote electrical neuromodulation (REN) may offer an alternative to pharmacologic interventions for patients with acute migraine or it may decrease the use of abortive medications and the risk of medication overuse to treat acute migraines. The only currently available REN device (Nerivio™) cleared for use by the Food and Drug Administration (FDA) is worn on the upper arm and stimulates the peripheral nerves to induce conditioned pain modulation (CPM). The conditioned pain in the arm induced by the Nerivio REN device is believed to reduce the perceived migraine pain intensity. Control of the REN device is accomplished through Bluetooth communication between the device and the patient's smartphone or tablet. For acute treatment, at onset of migraine or aura and no later than within 1 hour of onset, the user initiates use of the device through their mobile application. Patient-controlled stimulation intensity ranges from 0 to 100%, corresponding to 0 to 40 milliamperes (mA) of electrical current. Patients are instructed to set the device to the strongest stimulation intensity that is just below their perceived pain level. The device provides stimulation for up to 45 minutes before turning off automatically. The Nerivio manufacturer indicates that the device can be used instead of or in addition to medication.

Regulatory Status
In May 2019, Nerivio Migra™ (Theranica Bio-Electronics Ltd.) was granted a de novo classification by the FDA. This new classification applied to this device and substantially equivalent devices of this generic type. Nerivio Migra was initially cleared for treatment of acute migraine in adults who do not have chronic migraine.

In October, 2020, Nerivio was cleared for marketing by the FDA through the 510(k) process. FDA determined that this device was substantially equivalent to Nerivio Migra for use in adults. The device name changed to just "Nerivio" and the exclusion of chronic migraine patients was removed. The Nerivio device can provide more treatments than the predicate Nerivio Migra (12 treatments vs. 8 treatments) and has a longer shelf life (24 months vs. 9 months). In January, 2021, the Nerivio device was cleared for use in patients aged 12 to 17 years. In February 2023, Nerivio's indication was expanded to include preventive treatment of migraine with or without aura in individuals 12 years and age or older and was cleared for marketing through the 510(k) process. In May 2025, the Nerivio and rechargeable Nerivio Infinity devices were cleared for marketing (K241756) with an expanded indication for acute and/or preventive treatment of migraine with or without aura in patients 8 years and older.

Nerivio is contraindicated in patients with uncontrolled epilepsy and patients with an active implantable medical device, such as a pacemaker, hearing aid implant, or any implanted electronic device. Nerivio has not been evaluated in patients with congestive heart failure, severe cardiac or cerebrovascular disease, pregnancy, or patients under the age of 8 years.

CODING

Medicare Advantage Plans and Commercial Products
The following HCPCS code(s) are covered.

A4540 Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm

RELATED POLICIES

Not applicable

PUBLISHED

Provider Update, January/April 2026
Provider Update, December 2024
Provider Update, January 2024
Provider Update, October 2022

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