Joe Rogan has probably done more to popularize stem cell therapy than any single medical conference or journal article. When he described flying to Panama for high dose stem cell infusions, then coming back raving about how much better his shoulder and overall recovery felt, phones at many regenerative clinics started ringing with a new kind of question:

“I want what Joe Rogan had. Can you do that here?”

That spotlight is a mixed blessing. On one hand, it draws attention to a field that has real potential. On the other, it can flatten nuance, compress evidence, and turn a complex medical landscape into a celebrity testimonial.

As someone who practices in regenerative medicine, I hear versions of the Rogan question weekly. Let’s unpack, in plain language, what he reportedly did, what a regenerative medicine doctor actually does, what experts see as the biggest problems and promises in this field, and how all of that should inform your choices.

What is a regenerative medicine doctor, really?

Patients often ask, “What is a regenerative medicine doctor?” as if it were a formal board certification like cardiologist or neurologist. It is not.

Regenerative medicine is a strategy, not a specialty. The goal is to help the body repair, replace, or restore damaged tissues instead of only managing symptoms. A “regenerative medicine doctor” is usually a physician who has a primary specialty, for example:

- Physical medicine and rehabilitation
- Sports medicine or orthopedics
- Pain management (anesthesiology background)
- Rheumatology
- Sometimes family medicine or internal medicine with extra training

Then, on top of that base, they train in biologic therapies such as ***Regenerative Medicine Doctor Scottsdale*** platelet rich plasma (PRP), bone marrow or adipose derived cell preparations, certain types of stem cell or progenitor cell therapies, prolotherapy, or tissue engineering techniques.

Their day to day work may include:

- Evaluating joint, tendon, spine, or soft tissue problems with a detailed biomechanical and functional lens
- Deciding when regenerative options make sense and when surgery, standard injections, or conservative care are better
- Performing image guided (usually ultrasound or fluoroscopy) injections with biologic materials
- Managing expectations: which is often the hardest part

From the outside, patients see the procedure day. On the inside, most of the good outcomes come from careful case selection and realistic planning, not from the needle itself.

As for money, “How much do regenerative medicine doctors make?” has a wide range. A physiatrist or sports physician in a mixed insurance and cash practice might earn something like other specialists in their base field, often in the range of roughly 250,000 to 500,000 USD per year, sometimes more in high volume private clinics. A few in affluent markets with cash only boutique practices can exceed that, but that is not the norm and usually reflects business structure more than the medicine itself.

By comparison, if you are curious about extremes, what is the highest paid doctor specialty today tends to be fields like orthopedic surgery, plastic surgery, cardiology, and certain procedural subspecialties, where total compensation can exceed 600,000 to 1,000,000 USD in some settings. On the other end, what is the lowest paying doctor specialty commonly includes primary care fields like pediatrics, family medicine, and psychiatry in some regions, which may cluster around 200,000 to 260,000 USD in many markets. Geography, practice type, and ancillary services matter as much as specialty name.

Where did Joe Rogan get his stem cell treatment?

Rogan has publicly described going to Panama for his treatment, specifically to a clinic associated with Dr. Neil Riordan, often referred to as the Stem Cell Institute in Panama City. This center is known for using allogeneic umbilical cord derived mesenchymal stem cells, harvested from donated cord tissue after healthy births.

The protocol he described involved both intravenous infusions and direct injections to injured areas. The doses mentioned in interviews are significantly higher than what is commonly done in typical US clinics, partly because of US Food and Drug Administration (FDA) regulations that limit what can be done with cell products here.

It is important to be very clear on one point. Panama is outside the US regulatory environment. That does not automatically make it unsafe or illegitimate, but it means the guardrails are different. Their protocols are not FDA approved treatments. They operate under Panamanian regulations, which allow therapies that are still considered experimental or restricted in the US.

Patients hear that Rogan felt dramatically better after large doses of cord derived cells and understandably wonder: should I go there too?

To answer that, we have to pull apart what he likely received and how regenerative doctors think about it.

What did Rogan's protocol probably involve?

Different interviews from Rogan and the Panamanian team point to a basic structure that looks roughly like this:

- Use of allogeneic mesenchymal stem cells derived from donated umbilical cord tissue
- High total cell dose compared with standard US procedures
- Intravenous infusions to reach systemic circulation
- Targeted injections into joints or soft tissue for local problems such as shoulder pain

From a biologic standpoint, these cells are not magic building blocks that simply turn into new cartilage or tendon on command. Most modern stem cell science suggests they act more as signaling or "medicinal" cells. They release a mix of growth factors, cytokines, and other molecules that can calm inflammation, modulate the immune environment, and, in some situations, encourage resident cells to repair.

Rogan reported marked improvements in pain, recovery capacity, and how his shoulder felt under heavy training loads. His story is one powerful data point. It is not a controlled trial.

How regenerative specialists interpret his experience

When doctors who actually work with biologics listen to Rogan describe his outcomes, several things come to mind.

First, he was a motivated, high performance individual already near the top of what can be achieved with training, nutrition, rehab, and sleep. That often magnifies any additional benefit, because the "noise" from lifestyle variables

is lower.

Second, his main issues were orthopaedic and soft tissue, areas where regenerative therapies like PRP and cell based treatments have some of the best supporting data. Chronic knee osteoarthritis, rotator cuff tendinopathy, and certain ligament injuries are not the wild west of regenerative medicine; they are among the best studied indications.

Third, he received a protocol that is not reproducible exactly the same way in most US clinics. Our regulations limit the ability to culture expand or extensively manipulate cells, and heavily restrict the use of non autologous (someone else's) stem cell preparations outside clinical trials.

From the lens of an experienced regenerative clinician, Rogan's case sits in the overlap of possibility and uncertainty. It is plausible he obtained real benefit. It is also plausible that some of that benefit came from stacking everything he already did with a high dose biologic push and the psychological lift of investing heavily in his own recovery.

The crucial point for patients is this: regenerative medicine is not a monolithic thing. The stem cell treatment Rogan had in Panama is one specific protocol among hundreds, not a standard of care or a template that can simply be copied everywhere.

What is the biggest problem with regenerative medicine?

When I am honest with patients, I tell them the biggest problem with regenerative medicine is not lack of potential. It is the gap between marketing and evidence.

Several issues play into that.

First, heterogeneity. "Stem cell therapy" can mean bone marrow aspirate concentrate from your own hip, minimally processed adipose tissue from your belly, cultured cord derived cells from a donor, or even exosome rich biologic fluids. They behave differently. They are regulated differently. Yet the public hears a single phrase and assumes equivalence.

Second, limited high quality trials. For certain orthopedic uses, such as knee osteoarthritis with PRP, we now have reasonably good data showing meaningful improvements for many patients compared to corticosteroids or hyaluronic acid. For others, like systemic infusions of allogeneic stem cells for general "anti aging" or brain performance, the evidence is thin and mostly early stage.

Third, regulation and enforcement. In the US, the FDA has cracked down more aggressively in recent years, but hundreds of clinics still operate in gray zones, sometimes offering unproven products with grandiose claims. That erodes trust, even for responsible clinicians who stay within guidelines.

Fourth, cost and access. Cash pay procedures with price tags in the thousands create perverse incentives. A desperate patient with chronic pain or a degenerative condition is vulnerable to reassurance and hope. Not every provider resists the temptation to oversell.

Underlying all of this is a simple reality. Regeneration is slow, partial, and probabilistic. Most patients do not regrow a pristine 18 year old knee. They get a percentage improvement in pain and function, which can still be life changing, but rarely matches the loftiest promises.

Who is a good candidate for regenerative medicine?

I tend to think of candidacy in layered terms, not "yes" or "no."

From an orthopedic perspective, good candidates usually share several traits:

- A structural problem that is significant enough to cause symptoms, but not so advanced that the tissue is beyond reasonable salvage
- Some preserved joint space and alignment in arthritis cases, not bone on bone across the entire joint
- A willingness to engage in rehab, strength training, and movement retraining so the injected tissue is not asked to function in the same destructive environment
- Realistic goals, such as decreasing pain by half and delaying or avoiding surgery, not turning a severely degenerated spine into that of a teenager

Outside orthopedics, for autoimmune or neurologic uses, candidacy becomes much more complex. Those therapies are often in clinical trial territory rather than routine practice. Safety, mechanism, and dose are less well understood.

If you are trying to decide for yourself who is a good candidate for regenerative medicine, a practical starting point is this. If conventional options have failed or are unacceptable to you, if your diagnosis has at least some supportive data for biologic therapies, and if you can afford the treatment without financial harm, then a consultation with a reputable regenerative specialist is reasonable.

Is regenerative medicine painful?

The honest answer is: usually mildly to moderately uncomfortable, occasionally very painful for a short period, and almost always manageable if done properly.

For PRP or bone marrow based injections into joints or tendons, the pain profile depends on the site and technique. Drawing blood for PRP is like any blood test. Harvesting bone marrow from the iliac crest has a reputation, but with local anesthetic and good technique, most patients describe it as pressure plus a brief, deep ache.

The injection itself can create a post procedure flare that lasts a few days. That is actually part of the intended healing response. Many clinics use oral pain medications, ice, and temporary activity modification to get patients through that window.

Spine injections or deeply placed hip or shoulder injections can be more intense in the moment, which is why image guidance and experienced hands matter so much.

Stem cell infusions through an IV are generally well tolerated. Some patients feel transient chills, fatigue, or flu like symptoms afterward, which may represent an immune response to the infused cells and their secreted factors.

If you are nervous about pain, tell your doctor ahead of time. There are different options for numbing, mild sedation, or staged procedures that can make it more comfortable.

What are the 4 types of regeneration?

Biologists use several different ways to classify regeneration, and textbooks sometimes debate the exact categories. In a clinical context, when patients ask about “types of regeneration,” they are usually blending biologic theory with medical practice.

A reasonable framework that bridges the two looks like this:

1. Epimorphic regeneration, where a structure regrows from a mass of proliferating cells, as in salamander limb regrowth. Humans have limited capacity for this; fingertip regrowth in young children is a classic example.
2. Compensatory regeneration, where remaining tissue enlarges or changes function to replace lost capacity, like the liver regrowing volume after partial resection. Many human organs rely on this principle.
3. Cellular or stem cell mediated regeneration, where resident or transplanted stem or progenitor cells restore or replace specific cell populations. This is what most people picture when they hear “stem cell therapy.”
4. Tissue engineering and scaffold based regeneration, where cells, biomaterials, and mechanical forces are combined to guide repair, for example lab grown cartilage constructs implanted into joints.

In modern regenerative medicine practice, procedures pull levers from these different categories rather than fitting cleanly into one box. A PRP injection into a tendon may stimulate resident cells (cellular regeneration), while also encouraging compensatory strengthening of surrounding structures through rehab.

What is the success rate of regenerative medicine?

There is no single success rate, just as there is no single antibiotic success rate. Everything depends on the condition, the specific treatment, and the definition of success.

For example, PRP for mild to moderate knee osteoarthritis has shown, in multiple controlled studies, that roughly 60 to 80 percent of patients experience meaningful pain relief and functional improvement compared to baseline at 6 to 12 months. That does not mean complete cure, and it does not last forever, but it is better than many standard options in appropriately chosen patients.

For chronic tendinopathies like tennis elbow or patellar tendinitis, PRP and other biologics also show moderate to strong evidence of benefit in a majority of patients.

On the other hand, intravenous infusions of allogeneic stem cells for systemic anti aging or general wellness have far Regenerative Medicine Doctor Scottsdale less rigorous data. Here, “success” is often self reported energy, sleep, or vague improvements that are hard to quantify, and placebo effects loom large.

When evaluating advertised success rates, ask three questions:

What exactly are they measuring? Pain scores, time to surgery, strength, imaging changes, or just subjective satisfaction?

Over what timeframe? A 3 month boost that fades is not the same as sustained improvement at 2 years.

In which patients? Early stage disease in healthy, athletic individuals behaves very differently from late stage disease in deconditioned, multi morbid patients.

If a clinic quotes a 90 plus percent success rate for almost everything, without details, that is a red flag.

Does fasting for 72 hours regenerate cells?

The notion that a 72 hour fast can “reset your immune system” or regenerate cells came from intriguing mouse studies and small human data suggesting that prolonged fasting may reduce circulating white blood cells and promote a rebound of new immune cells once feeding resumes.

Mechanistically, fasting upregulates processes like autophagy, where cells clear damaged components, and can shift stem and progenitor cell behavior in certain tissues. It is a biologically plausible way to nudge regeneration and repair, at least modestly.

However, translating that into “three days of fasting will regenerate your body” is too strong. In real humans, the effects are variable, and longer or repeated fasting is not benign. It can stress the cardiovascular system, destabilize blood sugar, and cause lean mass loss without careful planning.

In practice, I see fasting as one tool among many that can support cellular housekeeping and metabolic health in selected individuals, not a primary regenerative treatment. Anyone with diabetes, cardiovascular disease, or on multiple medications should not embark on a 72 hour fast without medical supervision.

What are the disadvantages of regenerative medicine?

Regenerative treatments come with trade offs that need to be understood upfront.

The most obvious is cost. What is the average cost of regenerative medicine for an orthopedic application like PRP or autologous cell injections in the US tends to fall somewhere in the 800 to 2,500 USD per joint range for PRP, and 3,000 to 8,000 USD or more for bone marrow or adipose derived cell procedures. Offshore stem cell trips like Rogan’s can run 10,000 to 30,000 USD or higher, including travel.

Then there is uncertainty. Even in the best indication, response rates are not 100 percent. Some patients see little or no benefit despite the expense and effort.

Timing is another disadvantage. Regeneration, when it happens, often unfolds over weeks to months. If you need an immediate structural solution, as in a complete tendon rupture retracting far from its origin, surgery may be far more reliable.

Regulation and legal recourse add a layer of risk. If you go to a country or clinic offering therapies outside your home jurisdiction, you may have limited options if something goes wrong.

Finally, the field moves quickly. A therapy that looks promising today may be outdated in a few years, or vice versa. That is exciting scientifically, but frustrating for patients making high stakes decisions now.

Will insurance pay for regenerative medicine?

At this point, "Will insurance pay for regenerative medicine?" is usually answered with: not really, at least not for the procedures that most people have in mind.

In the United States and many other countries, insurers typically:

- Do not cover PRP for orthopedic uses, labeling it investigational, though there are rare exceptions in specific plans or situations
- Generally do not pay for stem cell or other cell based injections for musculoskeletal conditions outside clinical trials
- May cover some tissue grafts or biologic implants used by surgeons in the operating room under different billing codes

When patients ask specifically, "Does insurance cover Kinetix?" referring to branded regenerative products or protocols, the answer is almost always no if the product is categorized as experimental or not explicitly included in the plan's coverage policies. Kinetix labeled services are usually positioned as cash pay.

There are a few narrow corridors where regenerative adjacent therapies are covered, such as certain wound healing products for diabetic ulcers, or surgical uses of bone graft substitutes. But the kinds of office based PRP or stem cell injections popularized in sports and wellness circles are, for now, out of pocket.

What country is best for stem cell treatment?

Patients often frame it that way: "What country is best for stem cell treatment?" That framing hides an important distinction. Best for access is not always best for safety or evidence.

The United States, Canada, much of Western Europe, and a few other regions have stricter regulations. That limits some innovative uses, but it also protects patients from the most unproven or risky interventions. If you are eligible for a formal clinical trial, those countries may be among the best places to receive highly monitored, research grade stem cell therapies.

Countries like Panama, Mexico, and certain Asian or Eastern European nations are more permissive. That allows clinics there to offer cell doses and preparation methods that are not legal in the US outside trials, as in Rogan's case. Some of these centers are run by capable physicians collaborating with serious scientists. Others are not.

Rather than asking which country is best, a more productive question is: which specific clinic, for my specific condition, has the strongest combination of safety standards, realistic indications, transparent data, and follow up? That answer may be local, or it may be abroad, but it will never be "every clinic in Country X."

How Joe Rogan's story should inform your decisions

Rogan's stem cell journey has energized public interest in regeneration, and there is value in that. Hearing a high profile, physically demanding individual describe a meaningful improvement pulls this field out of abstract science and into lived experience.

At the same time, his protocol sits toward the adventurous edge of current practice. High dose, allogeneic, offshore stem cell therapies are not routine medicine. They sit in a space where early promise, personal testimony, regulatory gaps, and commercial incentives all intersect.

If you are considering regenerative medicine for yourself, the practical path forward is more grounded.

Start by clarifying your diagnosis, current imaging, and what has already been tried. Seek a consultation with a physician who has a core specialty relevant to your problem and additional training in biologic therapies. Ask about specific evidence for your condition, realistic success percentages, and what failure looks like.

Understand the full cost, including follow up and rehab, and how it fits your budget if insurance does not contribute. Identify where on the spectrum you are comfortable sitting: more conservative, mostly autologous treatments with stronger data, or more speculative, often offshore protocols closer to what Rogan pursued.

Most importantly, remember that regenerative medicine is a tool, not a miracle. Used wisely, for the right person at the right time, it can extend the lifespan of a joint, help a tendon finally heal, or reduce the need for certain medications or surgeries. Used indiscriminately, it can drain resources and hopes with little to show for it.

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