Behavioral Health Clinical Practice Guidelines Quarterly Feature

For the remainder of 2025 we will be featuring Aetna Better Health of Louisiana's clinical practice guidelines (CPGs) for frequently diagnosed and treated mental health disorders. CPGs are evidence-based guidelines designed to assist providers in making informed decisions about member care. Evidence suggests that utilizing CPGs can improve treatment outcomes. Providers should consider the individuals needs of each member when utilizing CPGs. Providers' incorporation of CPGs into their practice are reviewed as part of Aetna Better Health of Louisiana's Behavioral Health Provider Monitoring Quality reviews.

Major Depressive Disorder Clinical Practice Guidelines

Sufficient evidence to support the diagnosis of Major Depressive Disorder must be found. Medical conditions that might cause depression or complicate treatment should be ruled out.
Education about Major Depressive Disorder and its treatment should be delivered to the member, and if appropriate, to their family.
If psychotic features are found, the treatment plan should include the use of either antipsychotic medication or ECT, or it should be clearly documentation why not.
If Major Depressive Disorder is of moderate severity or above, the treatment plan should use a combination of psychotherapy and antidepressant medication, or clearly documentation why not.
The psychiatrist should deliver education about prescribed medication, including signs of new or worsening suicidality, and the high-risk times for this side effect, if applicable to the medication prescribed.
If provider id not a medical doctor, there is documentation of a referral for a medical/psychiatric evaluation if any of the following are present: psychotic features, complicating medical/psychiatric conditions, severity level of moderate or above.

Schizophrenia Clinical Practice Guidelines

Assessment for other psychiatric disorders and medical conditions that may cause symptoms and/or complicate treatment must be completed.
Education must be delivered regarding schizophrenia and its treatment to the member and the family.
If significant risk is found, the provider must implement a plan to manage the risk, including a plan for diminishing access to weapons/lethal means.
If provider is a not a medical doctor, documentation of a referral for a psychiatric evaluation must be included in the member record.
If a psychiatric referral was made, the provider must document the results of that evaluation and make any relevant adjustments to the treatment plan.
If provider is a medical doctor, and there are several unsuccessful medication trials and/or severe suicidality, then the member should be considered for ECT and/or Clozapine.

ADHD Clinical Practice Guidelines

Member diagnosis should be determined based on input/rating scales from family members/caregivers, teachers, and other adults in the member's life.
Medical evaluation should be reviewed to rule out medical causes for the signs and symptoms.
Psychoeducation should be delivered to all members with ADHD and in the case of minors, to the parents/caregivers.
The treatment plan and rationale as well as available treatments, including medications and their benefits, risks, side effects, should be discussed with the member and the parent/caregiver in the case of minors.
If the member is a minor, family interventions that coach parents on contingency management methods should be used.
A comprehensive assessment for comorbid psychiatric disorders should be conducted.

Generalized Anxiety Disorder Clinical Practice Guidelines

Member's diagnosis of Generalized Anxiety Disorder should be based on DSM-5-TR criteria.
Member should receive education from physician about Generalized Anxiety Disorder, options for treatment and general prognosis.
Cognitive Behavioral Therapy based psychotherapy and/or psychopharmacotherapy should be considered as first line treatment.
Ongoing monitoring of symptoms and assessment for severity must take place.

Suicide Risk Clinical Practice Guidelines

High to intermediate level of acute risk for suicide and use of a risk assessment must be documented.
A psychosocial evaluation must be completed.
An assessment for lethal means and a plan for limited access to lethal means must be completed if needed.
Member must be assessed for indications that inpatient admission is needed.
A safety plan that includes social support must be developed if risk is not imminent
Continued monitoring of patient status and reassessment of risk in follow-up contacts must take place.

Oppositional Defiant Disorder Clinical Practice Guidelines

Member diagnosis must be based on DSM-5-TR criteria.
A comprehensive assessment for comorbid diagnoses must be conducted.
A biopsychosocial assessment must be utilized to develop an individualized treatment plan.
Education about Oppositional Defiant Disorder, options for treatment, and general prognosis must be provided to the member.
For individuals 18 years of age and younger, the legal guardian/caretaker must be involved in treatment interventions.

Substance Use Disorder Clinical Practice Guidelines

Education about substance use disorder should be delivered to the member.
A plan for maintaining sobriety, including strategies to address triggers should be developed, and the role of substance use in increasing suicide risk must be discussed.
The treatment plan should include a referral to self-help groups such as AA, Al-Anon, and NA.
Evaluation should include the consideration of appropriate psychopharmacotherapy
If provider is a medical provider, abstinence-aiding medications should be considered.
If provider is not a medical provider, a referral for abstinence-aiding medication or a diagnostic consultation should be considered.

Bipolar Clinical Practice Guidelines

Member's diagnosis should be documented by type (acute manic, hypomania, mixed, or acute depressive episode).
A complete psychological assessment should take place. First-line treatment that includes psychotherapy using trauma-focused therapy or stress management and/or pharmacotherapy should be used.
Psychoeducation, psychotherapy, and family intervention should be provided as indicated.
Medication monitoring and managing of adverse effects must take place if provider is a medical provider.

Post Traumatic Stress Disorder Clinical Practice Guidelines

Member's diagnosis should be based on DSM-5-TR criteria.
A comprehensive assessment for comorbid diagnoses must be conducted.
Education must be delivered about Post Traumatic Stress Disorder, its treatment, and benefits/risks associated with trauma related treatment interventions
If provider is a prescriber, an SSRI should be considered as first line treatment.
If provider is not prescriber, a referral to a prescriber to evaluate for appropriateness of psychopharmacotherapy should take place.
If provider made referral to and/or member has established prescriber, coordination of care with member's prescriber should take place.