

Regenerative medicine sits in a strange space between hope and hesitation. Patients walk into my office holding printouts about stem cells, platelet rich plasma, and “cell regeneration fasting” protocols. They are excited, sometimes desperate, and almost always confused about one thing: will insurance help pay for any of this?

The honest answer is, it depends, and usually not as much as people expect.

This article reflects the kind of conversation experienced clinicians have with patients when regenerative medicine meets the realities of health insurance, safety, and outcomes. If you are weighing these therapies, you should understand not only the science and the marketing, but also how doctors think about cost, coverage, and risk in the real world.

## **What exactly is a regenerative medicine doctor?**

Patients often ask, “What is a regenerative medicine doctor, and is it a real specialty?”

Regenerative medicine is not a single board-certified specialty the way cardiology or dermatology is. It is a clinical focus that cuts across several fields. The physicians who most often provide regenerative therapies usually come from:

- physical medicine and rehabilitation (PM&R or physiatry)
- orthopedic surgery
- sports medicine and pain medicine
- rheumatology
- sometimes dermatology, plastic surgery, or ophthalmology

They use techniques aimed at helping the body repair or replace damaged cells, tissue, or organs. In practice, that usually means things like platelet rich plasma (PRP), bone marrow aspirate concentrate, adipose (fat) derived cell products, and, in a few well regulated settings, FDA approved cell based products.

A good regenerative medicine doctor, in my view, is first a solid specialist in their original field. They should be able to discuss standard options like physical therapy, medications, or joint replacement as fluently as they discuss stem cells or PRP. When a physician only offers “regeneration” as the answer to everything, that is a red flag.

## **The four broad types of regeneration doctors talk about**

Scientists describe “regeneration” in several ways, but in clinical practice physicians usually refer to four broad categories of regenerative processes or treatments:

Cellular replacement, where cells are transplanted or stimulated to replace damaged ones. Examples include hematopoietic stem cell transplants for blood cancers, or experimental mesenchymal stromal cell treatments for joint disease.

Tissue engineering, which involves scaffolds, biomaterials, or lab grown tissues like engineered cartilage or skin substitutes.

Biologic stimulation, where growth factors, PRP, or certain small molecules nudge existing cells to repair and remodel tissue.

Organ and structural regeneration, a long term goal involving organoids, 3D printed tissues, and potentially bioengineered organs.

A lot of what gets marketed to the public as “stem cell therapy” actually falls into the third category: concentrated platelets or minimally manipulated cells intended to modulate inflammation and support repair, rather than fully regrow cartilage or an organ.

## What is the biggest problem with regenerative medicine right now?

If you ask most clinicians who practice responsibly in this area, the single biggest problem is mismatch between hype and evidence.

Patients see celebrity testimonials, dramatic clinic marketing, or podcasts where athletes praise “miracle” recoveries. Joe Rogan has spoken at length about traveling to Panama for stem cell treatment, for example, which naturally drives questions like “What country is best for stem cell treatment?” and “Why can’t I get that here?”

On the ground, the reality looks more like this:

Outcomes are variable. Some patients report excellent pain relief and functional improvement, others see minimal benefit, and a few worsen.

Studies are improving but still patchy. For some uses, such as PRP for knee osteoarthritis or lateral epicondylitis, there is a reasonable body of randomized trials suggesting benefit for certain patients. For many other indications, the data are small, heterogeneous, or absent.

Regulation is uneven. In the United States, only a narrow set of cell based products is fully FDA approved, usually for very specific conditions. Many clinics operate in a gray zone, claiming compliance by using “minimally manipulated” autologous tissues, while regulators and professional societies argue over what counts as compliant.



Costs are high and usually out of pocket. That creates strong financial incentives to oversell.

This evidence gap, combined with aggressive marketing and high emotional stakes for patients with chronic pain or neurodegenerative disease, is what keeps many mainstream physicians cautious.

## **What is the success rate of regenerative medicine?**

There is no single number for “the success rate of regenerative medicine” because the term covers dozens of different treatments and conditions.

For example, some orthopedic and sports medicine literature reports:

PRP for mild to moderate knee osteoarthritis shows clinically meaningful improvement in pain and function for perhaps 50 to 70 percent of well selected patients over 6 to 12 months, with best results in younger individuals and earlier disease.

PRP for tennis elbow or certain tendinopathies often outperforms steroid injections in medium term pain relief, though protocols differ and not every study agrees.

Stem cell like preparations for advanced knee arthritis or spine conditions show more modest and inconsistent results, with some patients doing well and others no better than placebo or standard care.

Hematopoietic stem cell transplants for hematologic cancers can, of course, be life saving, but that is a completely different clinical universe from orthopedic stem cell injections.

When a doctor quotes a “success rate,” you should always ask: for which condition, with which protocol, in what kind of patients, and compared to what? A responsible physician will talk in ranges and probabilities, not guarantees.

## **Is regenerative medicine painful?**

Most regenerative procedures involve some level of discomfort, but the degree varies.

Blood draws and simple PRP injections often feel similar to other joint or tendon injections. Discomfort generally peaks in the first 24 to 72 hours, as the injected area reacts to the concentrated platelets and induced inflammation. Many patients describe it as a “bad flare” of their usual pain, followed by gradual improvement over weeks.

Bone marrow aspirate procedures, where marrow is taken from the pelvis, can be more uncomfortable. Local anesthetic helps, and some clinics offer light sedation. Patients usually tolerate it, but they should not expect it to feel like a quick vaccine shot.

Most doctors advise planning for at least a few days of activity modification, icing, and over the counter analgesics that do not interfere with platelet function, such as acetaminophen. Nonsteroidal anti inflammatories are often avoided around the time of PRP.

If a clinic insists a procedure is “completely painless,” that is marketing, not medicine.

## **Does fasting for 72 hours regenerate cells?**

You will hear claims online that a 72 hour fast “resets” the immune system or triggers massive stem cell regeneration. The science is less dramatic and more nuanced.

Animal studies and some small human trials suggest that prolonged fasting or very low calorie diets can activate autophagy and change immune cell populations. There is early evidence that metabolic stress can influence stem

cell behavior and tissue repair.

However:

The human data are limited and not specific to orthopedic or neurologic regenerative goals.

A 72 hour fast is not a replacement for medically delivered regenerative therapies.

For some people, such as those with diabetes, eating disorders, or certain medications, prolonged fasting can be risky.

Some regenerative medicine doctors may discuss nutrition, intermittent fasting, or weight loss as part of a comprehensive plan, especially for joint disease where mechanical load matters. But reputable clinicians do not present a 72 hour fast as a stand alone, proven "cell regeneration treatment."

## **Who is a good candidate for regenerative medicine?**

When I talk to a patient about whether they are a good candidate for regenerative therapy, I am really asking several practical questions.

Here is the kind of informal checklist many physicians use, stated plainly:

- The diagnosis is clear and fits conditions where regenerative approaches have at least moderate supporting evidence, such as certain tendon injuries or early osteoarthritis, rather than completely experimental uses like advanced dementia.
- The problem is significantly impacting quality of life despite appropriate standard care, including physical therapy, weight management, and reasonable medication trials.
- The patient's expectations are realistic, meaning they understand the goal is pain reduction and functional improvement, not magical regrowth of a destroyed joint.
- Comorbidities like uncontrolled diabetes, severe immune disorders, or active infection are either absent or well controlled.
- The patient can afford the treatment without sacrificing basic needs, and understands that future booster procedures may sometimes be recommended.

Age alone is not an absolute barrier. I have seen active 70 year olds respond beautifully to PRP, and younger patients with poor results. Biology, severity of structural damage, and adherence to rehab often matter more than the birthdate on the chart.

## **What is the average cost of regenerative medicine?**

Costs vary dramatically by location, type of procedure, and who is performing it. As of the past few years in the United States, ballpark figures for common orthopedic and sports medicine applications look roughly like this:

PRP injections for a single joint or tendon might run from 500 to 2,500 dollars per session.

Bone marrow derived cell preparations or adipose tissue derived products often range from 3,000 to 8,000 dollars, sometimes more if multiple joints or spine levels are treated.

Multi site packages or "whole body" approaches marketed by some clinics can exceed 10,000 dollars.

Cosmetic and dermatologic applications, such as PRP for hair loss or skin rejuvenation, fit similar ranges but depend heavily on the market.



Most of this is paid out of pocket. That is where insurance comes in, or fails to.

## **Will insurance pay for regenerative medicine?**

This is usually the decisive question. Patients ask, “Will insurance pay for regenerative medicine?” expecting a simple yes or no. Instead, they get a thicket of terms like “experimental,” “investigational,” and “off label.”

Here is the blunt reality in many countries with private or mixed insurance systems, including the United States:

PRP for musculoskeletal conditions is sometimes covered, but more often not. A few progressive plans or self insured employers may cover it in specific situations, yet for many patients it is self pay.

Most **Regenerative Medicine Doctor Scottsdale** orthobiologic stem cell like injections for joints and spine are not covered. Insurers typically classify them as experimental or investigational, pointing to inconsistent evidence and lack of FDA approval for those indications.

FDA approved cell based therapies for blood cancers, inherited disorders, or corneal reconstruction are covered in many cases, because they meet traditional thresholds for safety, efficacy, and regulatory status.

Some components of the care episode, such as office visits, diagnostic imaging, or physical therapy, are covered in the usual way, even when the regenerative procedure itself is not.

The result is a patchwork. Two patients with the same knee condition, in different states under different employer plans, may face completely different coverage decisions.

## **How doctors explain insurance coverage at the visit**

Most physicians who practice ethically in this space have a well rehearsed conversation about money and coverage before any procedure is scheduled. It typically includes a few key steps.

Clarifying medical necessity. The doctor documents the diagnosis, prior treatments tried, and the clinical rationale for suggesting a regenerative approach. This is critical if you want even a slim chance of prior authorization.

Naming the procedure specifically. "Stem cells" is too vague. Insurers will want to know whether the plan is PRP, bone marrow aspirate concentrate, an FDA approved product, or something else.

Discussing coding strategy without gaming the system. A recurring ethical concern is clinics billing a regenerative procedure under a different code, such as a standard injection, to get paid. Responsible clinicians do not miscode to deceive payers.

Separating covered and non covered charges. Many practices clearly outline what portion of the visit is billable to insurance and what is cash only. For example, the consultation and ultrasound may be billed to insurance, while the actual PRP preparation and injection are self pay.

Patients who walk out understanding their total expected cost, possible future costs, and refund policies almost always feel less burned, even if the answer is "this is not covered."

## **Questions to ask your insurer before treatment**

Once your doctor has explained the clinical side, it helps to speak directly with your insurer or benefits office. Patients who get clear answers in advance avoid nasty surprises later.

Useful questions include:

- What is your policy on PRP or stem cell like injections for my specific diagnosis?
- If these procedures are classified as experimental, are there any exceptions or pilot programs?
- Are there any FDA approved regenerative products for my condition that you do cover?
- Will you cover related imaging, anesthesia, or facility fees even if the injection itself is not covered?
- Do you require pre authorization, and if so, what documentation do you need from my doctor?

Take notes, ask for written confirmation if possible, and remember that front line call center staff may not always understand these treatments. Sometimes you have to push gently for a supervisor or clinical reviewer.

## **Does insurance cover Kinetix and similar branded options?**

Patients increasingly arrive having researched specific branded protocols: Kinetix, Regenexx, and others. The question "Does insurance cover Kinetix?" reflects a broader issue: insurers do not usually credential brands, they credential procedure codes and medical necessity.

For a branded PRP based or orthobiologic protocol, insurers generally evaluate:

What is being injected (platelets, bone marrow concentrate, fat derived cells, an FDA approved product, or something else).

How it is processed, and whether that crosses regulatory lines from minimal to more than minimal manipulation.

Where it is injected and for what diagnosis.

In most cases, if the underlying procedure is categorized as experimental, it will not be covered simply because it has a branded name. A few large employers with direct arrangements may make exceptions, but this is not the

norm.

## **What are the disadvantages and risks of regenerative medicine?**

Every therapy has trade offs. The disadvantages of regenerative medicine, especially in the cash pay sphere, usually fall into several buckets.

Cost and financial strain. Spending thousands on therapy with uncertain benefit can create real hardship, particularly if multiple rounds are recommended.

Uncertain benefit. Even under the best protocols, not every patient responds. You might be in the responder group or you might not, and we do not yet have perfect predictors.

Lack of standardization. Not all PRP is the same. Concentration, leukocyte content, injection technique, and rehab protocols vary widely. This makes it hard to compare clinics or reproduce outcomes.

Regulatory and safety issues. Although serious complications are rare in responsible hands, infections, inflammatory reactions, and nerve or tissue injury can occur. In less regulated settings, including some overseas clinics, oversight and sterility standards may be lower.

Opportunity cost. Time and money spent on regenerative options can sometimes delay other effective treatments, such as joint replacement, appropriate medication adjustments, or structured rehab.

A good doctor will walk through these candidly rather than glossing over them.

## **Which country is “best” for stem cell treatment?**

Patients often ask about going abroad for stem cell therapy, partly influenced by stories like Joe Rogan traveling to Panama. Clinics in Panama, Mexico, Costa Rica, and parts of Eastern Europe and Asia market expanded cell products and intravenous treatments that are not allowed, or not yet approved, in the United States.

“Best” can mean several things: most aggressive, most cutting edge, or most regulated and evidence based. Those can point in very different directions.



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Countries with strong regulatory systems, like the United States, much of Western Europe, and Japan, tend to restrict stem cell use to specific, well studied indications. This can feel frustratingly conservative, but it usually reflects concern about safety and reproducibility.

Medical tourism hubs may offer broader menus, including high dose intravenous cell infusions for aging, autism, or neurodegeneration, with far less rigorous trial data. Some patients report benefit; others spend large sums with little change. Long term safety data for many of these indications are sparse.

When doctors are cautious about endorsing specific countries or clinics, it is not because they want to hoard therapies, it is because they have seen patients come home with infections, empty wallets, or complex complications that are difficult to treat.

## **How much do regenerative medicine doctors make?**

Patients sometimes ask, only half joking, "How much do regenerative medicine doctors make from this?" It is a fair question, [Regenerative Medicine Doctor Scottsdale](#) because financial incentives can color recommendations.

There is no single salary band for "regenerative medicine doctors," since they come from many specialties. Income typically reflects their underlying specialty plus any additional cash based procedures.

In the United States, orthopedic surgeons, interventional pain physicians, and sports medicine specialists can already be toward the upper middle of physician compensation. While figures shift year by year, specialties like orthopedics, plastic surgery, cardiology, and radiology often jockey for the title of highest paid doctor specialty, with median incomes that can exceed 600,000 dollars annually in some surveys.

At the opposite end, fields like pediatrics, family medicine, and some primary care internal medicine roles frequently sit among the lowest paying doctor specialties, with medians closer to 200,000 to 260,000 dollars.

A busy regenerative practice that offers mostly cash pay procedures can add significantly to a doctor's revenue, especially if overhead is managed carefully. That does not mean every recommendation is profit driven, but it is one more reason you should expect full financial transparency and a genuine discussion of nonprocedural options.

Many clinicians who practice responsibly try to insulate their decision making from revenue by following clear internal criteria: they will not offer regenerative injections when imaging and exam suggest that the chance of meaningful improvement is very low.

## **Practical advice for patients considering regenerative treatments**

If you are weighing treatment, you do not need to become a biologist, but you do need a basic strategy.

First, get a firm diagnosis from a qualified specialist. Regenerative treatment for misdiagnosed pain rarely helps.

Second, exhaust reasonable conservative options. For musculoskeletal issues, that usually means appropriate physical therapy, weight management, ergonomics, and evidence based medications.

Third, ask your doctor specifically what type of regenerative treatment they recommend, what data support that use in your condition, and how they track outcomes in their own practice. A doctor who can say, "In our clinic, about half of patients like you achieve at least 50 percent pain reduction" is being much more honest than one who simply promises "great results."

Fourth, look closely at finances. Know the full cost, the realistic odds of needing repeat treatments, and what share, if any, your insurance might cover.

Finally, remember that regenerative therapies work best as one element in a broader plan: rehab, sleep, nutrition, mental health, and realistic activity goals. Even the most promising biologic injection rarely succeeds in isolation.

Regenerative medicine will likely become more precise, more regulated, and better covered by insurance over the next decade, as evidence accumulates and products gain formal approvals. Until then, a careful, fully informed conversation with your doctor, including a sober look at insurance realities, remains your best tool for deciding whether these treatments are right for you.

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